Trinity College Dublin
Coláiste na Tríonóide, Baile Átha Cliath
The University of Dublin

Tallaght 2024

Health Assets and Needs Assessment (HANA)

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South Dublin County Council
CDI Childhood Development Initiative

Acknowledgements

The Research Team would like to express sincere thanks to the Adelaide Health Foundation and the Health Service Executive (HSE) Dublin South City & West, Dublin South West, Kildare & West Wicklow Integrated Healthcare Areas, HSE Dublin & Midlands for funding this research. We are also grateful to Tallaght University Hospital, Childhood Development Initiative, South Dublin County Council and South Dublin County Partnership for their invaluable resources, inputs, and support throughout the project, and particularly their facilitative help in the collation of data for the health assets.

We appreciate the expertise and resources provided by the HSE Health Intelligence Unit, HSE Health & Wellbeing and to Orla Sheridan in the School of Natural Sciences, Trinity College Dublin in creating the asset maps. We thank Dr Allyson Gallant for her assistance with producing the infographics to display some of the data visually. A special thanks to the market research team from Ipsos B&A (Behaviour and Attitudes) who conducted fieldwork on behalf of Trinity College Dublin.

Finally, and most importantly, we wish to thank all the households in Tallaght who gave generously of their time to participate in this research.

Foreword

As Chair of the Steering Committee for the 2024 Health Assets and Needs Assessment (HANA), it is with great pride that I present this third iteration of our study. Since its inception in 2001, and subsequent round in 2014, the HANA project has been integral to understanding the evolving needs and assets of Tallaght's community. Each cycle has provided us with invaluable insights into the health landscape of Tallaght, informing targeted, evidence-based actions to promote community wellbeing.

This iteration arrives at a pivotal moment for Tallaght, reflecting not only increasing demands for care but also substantial investments and progress in healthcare infrastructure and community health and wellbeing services. Tallaght University Hospital has expanded its capacity significantly over the last decade, with new outpatient and diagnostic facilities, while HSE Community Care Services have introduced enhanced home care packages, mental health supports, and community-based clinics. These advancements represent a commitment to addressing both acute and long-term health needs in a rapidly evolving environment. There has been significant investment by South Dublin County Council in terms of how the built environment can be altered to enhance wellbeing within communities including enhancements to parks and play spaces, and new cycle and walking infrastructure to promote active travel and social connectedness. Similarly, South Dublin County Partnership has continuously invested time and resources into supporting social capital in communities around the 13 Electoral Divisions (EDs).

The 2024 HANA study builds on the robust methodologies established in previous assessments, combining rigorous household surveys with comprehensive mapping of community assets. In addition to identifying needs, we have updated the inventory of healthcare, recreational, and community resources, highlighting how these assets can support the wellbeing of Tallaght's residents. This innovative approach enables us to not only address deficits but also leverage existing strengths to promote sustainable, community-driven solutions.

This study paints a vivid picture of a community experiencing significant demographic shifts. An ageing population, rising homeownership, and changes in employment patterns underscore the importance of tailoring policies to meet evolving needs. At the same time, the report reveals persistent challenges, including concerns about anti-social behaviour, financial strain, and barriers to accessing healthcare and other essential services. These findings call for a proactive, multi-sectoral approach to enhance community safety, health equity, and social cohesion.

The recommendations arising from this assessment are ambitious yet achievable. They range from improving cycling and walking infrastructure to addressing gaps in mental health services, and from supporting smoking cessation initiatives to enhancing access to chronic disease management programmes. Importantly, the report highlights the need to accelerate the implementation of Sláintecare, Ireland's roadmap for integrated and equitable healthcare. By addressing cost barriers, reducing waiting times, and expanding localised services, Sláintecare represents a pivotal opportunity to transform healthcare delivery in Tallaght and beyond.

This report is a testament to the power of collaboration and dedication. I extend my deepest gratitude to the residents of Tallaght who shared their experiences and gave generously of their time to participate in this research. I also thank the dedicated research team from Trinity College Dublin and the Adelaide Health Foundation and the HSE Dublin South City & West, Dublin South West, Kildare & West Wicklow Integrated Healthcare Areas, HSE Dublin & Midlands whose funding and support made this study possible. Special thanks go to all our partners involved in this project – the HSE Health Intelligence Unit, Tallaght University Hospital, Childhood Development Initiative, South Dublin County Council, and South Dublin County Partnership for their invaluable inputs, resources, and support. It is through these collective efforts, reflecting a shared commitment to Tallaght's community, that we can continue to drive meaningful change and ensure a healthier future for all.

As we move forward, I encourage policymakers, funders, community leaders, healthcare staff, and residents to engage with this report, embrace its findings as a guide for action and collaborate to deliver sustained, meaningful change for residents. Together, we can build a healthier, more connected, and more resilient community in Tallaght.

Marian Quinn,

Chair of the Health Assets and Needs Assessment in Tallaght Steering Committee
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Glossary of terms

Asset: A useful and valuable factor or resource, which enhances the ability of individuals, communities, and populations to generate, maintain and sustain health and wellbeing.

Asset mapping: A process of building an inventory of assets within a community, of physical structures such as community centres, parks, or health centres.

Chronic illness: An illness which has a long duration with progression of symptoms impacting on physical, emotional, and mental wellbeing of individuals, leading to a reduced quality of life and increased morbidity and mortality. For example, cardiovascular disease (heart attacks and stroke), cancers (particularly breast, prostate, and colonic cancer), chronic respiratory diseases (chronic obstructive pulmonary disease and asthma) and diabetes.

Chronic Disease Management (CDM) hub/treatment programme: The programme is for people aged 18+ years who have a medical card, GP visit card or a Health Amendment Act card and have a specific chronic disease or diseases (i.e., type 2 diabetes, asthma, chronic obstructive pulmonary disease (COPD), and cardiovascular disease, including heart failure, heart attack, stroke, and irregular heartbeat.

Cluster sampling method: a method of sampling where the population is divided into groups, known as clusters, and a random sample of these clusters is selected to represent the whole population.

Community Healthcare Network (CHN): A local system that organises and delivers integrated care, including services for older people, emergency care and specialised teams for managing chronic diseases.[1]

Community Specialist Teams (CSTs): Healthcare teams that support individuals aged 16 and over with chronic illnesses by providing early detection and intervention, diagnostic services, GP access, specialist community support and targeted help for conditions such as COPD.[1]

Disability Allowance: A means tested weekly allowance paid by the Department of Social and Family Affairs to a person with a disability, who is over the age of 16 years.

Deprivation Index (DI): Using data from the CSO Census 2022, the Pobal HP Deprivation Index measures an area's level of disadvantage by educational background, employment status, and the numbers of individuals living in a household.[2]

Electoral Division (ED): The smallest legally defined administrative areas in Ireland for which Small Area Population Statistics are published from the CSO Census 2022.

Geographical information system (GIS): A computer software programme used to deal with spatial information by integrating digital data, computer hardware and software. This is achieved through data processing, visualization, geo-processing, and analysis to reveal spatial relationships, patterns, and trends in the form of maps.

Health asset assessment: An asset-based health assessment approach helps to identify the protective and promoting factors that affect health and wellbeing.

Health needs assessment: A health needs assessment seeks to determine what is 'lacking in the physical, social, psychological and environmental conditions under which residents of the area live and what can be done to improve them'.

Health & wellbeing: A state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity.

Healthy Ireland: A Government strategy, which seeks to improve the health & wellbeing of the population of Ireland.

Integrated Healthcare Areas (IHAs): Local regions within larger healthcare areas that combine community health services and specialists to care for up to 300,000 people, providing access to hospitals and support services tailored to local needs.[3] Areas covered in the remit of this project are Dublin South City & West, Dublin South West, Kildare & West Wicklow Integrated Healthcare Areas, HSE Dublin & Midlands.

Primary carer (respondent): The primary carer is the person in the household who manages the welfare and health of the family/household. In a house of renters this was the person who pays the bills or whose name was on the rent agreement. For clarity, primary carers are referred to as "respondents" throughout the report.

Small Area Health Research Unit Deprivation Index (SAHRU DI): Four indicators are used to create the index: Unemployment, Low social class, No car, and Local authority rented accommodation.

SLAN: 'Survey of Lifestyle, Attitudes and Nutrition in Ireland' - a national survey conducted in Ireland in 2007.

Social capital: This refers to a person's sense of social connections or social networks within a community. An important facet of this is 'trust' which is seen as a determinant of social connectedness.

Social prescribing: A free service where GPs and other health professionals signpost patients to a range of non-clinical community supports which can have significant benefits for their overall health and wellbeing. For example, dance classes, walking groups, arts and crafts workshops, supportive peer networks, cooking classes, caregiver supports, volunteering roles, gardening/allotments etc.

Tallaght: The 13 electoral divisions of Tallaght i.e., Belgard, Glenview, Kilnamanagh, Kingswood, Millbrook, Oldbawn, Springfield, Avonbeg, Fettercairn, Jobstown, Killinarden, Kiltipper, and Tymon (North and South).

TLC: Tallaght, Lucan and Clondalkin GP 'out-o-hours' co-operative service, located in Carbury House, Tallaght.

Summary

What we set out to do:

- We set out to update the findings of a health needs assessment carried out in Tallaght in 2001 and 2014. In addition, we wished to assess the health and wellbeing assets of the participating households in relation to what is available in the community in 2024. This asset-based mapping aspect was not included in the 2001 survey but was included in 2014.

How we did it:

- Similar to Rounds one and two, we conducted a household survey across the 13 Electoral Divisions (ED's) of Tallaght. We mailed invitations to participate in the survey to 420 randomly selected households.
- Using a cluster sampling method (see glossary for definition), we selected 420 households from addresses provided by the Health Service Executive's National Health Intelligence Unit. This approach ensured a geographically representative sample from across Tallaght.
- From the 13 ED's, we randomly chose 30 clusters, each consisting of seven adjacent households. We selected these clusters from both the six less deprived and seven more deprived electoral divisions. To account for potential low response rates, we also sent invitation letters to three additional households per cluster.
- For areas with high non-participation or where addresses were found to be ineligible, we sent follow-up letters either as reminders or to replace ineligible addresses.
- A market research company were contracted to carry out the survey field work data collection across all 13 ED's of Tallaght.
- The market research company conducted interviews in person in homes using a structured questionnaire (Appendix A).
- The research team analysed the collected data to develop evidence-based recommendations aimed at improving community health and wellbeing across Tallaght.
- We updated and expanded on the inventory of assets from the previous round conducted in 2014 and created a series of maps which physically plot the location of healthcare services and facilities, community facilities, parks and hobby or recreational facilities.

What we found:

Response rate: A total of 274 randomly selected households completed the survey from a total of 420 households invited. This represented a response rate of 65.2%.

In previous rounds, the response rate was 81.6% in 2014 (N=343/420) and the 81.9% (N=344/420) in the 2001 health needs assessments.

The people of Tallaght: This report provides a detailed demographic and socio-economic profile of individuals and households involved in the study. We highlight the composition, employment status, housing characteristics, and educational attainment of household members. We provide an overview of the quality of home life and living conditions of households. We examined aspects such as car ownership, digital literacy, accessibility to essential services, and financial wellbeing. We report on the health and wellbeing of the members of the household, including their experiences of using community services and local healthcare services, such as community centres as well as Tallaght University Hospital and local primary care and general practice services.

Figure 1 Summary of key demographic findings of the households

Demographic characteristics of households

43% of respondents were employed full-time
up 14% since 2001

67% of respondents were female: 91% identified as White

50% of respondents were married:
1 in 4 were single

Household tenure

Household composition

Household size

68% of households contained 2-4 members

Change in population age

3X Increase in adults aged 65+ living in Tallaght between 2001-2024

Car ownership

3 in 4 households owned a car

Health cover

Demographic characteristics of households:

Household composition:

- A total of 755 individuals were reported across participating households.
- Of these household members, 52.1% (N=247/ 474) were children, 35.4% (N=168/474) were spouses, and 12.4% (N=58/474) included other relatives or non-family members.
- Gender distribution was nearly equal, with 51.2% (N=383/748) identifying as female and 48.1% (N=360/748) as male.
- Age groups were well represented, with the highest proportion in the 40-49 age group (19.9%; N=148/743) followed by 30-39 (14.9%; N=111/743) and 50-64 (14.7%; N=109/743).
- Individuals aged 0-9 years accounted for 13.6% (N=101/743) and 65+ years accounted for 13.9% (N=103/743) of the population, highlighting a presence of both young children and older adults.

Changes to the age of the population over time:

- Growth in the older population was seen with the proportion of adults aged 65+ years tripled, increasing from 3.4% (N=45/1,313) in 2001 to 13.9% (N=103/743) in 2024, marking the most dramatic shift.
- There is a decline in younger populations. For example, children aged 0-9 years rose to 16.7% (N=178/1,065) in 2014 but declined to 13.6% (N=101/743) by 2024; teens (10-19 years) and young adults (20-29 years) showed consistent decreases, with young adults dropping from 19.7% (N=259/1,313) in 2001 to 9.3% (N=69/743) in 2024.
- There were some fluctuations in the middle age groups, with the 30-39 age group showing variability, while the 40-49 age group rose significantly from 9.8% (N=104/1,065) in 2014 to 19.9% (N=148/743) in 2024.
- These findings underscore a shift toward an older demographic, with declining proportions of younger age groups and increasing numbers in middle and older age categories.

Household characteristics:

- Most households consisted of two to four members (67.6%; N=184/274); the average household size was 1.91 persons, with the median size being two: lower than the national average of 2.74 persons per household.[4]
- Most respondents had lived in their current household for less than 10 years (38.7%; N=106/274), though 27.7% (N=76/274) had resided there for over 30 years.

- Looking at changes over time, the percentage of households living in their homes for 0-10 years remained stable (35.9%; N=122/340) in 2001 and (38.7%; N=106/274) in 2024. Similarly, those living in their homes for 31+ years grew significantly from 3.2% (N=11/340) in 2001 to 27.7% (N=76/274) in 2024 (X^2 = 117.35, $p < 0.001$).

Housing tenure:

- Ownership rates were high, with 38.0% (N=104/274) owning their homes outright and a further 26.6% (N=73/274) having a mortgage.
- About 17.9% (N=49/274) were renting through public schemes, and 13.9% (N=38/274) rented privately.
- There were shifts in home ownership over time, with outright ownership increasing from 21.7% (N=74/341) in 2001 to 38.0% (N=104/274) in 2024, while reports of those with a mortgage decreased from 42.2% (N=144/341) to 26.6% (N=73/274) in 2024. There was an increase in private rentals, with households renting privately rising from 4.1% (N=14/341) in 2001 to 13.9% (N=38/274) in 2024.

Employment status:

- Among working-age household members, 41.3% (N=305/738) were employed full-time, and 26.9% (N=199/738) were engaged in education.
- A smaller proportion were retired (12.5%; N=92/738), working part-time (7.3%; N=54/738), or unemployed (2.6%; N=27/738).
- Full-time employment among respondents rose from 29.1% (N=100/344) in 2001 to 43.4% (N=119/274) in 2024, while part-time work decreased from 25.0% (N=86/344) to 14.2% (N=39/274) (X^2 = 38.46, $p < 0.001$).

Respondent demographics:

- The majority of respondents were female (67.2%; N=184/274) in the 2024 round. This represented a decrease from 93.0% (N=320/344) in 2001, while male respondents increased from 7.0% (N=24/344) to 32.8% (N=90/274) over the same period (X^2 = 77.22, $p < 0.001$).
- In terms of age, 39.1% (N=107/274) were aged 35-49, while 23.4% (N=64/274) were over 65 years old. Looking at the age profile over time, the proportion of respondents aged 65+ years grew from 7.1% (N=26/341) in 2001 to 17.8% (N=65/274) in 2024, while the younger age group (20-34 years) declined from 23.5% (N=80/341) to 13.9% (N=38/274) (X^2 = 49.65, $p < 0.001$).
- Ethnic background was predominantly White (90.5%; N=248/274), with smaller representations from Asian or Asian Irish (5.5%; N=15/274) and Black or Black Irish (3.3%; N=9/274) groups.

Education and language proficiency:

- Educational attainment varied among respondents: 25.5% (N=70/274) had a degree or professional qualification, while 16.8% (N=46/274) held technical or vocational training.
- Looking at changes over time, the proportion of respondents with a degree or higher increased from 5.2% (N=18/344) in 2001 to 34.6% (N=95/274) in 2024, while those with primary education or less dropped from 36.0% (N=124/344) to 8.4% (N=23/274) ($X^2 = 152.92$, $p < 0.001$).
- Approximately 17.2% (N=47/274) of respondents reported speaking a language other than English or Irish at home, with nearly all indicating proficiency in English.

Marital and employment status:

- Half of the respondents were married (50.0%; N=137/274), while 25.9% (N=71/274) were single.
- Employment was varied, with 43.4% (N=119/274) working full-time, 21.9% (N=60/274) retired, and 14.2% (N=39/274) employed part-time.

Car ownership:

- A significant majority (75.2%; N=206/274) of households own a car, providing greater mobility and access to services, while 24.8% (N=68/274) do not have a vehicle. The percentage of households with car ownership remained consistent over time, with 77.0% (N=264/343) in 2001 and 75.2% (N=206/274) in 2024.

Health cover:

- Among the 274 respondents, 36.1% (N=99/274) reported having private medical insurance, 35.0% (N=96/274) had a medical card/GMS, 24.5% (N=67/274) had neither medical card nor private insurance, 10.9% (N=30/274) had a doctor visit card, and a small, unspecified number (~) were unsure of their health cover status.
- Looking at changes over time the trends in health cover indicated that private health insurance uptake increased from 32.8% (N=113/344) in 2001 to 36.1% (N=99/274) in 2024, while reliance on medical cards dropped from 54.8% (N=187/341) in 2014 to 35.0% (N=96/274) in 2024 ($X^2 = 113.21$, $p < 0.001$).

Figure 2 Summary of key quality of life findings

Quality of life

Top 3 'good' things about living in Tallaght

- Amenities 73%
- Community spirit 61%
- Proximity to parks, natural spaces 47%

Top 3 'bad' things about living in Tallaght

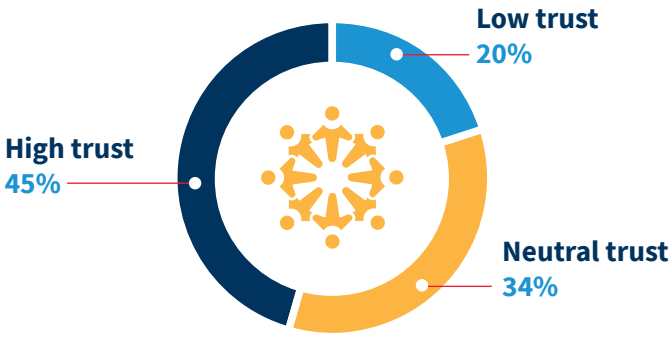
- Antisocial behaviour 72%
- Lack of amenities 61%
- CrIme & lack of Garda 33%

1 in 5 worried about debt all the time

16% were regularly cold at home due to energy cost savings

31% delayed or did not seek medical care due to costs

Social capital



Community behaviours

1 in 10 volunteered in the community

80% had concerns about antisocial behaviour, which affected their decisions to walk or cycle

98% reported easy access to fresh foods

78% found the air quality to be good or very good

73% reported good digital literacy skills

Quality of life:

Top three 'good' things about living in Tallaght:

- The availability of amenities (72.7%; N=173/238) was rated the best thing about living in Tallaght, followed by a strong sense of community spirit (61.3%; N=146/238) and Tallaght's proximity to other locations such as natural spaces and parks (47.4%; N=113/238).

Top three 'bad' things about living in Tallaght:

- A total of 71.7% (N=168/234) reported antisocial behaviour and not feeling safe, a lack of amenities (61.1%; N=143/234) and crime and lack of Gardaí (32.8%; N=77/234) as being the main 'bad things' about living in Tallaght.

Antisocial behaviour:

- A total of 80.6% (N=216/268) indicated that concerns about antisocial behaviour impacted their decision to walk or cycle in certain areas. Residents reported that gangs, drug use, and a lack of Gardaí presence contributed to feelings of insecurity.

Social capital:

- The respondents indicated a mixed perception of trust; a total of 20.4% (N=56/271) of respondents reported a neutral trust, 33.5% (N=92/274) expressed lower trust, 44.8% (N=103/274) reported higher trust levels (on a scale of 1-10), of this 7.3% (N=20/274) indicated the highest trust score of 10.

Community volunteering:

- Participation among respondents was low relative to the national average of 14.0% participating in volunteering.[5] Only 9.7% (N=26/267) of individuals reported involvement in volunteering activities within their neighbourhoods. The vast majority, 90.2% (N=241/267), indicated they do not participate in such activities.

Household energy and health costs:

- 16.0% (N=44/273) reported feeling cold in their homes regularly due to energy cost savings, while 20.1% experienced this occasionally (N=55/273).
- Financial constraints also impacted healthcare decisions, with 31.0% (N=85/269) delaying or forgoing medical care due to cost concerns.

Financial wellbeing:

- Financial worry is a concern for many: 19.3% (N=53/271) worry about debt "all of the time," while 34.7% (N=95/271) experience financial stress "sometimes".
- There is a gap in awareness of debt support services: 40.9% (N=112/274) were unaware of where individuals in debt could seek advice, though 30.3% (N=83/274) identified MABS as a primary resource.

Access to fresh food:

- Almost all respondents (97.8%; N=268/274) reported easy access to shops providing fresh fruit, vegetables, and meat, indicating strong food security within the community.

Local environmental quality:

- Air quality was generally rated positively, with 78.2% (N=212/271) describing it as "good" or "very good".
- However, 7.0% (N=19/271) rated it as "poor" or "very poor," suggesting some areas may be experiencing localised environmental issues.

Digital literacy:

- Approximately 72.9% (N=201/273) of respondents agreed or strongly agreed that they can use applications and programmes without assistance, while 20.8% (N=57/273) reported difficulty.
- Similarly, 74.8% (N=205/272) felt confident using video chat, and 68.2% (N=187/274) reported being able to solve basic technical issues independently.
- However, there remains a notable minority (N=57/273; 20.8%) who lack confidence in using digital tools, highlighting a need for support in digital skills.

Figure 3 Summary of key health & wellbeing asset findings

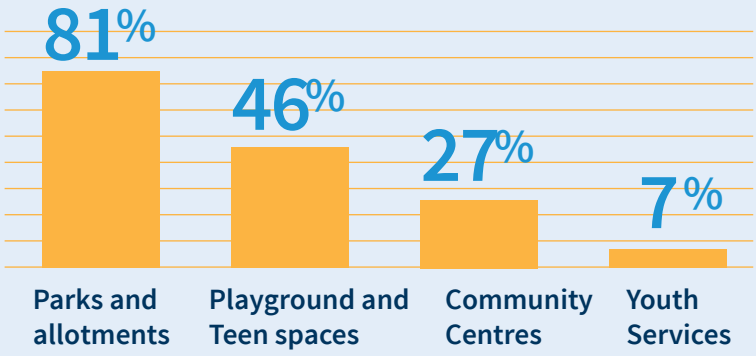
Health and wellbeing assets

98-100%

of respondents valued:

- Tallaght parks and allotments
- Playgrounds and teen spaces
- Community centres
- Sports clubs and facilities
- Hobby facilities

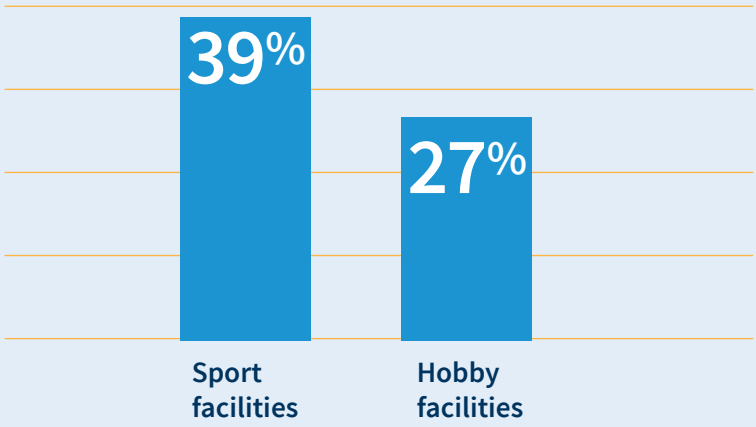
Use of community facilities



Public transport and connectivity

84% used public transport services

Use of sport and hobby facilities



Suggestions for improved facilities and connectivity

- More sport clubs
- Additional youth facilities
- Connecting cycle lanes
- Better street lighting
- Improved public safety

Health & wellbeing assets:

Comprehensive inventories of community services and amenities, including facilities for sports and hobbies, were developed and updated by the research team supported by project partners and community organisations. These resources were mapped across the 13 EDs in the area. During interviews, these inventories were shared with respondents to support their responses regarding service usage in Tallaght and to gauge their perceptions of these services as community assets.

- Amenity use and gaps: Although 63.2% (N=141/223) of households regularly used parks and allotments, 27.9% (N=24/86) reported a lack of amenities, especially for teenagers. Specific concerns were raised regarding the need for more sports clubs and youth facilities.

- Public transport and connectivity: Public transport services were highly utilised (84.3%; N=231/274), but 49.6% (N=136/247) opposed further expansion of active travel infrastructure. Suggestions included better cycling lanes and improved public safety, particularly around poorly lit areas and parks.

Community facilities inventory:

- 81.2% (N=223/274) of respondents used parks and allotments, primarily within Tallaght, with 100.0% (N=205/205) viewing them as beneficial.
- Playgrounds and Teen Spaces were used by 45.6% (N=125/274), with 99.1% (N=111/112) valuing these spaces.
- Community centres had a usage rate of 26.6% (N=73/274) and all users considered them valuable.
- Other services like youth and support groups had under 10.0% usage, but most considered these assets to be valuable in the community (ranging from 93.8% and 100.0%).

Sport and hobby facility inventory:

- In the past year, 39.1% (N=107/274) of respondents reported to use sports clubs and facilities, primarily within Tallaght (29.6%; N=81/107).
- 97.8% (N=91/93) of respondents viewed sports clubs and facilities as valuable community assets.
- 27.0% (N=74/274) of respondents used hobby facilities, the majority being within Tallaght (81.1%; N=81/107).
- 98.5% (N=91/93) considered hobby facilities beneficial to the community, with 66.2% (N=43/65) visiting them weekly.

Figure 4 Summary of key physical & social wellbeing findings

Physical and social wellbeing

39% rated their health as good; down 7% from 2014

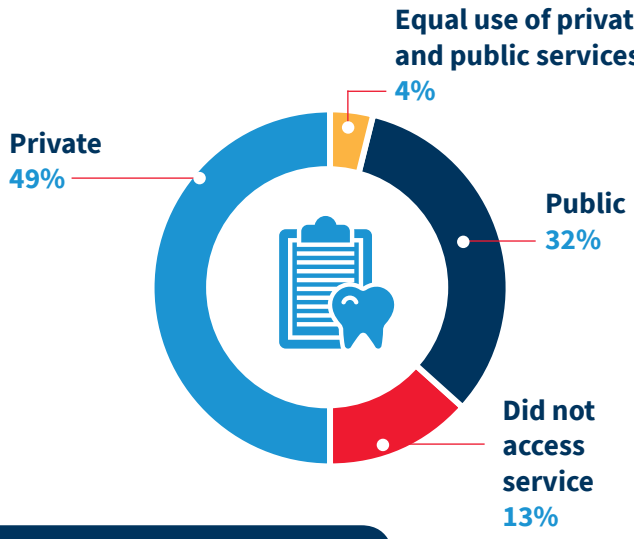
49% reported they would need dental work if they went to the dentist tomorrow

69% of households reported consuming alcohol

Physical activity

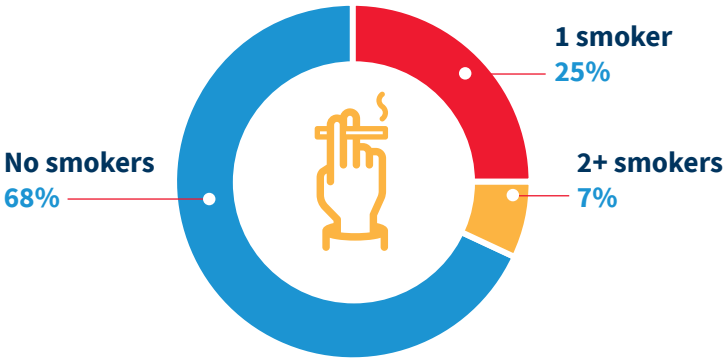
47% walked for 30 minutes or more a day more than 5 times a week

Accessing dental services



49% reported using over the counter pain medication regularly

Household smoking habits



37% decrease in 1+ smoker households since 2001

Physical & social wellbeing:

Self-rating of health:

- Most respondents reported 'good' (39.1%; N=109/273) or 'very good' (30.3%; N=83/273) health.
- In comparison to 2014, most respondents reported their own general health as being 'good' (46.2%) or 'very good' (24.6%).

Dental health:

- A total of 49.3% (N=135/274) of respondents reported they think they would need dental treatment if they went to the dentist tomorrow.
- A fifth of respondents (20.8%; N=57/274) reported occasionally experiencing pain or aching in their mouth in the last four months, with 55.8% (N=154/274) reporting never having experienced pain.
- Nearly half of respondents (49.3%; N=135/274) reported accessing dental services privately, followed by 31.7% (N=87/274) accessing through public dental care services and 13.1% (N=36/274) not accessing any dental care services.
- A total of 40.5% (N=111/274) reported visiting the dentist one to two times in the last two years.

Physical activity:

- A total of 64.7% (N=165/255) of respondents reported no strenuous exercise.
- Mild exercise was more common, with 27.9% (N=72/258) engaging in activities such as yoga or light walking more than five times a week.
- Walking was the most prevalent activity, with 46.6% (N=124/267) walking for more than 30 minutes daily.
- Since 2014, there have been statistically significant improvements in physical activity levels across all categories:
  - Reports of no strenuous exercise dropped from 83.2% to 64.7%. Those exercising less than five times a week increased from 14.1% to 29.4%, and more than five times a week rose from 2.7% to 5.8% ($X2=23.6$, $p < 0.001$).
  - Moderate exercise improved as well, with a reduction in no exercise from 57.0% to 43.7% and an increase in exercising less than five times a week from 27.3% to 40.6% ($X2=35.1$, $p < 0.001$).
  - For mild exercise, reports of no participation decreased from 35.3% to 26.3% ($X2=8.2$, $p < 0.01$).
  - Walking habits remained prevalent, though they slightly declined from 100.0% in 2014 to 97.4% in 2024 ($X2=7.2$, $p < 0.05$).

Smoking and vaping habits:

- Within households, 67.0% (N=183/270) reported no smokers and 82.0% reported no vapers (N=220/268).
- However, 25.0% (N=68/270) reported one person smoking, and 15.0% reported one person vaping (N=40/268). A small percentage (6.7%; N=18/270) had two or more smokers.
- Looking at trends over time, the proportion of households reporting one or more smokers decreased significantly over time (X^2=89.0, p<0.001), from 69.0% (N=238/344) in 2001 to 44.0% (N=151/340) in 2014, and further to 32.2% (N=87/270) in 2024. The proportion of households reporting no smokers increased inversely, from 30.8% (N=106/344) in 2001 to 55.6% (N=189/340) in 2014, and 67.8% (N=183/270) in 2024.
- Among respondents, 64.4% (N=56/87) identified as smokers, of which 41.1% (N=23/56) attempted to quit in the last 12 months, primarily using the “cold turkey” method (60.9%; (N=14/23).

Substance use in households:

- Alcohol was the most frequently reported substance used in the household (69.3%; N=190/274).
- Almost half (48.9%; N=134/274) reported using over-the-counter pain medications regularly, while the reported of use of illegal substances was minimal.
- Cannabis and weed were reported by a small proportion of households (2.6%; N=7/274 and 2.9%; N=8/274), respectively; and unprescribed sedatives such as Valium were used in 2.2% (N=6/274) of households.

Figure 5 Summary of key stress & loneliness findings

Stress and loneliness

2 in 3 respondents experienced stress in the past year

Reasons for stress

- 41% - Family
- 18% - Work/unemployment/study
- 17% - Finances

68% Experienced stress induced anxiety

24% Experienced illness-related stress

18% used prescription medication to manage stress

2X increase in financial stress since 2001

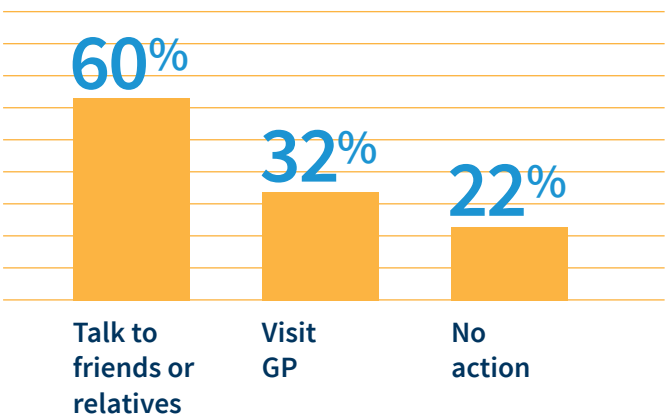
60% reported rarely of never feeling lonely

Stress symptoms

67% Experienced sleeplessness

51% Experienced irritability

Stress management



Stress and loneliness:

- A total of 66.1% (N=181/274) of respondents reported experiencing stress in the last 12 months, the primary reasons for stress were reported to be family 41.4% (N=75/181), work/unemployment/study 18.2% (N=33/181) followed by finances (16.6%; N=30/181).
- There were fluctuations in reported stress over time with the proportion of respondents reporting stress remaining high but varying significantly (X^2=7.88, p<0.05). Stress levels increased from 59.3% (N=204/344) in 2001 to 67.0% (N=227/339) in 2014, before declining to 54.9% (N=189/272) in 2024. The percentage rating their stress as 'very serious' increased from 19.2% (N=39/203) in 2001 to 31.6% (N=71/225) in 2014 but decreased slightly to 27.0% (N=51/189) in 2024 (X^2=19.18, p<0.05).
- There was a sense of the evolving causes of stress with family-related stress, the leading cause in 2001 (54.8%, N=108/197), declining to 38.6% (N=70/181) in 2024. Financial stress increased from 9.6% (N=19/197) in 2001 to 18.2% (N=33/181) in 2024. Illness-related stress rose steadily, from 18.8% (N=37/197) in 2001 to 23.7% (N=43/181) in 2024 (X^2=18.29, p<0.01).
- The most common stress-related symptoms included anxiety (68.3%; N=129/189), sleeplessness (67.2%; N=127/189), and irritability (51.3%; N=97/189).
- Stress management strategies varied, with 60.3% (N=114/189) talking to friends or relatives, 32.3% (N=61/189) visiting a GP, and 21.7% (N=41/189) taking no action.
- The preferred coping strategies changed somewhat over time with 'talking to friends or relatives' as the most common action, reported by 65.4% (N=125/191) in 2001 and 59.8% (N=113/189) in 2024. Visiting GPs peaked at 44.5% (N=101/227) in 2014 but dropped to 32.3% (N=61/189) in 2024.
- Despite high levels of stress, only 17.5% (N=33/189) used prescription medication, and online or peer support groups were underutilised.
- Loneliness was reported "hardly ever or never" by 59.5% (N=163/274) of respondents, while 29.2% (N=80/274) felt lonely "some of the time."

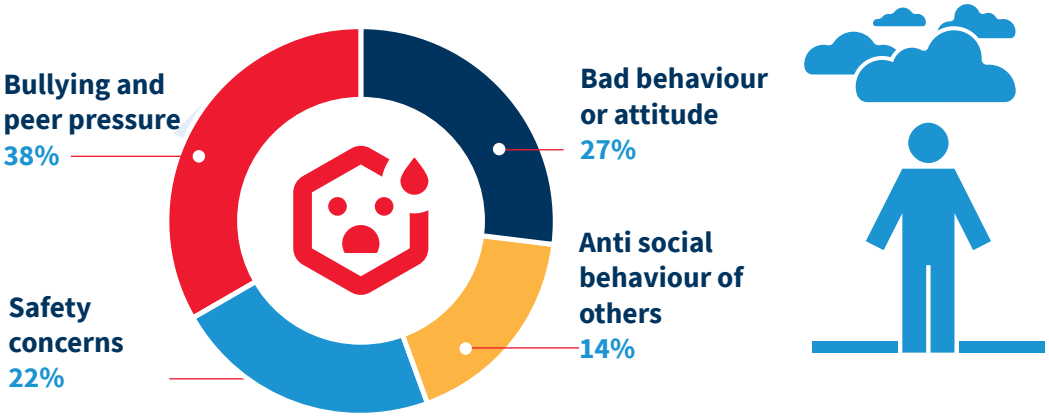
Figure 6 Summary of key teenage behaviour & family dynamics findings

Teenage behaviour and family dynamics

29% of respondents reported having teenagers in the household

Worrying about their socialising habits decreased from 60% in 2001 to 48% in 2024

Reasons for worrying



23% decrease in respondents reporting problematic behaviour with their teenager

78% of respondents are happy with their teenagers' friends

Teenage behaviour & family dynamics:

- Approximately 28.8% (N=79/274) of respondents had teenagers in the household, with 48.1% of these (N=38/79) expressing concerns about their socialising, primarily due to bullying, peer pressure (37.8%; N=14/79), and behavioural issues (27.0%; N=10/79).
- The proportion of respondents worrying about their teenager socialising decreased over time, from 59.6% (N=130/218) in 2001 to 48.1% (N=38/79) in 2024. Those not worrying increased from 40.4% (N=88/218) to 51.8% (N=41/79) during the same period.
- The percentage of respondents happy with their teenager's friends declined slightly, from 85.3% (N=186/218) in 2001 to 77.5% (N=69/79) in 2024. Conversely, dissatisfaction peaked in 2014 at 21.3% (N=19/89) before decreasing to 7.6% (N=6/79) in 2024.
- Reports of teenagers in the household displaying problematic behaviour showed a significant decline (X^2=13.67, p<0.01), from 45.5% (N=97/213) in 2001 to 22.7% (N=18/79) in 2024. Correspondingly, the proportion of respondents reporting no problematic behaviour increased from 54.5% (N=116/213) in 2001 to 77.2% (N=61/79) in 2024.
- Psychological or emotional conditions were present in 12.5% (N=8/64) of the teenagers, with over half of these (54.5%; N=6/11) having experienced these issues for more than two years.
- Despite these challenges, most affected teenagers had a diagnosis by a professional (72.3%; N=8/11), suggesting active engagement with mental health services.

Figure 7 Summary of key chronic illness & disability findings

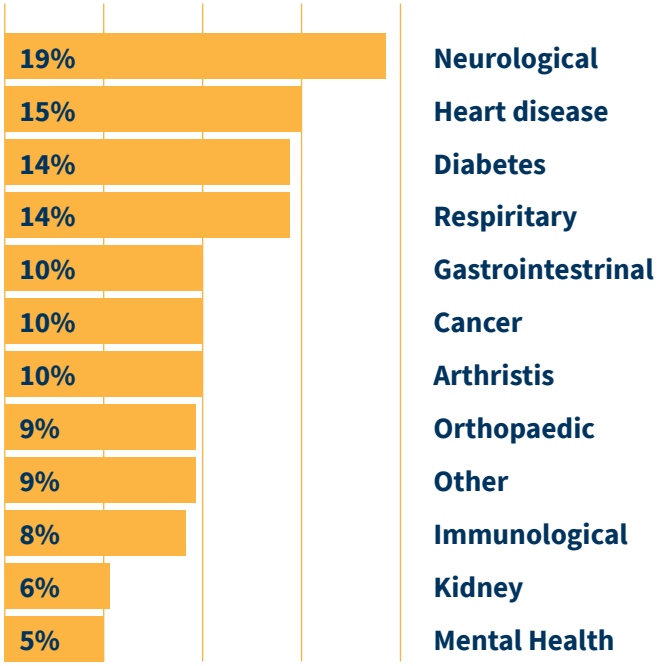
Chronic disease and disability

43% of individuals in the households reported having a chronic illness (N=111)

7% decrease in chronic disease prevalence since 2001

22% reported both a chronic illness and a disability

Most reported chronic illnesses



Chronic disease service utilisation

65% visited the GP for their chronic illness in the last 3 months

43% attended Tallaght University Hospital for their chronic illness in the last 3 months

15% used chronic disease management programme or hub

11% received home healthcare

1 in 3 with a chronic disease reported being on a waiting list for health services

11% of households received a disability allowance

Chronic illness & disability:

Prevalence of chronic illness:

- Among households surveyed, a total of 42.9% (N=111/259) of primary carers reported on individuals in the household having a chronic illness. 32.0% (N=83/259) reported having at least one individual with a chronic illness, and 5.4% (N=14/259) reported two individuals with a chronic illness.
- The most reported conditions included neurological disorders (18.9%; N=21/111), heart disease (15.3%; N=17/111), diabetes (14.4%; N=16/111), respiratory illness (14.4%; N=16/111), and gastrointestinal diseases (9.9%; N=11/111).
- Other conditions, such as cancer, orthopaedic issues, arthritis, immunological disorders, and mental health concerns, were also reported, highlighting a broad spectrum of health challenges within the community.
- Looking at changes over time, the proportion of individuals with a chronic illness has significantly decreased. In 2001, chronic disease prevalence was 21.6% (N=284/1313). This remained steady in 2014 at 21.6% (N=234/1082), before falling in 2024 to 14.7% (N=111/755). Changes in the types of chronic illnesses reported demonstrate evolving health trends over time. For example:
  - Heart disease was reported in 2001 as 23.6% (N=67/284), increasing slightly in 2014 to 29.1% (N=68/234), before decreasing significantly in 2024 to 15.3% (N=17/111). This reflects potential improvements in cardiovascular health management.
  - Reports of diabetes rose steadily from 7.7% (N=22/284) in 2001 to 12.8% (N=30/234) in 2014, reaching 14.4% (N=16/111) in 2024, indicating a growing burden of metabolic health conditions.
  - Respiratory conditions were reported in 2001 as 32.4% (N=92/284), dropping significantly to 12.4% (N=20/234) in 2014, with a slight rise to 14.4% (N=16/111) in 2024. This reflects sustained but plateauing reductions in respiratory illnesses.
  - Mental health and addiction increased from 4.9% (N=14/284) in 2001 to 10.3% (N=24/234) in 2014, before decreasing to 5.4% (N=6/111) in 2024, showing fluctuating trends in these conditions.
  - Reports of arthritis remained consistent over the years, from 8.1% (N=23/284) in 2001 to 7.3% (N=17/234) in 2014 and 9.0% (N=10/111) in 2024.
  - Chronic bowel disease saw an increase from 5.6% (N=16/284) in 2001 to 6.4% (N=15/234) in 2014 and 9.9% (N=11/111) in 2024, reflecting growing recognition or reporting.
  - While data on cancer were limited in 2001, reports rose from 5.6% (N=13/234) in 2014 to 9.9% (N=11/111) in 2024.
  - Neurological conditions showed a significant rise from 4.9% (N=14/284) in 2001 to 4.7% (N=11/234) in 2014 and 18.9% (N=21/111) in 2024, highlighting an increasing burden.
  - Orthopaedic conditions were not distinctly reported in 2001 or 2014 but were highlighted in 2024 at 9.9% (N=11/111), indicating emerging concerns about musculoskeletal health.

Healthcare utilisation for chronic illness:

- Of those with a chronic illness, 43.2% (N=48/109) attended Tallaght University Hospital in the last three months, and 33.0% (N=35/109) were currently on a waiting list for services.
- Primary care engagement was high: 64.8% (N=72/111) had visited a GP in the previous three months, with most (55.5%; N=40/72) making one to two visits. Repeat prescriptions and medical check-ups were the primary reasons for these GP visits (74.9%; N=29/39); Only 10.8% (N=12/111) received any form of healthcare at home, indicating a low uptake of home-based healthcare support despite significant chronic health needs.

Chronic disease management:

- Engagement with structured chronic disease management programmes was low, with 15.0% (N=16/107) participating in disease management hubs or programmes. This suggests a potential gap in the provision and uptake of chronic illness management services, which could benefit from increased support and awareness.

Prevalence of disability

- Disability allowance was reported in 11.2% (N=30/267) of households.

Prevalence of chronic illness and disability:

- 18.7% (N=50/267) indicated that one household member had both a chronic illness and a disability, while 3.7% (N=10/267) reported that two people in the household were affected.
- This dual burden of chronic illness and disability in some households underscores the need for comprehensive support services to address complex care needs.

Barriers to healthcare access and support:

- Limited use of home healthcare services (10.8%; N=12/111) and low engagement with public health nurse visits (9.0%; N=10/111) suggest barriers to accessing in-home support, which may be due to either availability or awareness.
- The findings indicate that while chronic illness is prevalent, healthcare service utilisation is fragmented, and there is an opportunity to enhance support for home care, structured management programmes, and integrated care pathways.

Figure 8 Summary of key experience of Tallaght University Hospital services findings

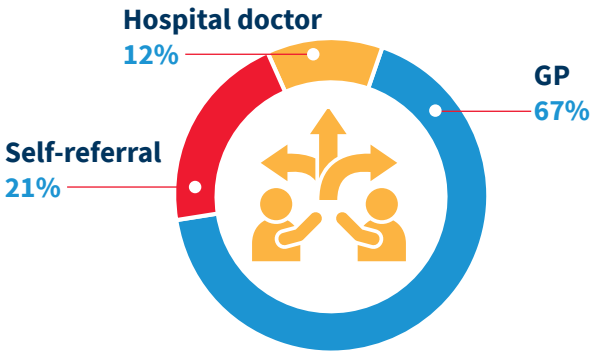
Experience of Tallaght University Hospital Services

47% attended TUH for tests or treatments in the last 12 months (N=125)

90% believed TUH is beneficial to the surrounding community

35% attended TUH Emergency Department in the last 12 months

TUH source of referral



67% were satisfied with services in TUH due to the:

- **77%** quality of care
- **76%** friendliness, respect and compassion provided by the staff
- **59%** good communication from the staff

41% would like to be involved in TUH decisions to change and improve services

57% reported waiting <24 hours before attending TUH Emergency Department

85% reported no unmet healthcare needs in the last 12 months

Top 3 reasons for attendance to TUH Emergency Department (N=95)

- General pain **24%**
- Respiratory and breathing issues **13%**
- Stomach and digestive issues **13%**

Experience of Tallaght University Hospital services

We highlight the findings on the utilisation, satisfaction, and community impact of services provided by Tallaght University Hospital (TUH), as experienced by respondents. The results encompass hospital visits, Emergency Department services, waiting lists, and suggestions for improvement, providing insight into the hospital's strengths and areas for development.

Utilisation of TUH:

- Nearly half (46.9%; N=125/266) of respondents attended Tallaght University Hospital for tests or treatment in the past 12 months, a significant increase from Round 2 which was 22.7% (N= 244/1077).
- The primary reasons for attendance included clinical investigations (27.2%; N=34/125), skeletal and muscular issues (12.8%; N=16/125), and heart and circulatory issues (12%; N=15/125).
- General Practitioners were the main source of referrals (67.2%; N=84/125), while 20.8% (N=26/125) were self-referrals.

Waiting lists:

- Most households (85.0%; N=229/269) reported having their healthcare needs met in TUH, with a small proportion (13.0%; N=35/269) reporting being on a waiting list due to delays in receiving treatment in TUH.
- Respondents suggested that reducing wait times (39.2%; N=78/199) and more staff (31.6%; N=63/199) would significantly improve the service.

Satisfaction with TUH services:

- Of those who used TUH services, 67.2% (N=84/124) reported being satisfied with their experience.
- The main reasons for satisfaction were the quality of care (77.4%; N=65/84) and the friendliness, respect, and compassion shown by staff (76.2%; N=64/85).
- A total of 32.0% (N=40/124) were dissatisfied, citing long waiting times (85.0%; N=34/40) and poor communication from staff (50.0%; N=20/40) as key reasons for discontent.

Impact of TUH on the community:

- A significant majority (89.8%; N=246/274) of respondents believe that TUH is beneficial to the surrounding community, primarily due to its location and proximity (71.1%; N=175/274) and the quality of services provided (20.3%; N=50/274).

Community involvement in TUH decisions:

- 14.6% (N=40/274) of respondents expressed a desire to be involved in decisions about service improvements, though 26.6% (N=73/274) indicated willingness if they felt it would make a difference.

Suggestions for improvement:

- When asked how TUH could improve, respondents prioritised hiring more staff, reducing waiting times, and enhancing communication with patients.
- A total of 72.6% (N=199/274) of respondents provided specific feedback on improvements, indicating high engagement and interest in seeing positive changes.

Experience with TUH Emergency Department services:

- A total of 34.7% (N=95/271) of respondents had attended the TUH Emergency Department in the previous 12 months, a reduction from 2014 where 39.6% (N=135/341) reported attending TUH Emergency Department.
- Self-referral was the primary source of referral (50.5%; N=48/95), followed by GP referral (28.4%; N=27/95) and 18.9% came in by ambulance (N=18/95).
- 'Out-of-hours' (43.8%; N=21/48) and GP was not available (21.3%; N=15/48) were the primary reasons for respondents not seeking care from another healthcare professional before attending the Emergency Department.
- More than half (56.8%; N=54/95) of respondents reported waiting less than 24 hours before attending, followed by 18.9% (N=18/95) waiting one to two days and 11.6% (N=11/95) waiting three to seven days.
- Reasons for dissatisfaction (66.3%; N=63/95), highlighted long waiting times (82.5%; (N=52/95) and poor communication (54.0%; N=34/95) as primary concerns.
- Nearly half of the households who attended TUH Emergency Department (45.3%; N=43/95) would recommend it to a friend or family member, suggesting scope for enhancing patient experience.

Figure 9 Summary of key general practice, 'out-of -hours' services and social prescribing findings

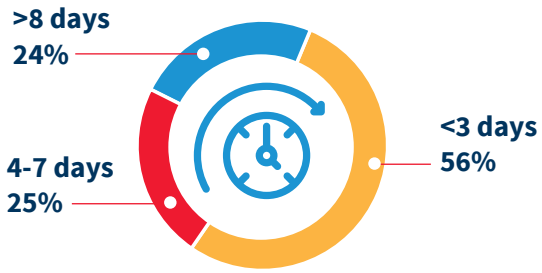
General practice, 'Out-of-hours' services and social prescribing

95% were registered with a GP

80% would recommend their GP

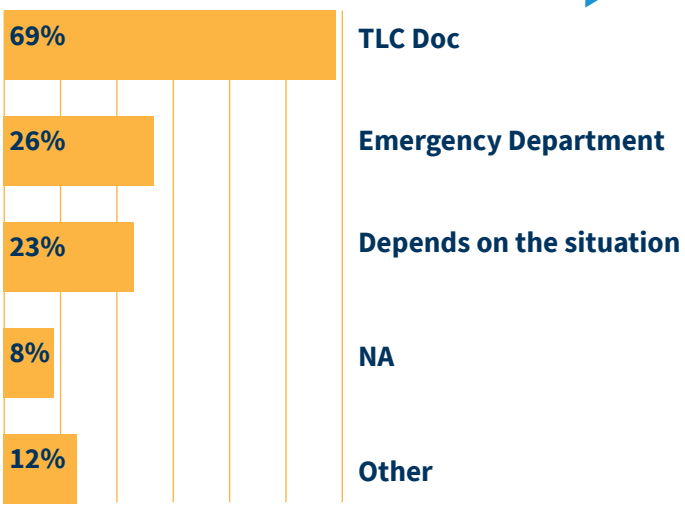
41% were satisfied with their 'Out-of -hours' options

Time to get an appointment



12% were aware of 'social prescribing' services (N=32)

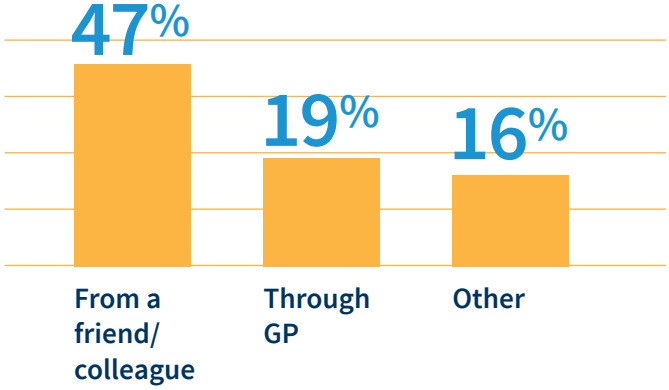
Where do you go 'out-of-hours'?



What might stop you from using social prescribing?

- **54%** Did not know about the service
- **13%** Availability of appointments
- **12%** No self-referral option/ have to go through GP

How did they hear about social prescribing?



General practice, 'out-of-hours' services and social prescribing:

General practice (GP) services:

- The majority (94.9%; N=260/274) of respondents are registered with a GP, with a small minority (4.4%; N=12/274) not registered due to reasons such as being on a waiting list or accessing services in other locations.
- While 55.7% (N=146/262) reported that their GP is within walking distance, 43.5% (N=114/262) stated their GP is not easily accessible by foot.
- In terms of appointment availability, 56.4% (N=140/248) were able to secure a GP appointment within three days, while 23.7% (N=65/248) reported waiting longer than eight days.

'Out-of-hours' services:

- When household members require 'out-of-hours' care, 69.2% (N=101/262) used the TLC Doc service, while 25.9% (N=71/262) go directly to the Emergency Department.
- Satisfaction with 'out-of-hours' services is low, with only 40.9% (N=112/262) expressing satisfaction and a significant proportion 38.7% (N=106/262) unsure about their options.

Satisfaction with GP services:

- Most respondents are satisfied with their GP with 81.6% (N=214/262) expressing satisfaction and 79.6% (N=218/274) reporting they would recommend their GP to others.
- A total of 18.3% (N=48/262) were dissatisfied, citing challenges such as waiting times and communication issues.

Social prescribing services:

- Awareness of social prescribing services is low, with 11.7% (N=32/274) of respondents having heard of these services prior to the survey.
- Of those aware, 46.9% (N=15/32) learned about it through a friend or colleague, while 18.8% (N=6/32) were informed via their GP surgery.
- Engagement is limited with 14.9% (N=11/74) reported being linked to a local service or activity through social prescribing, and 74.3% (N=55/74) stated they had not been connected to any specific services.

Barriers to using social prescribing services:

- The most cited barriers include a lack of awareness (53.6%; N=82/153), appointment availability (13.1%; N=20/153), and the need to go through a GP for referrals (11.8%; N=18/153).
- Additional barriers included distance, lack of transport, and concern over feeling judged.

Satisfaction with social prescribing services:

- Due to low awareness, satisfaction of social prescribing services was low, with 12.2% (N=9/74) reporting satisfaction and 68.9% (N=55/74) uncertain about the services.
- This indicates a need for improved outreach, education, and service delivery to enhance engagement and satisfaction.

Additional health services identified by the people of Tallaght:

Participants highlighted several key areas for improvement, including:

- Increased GP and Primary Care Services: 24.2% (N=46/190) indicated a need for more GPs to reduce waiting times.
- Mental Health and Addiction Services: 18.9% (N=36/190) called for more accessible mental health and addiction rehabilitation services.
- Specialised Healthcare Services: 14.2% (N=27/190) called for specialised services such as cancer treatment centres.
- Children's Services: There was a notable call (12.6%; N=24/190) for more paediatric and special needs services, particularly speech and occupational therapy.

Recommendations

1. Housing policy to meet the needs of a changing community:

Given the trends towards increased outright homeownership and private renting, alongside longer durations of respondents reporting living in their homes, housing policies should prioritise enhancing affordability and stability for renters in the private and public rental markets. This includes introducing measures to cap rent increases, increase the supply of affordable rental properties, and expand access to long-term rental agreements with consideration for private and County Council supports that provide tenants with greater security and stability.

2. Enhance safety measures to address anti-social behaviour:

Public safety is everyone's business and requires a joined-up response from all stakeholders. Implement community safety measures, such as improved lighting, enhanced Gardaí presence, and neighbourhood patrols to address the 80.6% (N=216/268) of respondents who reported avoiding walking or cycling in certain areas due to personal safety concerns. Alongside these measures, establish collaborative initiatives between residents, South Dublin County Council, the Gardaí, and community organisations to foster trust, strengthen social cohesion, and ensure long-term safety improvements. Engaging the community through education, outreach, and shared responsibility will help create safer, more inclusive public spaces.

3. Strengthen social capital and trust in the community:

Low levels of trust and a sense of insecurity are detrimental to social cohesion. Initiatives that encourage community interaction, such as neighbourhood associations, volunteer programmes, and community workshops, can rebuild trust and engagement. Programmes focusing on building relationships within and between neighbourhoods can foster a more connected and supportive environment.

4. Utilise local assets to further support social capital and community engagement:

Create a community resource that leverages existing asset inventories to enhance public awareness of healthcare, sport and hobby facilities, and community services. This resource would empower individuals to connect with local services and amenities independently. In partnership with community centres, social prescribing could be strengthened by improving programme delivery, increasing uptake and enhancing coordination between link workers, fostering greater community engagement and cohesion.

5. Promote community engagement and volunteering initiatives:

With only 9.7% (N=26/267) of respondents participating in community volunteering, the development of local engagement initiatives and volunteer programmes would foster a stronger sense of community.

6. Debt concerns and financial strain:

With high levels of worry about debt and economic insecurity, introduce financial literacy programmes and accessible support services, such as more localised Citizens Information centres and budgeting advice clinics. Partnerships with organisations like MABS (Monetary Advice and Budgeting Service) could help alleviate financial strain and reduce related stress, contributing to overall community wellbeing.

7. Address environmental concerns:

Enhance air quality monitoring and interventions in areas where 7.0% (N=19/271) of respondents rated air quality as ‘poor’ or ‘very poor’. Maintain strong access to fresh food, reported as ‘easy’ by 97.8% (N=268/274) to support community health.

8. Improve digital literacy:

Given that a significant portion of respondents report difficulty using digital tools, expand digital literacy programmes to improve confidence and skills in using technology for healthcare, education, and social connectivity. Partner with local libraries and community centres to provide training and access to resources for all, including greater accessibility to non-digital options.

9. Improve communication about existing amenities and recreational spaces:

Nearly two thirds of respondents (63.7%; N=141/223)reported that members of their household use existing recreational facilities, such as, playgrounds, allotments and parks. A notable minority identified gaps in amenities, particularly those catering for teenagers (27.9%; N=26/84)and a further minority (11.6%; N=10/86) indicated a need to enhance communication about existing amenities.

10. Improve cycling and walking infrastructure:

With only 43.6% (N=78/179) of respondents supporting the need for cycling infrastructure improvements and 40.5% (N=111/247) in favour of more active travel infrastructure, there is a need to create a comprehensive plan to connect existing cycle lanes, develop safe pedestrian routes, and consider bike rental schemes. Focus should be placed on high-traffic areas, schools, and public spaces as identified by participants.

11. Promote physical activity through community programmes:

To improve physical activity levels among respondents, it is essential to enhance and expand community-based physical activity programmes. With 64.7% (N=165/255) reporting no strenuous exercise and only 15.6% (N=40/256) participating in regular moderate exercise, targeted efforts are needed to encourage greater engagement. Building on the significant improvements observed between 2014 and 2024 (for example, the percentage of respondents reporting no strenuous exercise decreased significantly from 83.2% (N=278/334) in 2014 to 64.7% (N=165/255) in 2024); these initiatives should focus on accessibility, inclusivity, and sustainability. Expanding programmes such as community walking groups, yoga classes, or local sports activities can reach a wider audience and foster a supportive environment for physical activity. Providing incentives and tailored support, particularly for those currently inactive will help sustain participation. By highlighting success stories and promoting the practical and health benefits of regular exercise, these efforts can motivate more respondents to become active, improving overall well-being and community health.

12. Towards ‘smoke free’ homes:

To sustain and accelerate the decline in household smoking, targeted campaigns should focus on supporting the remaining 31.9% (N=86/270) of households with smokers through tailored cessation programmes (e.g., ‘We Can Quit’) and public health interventions, aiming to promote healthier, smoke-free environments. With more than one in five households affected, this is a key opportunity to make a lasting impact.

13. Improve access to affordable dental services:

With 31.0% (N=85/269) of respondents indicating that they had delayed healthcare due to costs and 49.3% (N=135/274) needing dental treatment, there is an urgent need to increase access to affordable dental services. Consider subsidising dental care and offering community health programmes focused on oral health education and regular check-ups.

14. Strengthen mental health and stress management support:

With 68.6% (N=188/274) of respondents experiencing stress in the last 12 months, predominantly due to family issues, illness, and finances, increasing access to mental health services, financial counselling, peer support groups, and stress management workshops would be highly beneficial. Promote community counselling services and make mental health resources more visible and easier to access (e.g., peer led Solace cafes), tailored to meet the evolving needs of the community.

15. Strengthen supports for positive adolescent development:

To support respondents and promote positive adolescent development, interventions should focus on addressing concerns about socialising, strengthening family relationships, and reinforcing positive behavioural trends among teenagers. Although concerns about teenagers socialising have decreased over time, they remain significant, with 48.1% (N=38/79) of respondents still worried in 2024. Additionally, satisfaction with teenagers’ friends has slightly declined, with 77.5% (N=69/79) of respondents happy in 2024, compared to 85.3% (N=186/218) in 2001. However, the decline in problematic behaviour—from 45.5% (N=97/213) in 2001 to 22.7% (N=18/79) in 2024—presents an opportunity to build on this positive trend by promoting further resilience and pro-social behaviours in teenagers.

16. Adapt healthcare priorities to address evolving chronic illness trends:

A significant proportion (42.9%; N=111/259) of households reported a member with a chronic illness. Expanding chronic disease management hubs and home care services would greatly benefit these individuals. To address the evolving trends in chronic illnesses, healthcare policymakers and providers should implement a multifaceted strategy focusing on prevention, targeted care, and robust data collection. This includes enhancing preventative health programmes to curb the rise in metabolic disorders such as diabetes, expanding specialised services for neurological and musculoskeletal conditions, sustaining successful interventions that have reduced respiratory and cardiovascular illnesses, and refining mental health services to address fluctuating trends. Additionally, improving the comprehensiveness and consistency of chronic illness reporting will facilitate evidence-based policymaking and efficient resource allocation, tailored to emerging health challenges.

17. Strengthen support systems for households affected by disability and chronic illness:

Given that 10.5% (N=28/267) of households' report having a member in receipt of disability allowance and 18.7% (N=50/267) of households indicate having a member with both a chronic illness and a disability, it is essential to enhance targeted support services to help address the specific needs of vulnerable households, promoting equity and wellbeing within the community. Policies should focus on increasing access to community-based healthcare and social support tailored to individuals with disabilities and chronic illnesses; streamlining eligibility processes for disability-related benefits to ensure timely support; and raising awareness of existing supports and services to improve uptake among eligible households.

18. Consider the expansion of the existing HSE Enhanced Community Care hubs:

The HSE's Enhanced Community Care programme currently focuses on older persons and persons with chronic disease. The integration of multiple services—GP, mental health support, addiction services, and chronic illness management—under one roof would streamline service provision and make it easier for residents to access the care they need in one convenient location. This will be particularly important given the changes in the ages of the community which over the three different rounds of the HANA project demonstrates the significant demographic shifts in age distribution from 2001 to 2024, with profound implications for policy and planning. Key findings reveal a significant decline in younger populations (children, teens, and young

adults) and a dramatic growth in the older population (65+ years), which has tripled over the period. These trends underscore the need for a strategic focus addressing the implications of these shifts.

19. Recognise and support the role of General Practice in providing both acute care and chronic disease management in the community:

General Practice is well-placed to expand the amount and breadth of services being provided to patients with high satisfaction rates, 81.6% (N=214/262) and high levels of registration, (94.9%; N=260/274). Area's worth exploring are increasing the registration for the population further so there is a close to universal cover as possible. Increased signposting of the TLC 'out-of-hours' service may be useful as well. To further improve the ability of General Practice to meet demand, strategies should be considered to attract more GPs into the area to support the development of robust, responsive practices that are proximal to all areas within Tallaght and can care for more marginalised groups or populations. The integration of care in relation to chronic disease between General Practice, Primary Care, Integrated Care Hubs and TUH should be further encouraged, with a focus also on digital integration to enhance its implementation.

20. Build on Tallaght University Hospital's strengths by continuing to address waiting times and enhancing communication:

Tallaght University Hospital (TUH) is a vital healthcare provider in the community, with the majority of users (67.2%; N=84/124) reporting satisfaction with its services, citing the quality of care (77.3%; N=65/84) and staff compassion (76.2%; N=64/84) as key strengths. To further enhance patient experiences, continuing to address waiting times and strengthening communication are opportunities for improvement, as highlighted by some respondents (85.0%; N=34/40) and (50.0%; N=20/40) respectively. Building on its existing patient-centred approach, TUH could explore targeted strategies such as improved patient management systems, regular updates, and streamlined appointment processes to ensure even greater satisfaction and accessibility.

21. Support the acceleration of Sláintecare to enhance healthcare access and affordability:

Tallaght University Hospital has demonstrated its importance to the local community, with 85.1% (N=229/269) of respondents indicating no unmet healthcare needs related to its services in the past year. However, for households facing challenges such as waiting lists or cost-related delays, advancing the implementation of Sláintecare could provide additional support. Measures such as increased funding for local health services, enhanced coordination between TUH and community care, and expanded eligibility for affordable healthcare could help ensure equitable access for all residents while complementing the high standards already in place at TUH.

22. Promote social prescribing to increase awareness and uptake:

With low awareness (11.7%; N=32/274) and usage (27.0%; N=74/274) of social prescribing services more effort is needed to promote these offerings through GPs and community organisations. Implementing a broader communication strategy, including digital platforms and local community centres, would help link residents to relevant activities and improve their overall wellbeing.

23. Address gaps in health and social services:

Many respondents indicated a need for expanded GP, mental health, and addiction services, as well as specialised healthcare and older persons homecare services. It is recommended to establish more localised healthcare centres, support services, and rehabilitation facilities to meet these needs, ensuring timely access and reducing dependency on emergency services.

Part 1 – Introduction and Methods

1.1. Introduction

Communities are rich sources of insights into health outcomes, experiences, and the effectiveness of health services. To fully understand these dynamics, it is essential to evaluate the relationship between health concerns, outcomes, and the ability of existing health systems to address these issues. This process must consider efficiency, cost-effectiveness, and the potential for fostering strong community partnerships.[6,7]

A robust approach for evaluating community needs is through a health needs assessment, which aims to identify what is lacking in the social, psychological, and environmental conditions of an area and what can be improved.[8] This methodology helps establish priorities for healthcare delivery and policymaking. A crucial component of these assessments is understanding the assets within a community, defined as any factor or resource that enhances the capacity of individuals and communities to sustain health and wellbeing.[9] An asset-based approach identifies protective and promotive factors that influence health, such as social capital—a person's sense of social connections within a community. Trust, a key aspect of social capital, is particularly vital in smaller communities, where social networks are more tightly woven, and individual actions can impact the entire community. Strong social trust fosters cohesion and positive health outcomes, whereas its absence can lead to disengagement and poorer health.[10,11]

Health, wellbeing, and community assets

Health is broadly defined by the World Health Organisation (WHO) as a state of complete physical, mental, and social wellbeing, not just the absence of disease.[12] The role of community health assets in promoting wellbeing is significant, as research consistently shows that social networks and relationships contribute to mental health and overall wellbeing.[13,14] These connections build identity, self-esteem, and resilience, which act as buffers against stress and motivate individuals to engage in healthier behaviours, thereby reducing health disparities.[15] Strong social networks are linked to reduced cardiovascular morbidity, decreased cancer recurrence, lower levels of depression and anxiety, and better outcomes for chronic conditions, as well as reduced hospital readmissions.[15-19]

The health of a community is also shaped by its social determinants, including infrastructure, socio-economic status, and resource access. Communities experiencing poverty often face compounded challenges such as limited healthcare access, inadequate infrastructure for active travel, and poorer air quality—all contributing to heightened health disparities. Social capital, encompassing community networks and social cohesion, improves health by facilitating access

to information, healthcare, and practical support. It also strengthens advocacy for health issues.[20] In lower socio-economic areas, social capital may be weakened due to financial strain, resulting in delayed healthcare seeking, which can affect individual and family health.[21-23] Supporting robust social capital through community infrastructure, safe housing, and access to recreational facilities is essential for building resilience and mitigating health inequalities.[24-30]

Policy frameworks supporting wellbeing and healthcare services

The Irish Government's *Healthy Ireland Framework (2013-2025)* recognises health as the foundation for individuals to reach their full potential. It aims to create environments where high-quality healthcare services are accessible, and people are empowered to make healthy choices. Social and economic factors such as housing, employment, transport, education, and social protection significantly influence the quality of life and health outcomes within a community.[31-32]

Complementing this, the *Sláintecare* Programme is a ten-year initiative designed to reform healthcare delivery by expanding access to preventative care, early intervention, and community-based services.[33] While Healthy Ireland sets the policy agenda, *Sláintecare* operationalises these goals, supporting environments where individuals can maintain healthy behaviours and manage chronic conditions throughout their lives. A health asset approach, which considers both needs and resources, enables communities to participate actively in improving their health and shaping local services.[9,34] In line with this the HSE in 2024 launched *A Framework for Health Needs Assessment* which provides guidance on conducting needs assessments for population health planning.[35]

Integrated care: A model for effective health service delivery

Effective health service delivery relies on integrated care models that place individuals and communities at the centre. This approach connects acute, primary, community, and social care services with public and private providers, resulting in a cohesive and supportive healthcare experience.[3] To establish this model, Ireland is creating Integrated Health Areas (IHAs; see glossary for definition), which will coordinate local services and non-governmental organisations through Community Healthcare Networks (CHNs) and Community Specialist Teams (CSTs), linking with hospitals to support vulnerable populations.[3]

This emphasis on health assets aligns with WHO recommendations to integrate these resources into public health strategies. Asset-based approaches build community resilience, address social determinants, and foster participatory methods.[12] They also highlight potential solutions for health disparities, promote healthier behaviours, and enhance service efficiency by focusing on community strengths.[34,36-41]

Challenges and opportunities

Despite its benefits, the integration of health assets faces challenges, such as the lack of a universal definition and the diverse nature of these assets.[37,42] Nonetheless, integrating these resources remains essential for effective public health practices and policies that support healthy communities.[34,36-41] A population-based approach addresses health inequalities by supporting integrated care. Although health needs vary regionally, a comprehensive health needs assessment helps governments allocate resources more effectively and plan services according to demographic needs.

Health Needs Assessments in Tallaght: A look back at rounds 1 and 2

The Tallaght community has been the focus of two major assessments in 2001 and 2014. The initial assessment, led by the Department of Community Health and General Practice and funded by the Adelaide Health Foundation, tailored services to better meet community needs and introduced new health services.[43] This success led to a follow-up in 2014, which expanded the focus to include an inventory of community assets alongside health needs.[44] The findings of both assessments informed local health planning, addressing specific needs and supporting service development.

HANA Round 3: A focus on change and continuity

The third iteration of the Health Assets and Needs Assessment (HANA) in Tallaght (2024) builds on previous work to capture shifts in health needs since 2014 (Appendix B). This assessment aims to identify gaps and emerging trends in health concerns while providing a comprehensive overview of available community assets. Service providers will evaluate these needs by considering the opinions and experiences of community members, helping tailor services to specific requirements.[36] This approach will guide resource allocation and policy decisions, ensuring that health services continue to evolve with the community's changing needs.

Objectives of the Current Study – Round 3

1. Obtain an updated understanding of the health and wellbeing needs of the community of Tallaght.
2. Map existing health assets in the community.
3. Establish the community's relationship with these assets.
4. Provide recommendations for health service delivery based on findings and current policy frameworks.

The 2024 Health Assets and Needs Assessment in Tallaght provides updated insights into the community's evolving health needs and assets. By evaluating changes since 2014, this study will serve as a foundation for future health planning and service development, ensuring that health initiatives remain responsive to the community's priorities and align with broader national policies such as *Healthy Ireland* and *Sláintecare*.

1.2. Methods

Design

Our approach was to assess the health needs of Tallaght's residents, ensuring our methodology aligned with that of the 2001 and 2014 assessments. A market research company was contracted to conduct the survey data collection across Tallaght's 13 electoral divisions.

Study area

The study area covered the 13 electoral divisions of Tallaght: Belgard, Glenview, Kilnamanagh, Kingswood, Millbrook, Oldbawn, Springfield, Avonbeg, Fettercairn, Jobstown, Killinarden, Kiltipper, and Tymon (North and South).

Deprivation is defined as *"observable and demonstrable disadvantage relative to the local community to which an individual belongs"*.[45,46] Deprivation significantly impacts health status[47,48] and service utilisation[49], making it crucial to consider this factor when selecting the survey sample.

In previous assessments, the Small Area Health Research Unit (SAHRU) deprivation index (DI) for health and health services research was used as it was standard in CSO Census data from 2011. It was based on four indicators to determine the classification of deprivation; the deprivation index is a classification system of 1 (least deprived) through 10 (most deprived).[45] Additional details on this previous classification of electoral divisions by level of deprivation are in Appendix C.

For the 2001 and 2014 health needs assessments, the SAHRU DI was applied. Following the CSO Census 2022, the deprivation measurement has shifted to the Pobal HP Deprivation Score, which better reflect social and economic disadvantage.[2] The sampling process involved creating clusters of addresses within each ED, with the number of clusters proportional to the population of each ED. Small areas (SAs) within each ED were randomly selected, and each cluster consisted of addresses within a single SA. A primary address was randomly chosen, and the 14 nearest addresses were included in the cluster. All sampled addresses were required to be residential, non-derelict and occupied. Additional addresses were selected to act as replacements due to unoccupied or unsuitable addresses. Clusters typically included at least 15 addresses, though clusters in apartment blocks might have had more due to shared coordinates.

Data sources for this sampling included the CSO Census 2022 for population and small areas, the GeoDirectory (HSE Health Intelligence Unit) for address selection, and Pobal for deprivation data.

Classification of EDs based on this decision can be seen in Table 1.

Table 1 Distribution of sample and population in both high and low deprivation electoral divisions.

Electoral Division (ED)	Sample households ED (N=274)	CSO 2022 Population of households per ED *50	Classified
	Total (%)	**Total (%)**	
Tallaght - Avonbeg	9 (3.3)	585 (1.7)	High
Tallaght - Belgard	10 (3.6)	580 (1.6)	High
Tallaght - Fettercairn	31 (11.3)	3,471 (9.9)	High
Tallaght - Jobstown	53 (19.3)	5,711 (16.2)	High
Tallaght - Killinarden	9 (3.3)	1,278 (3.6)	High
Tallaght – Millbrook	12 (4.4)	1,290 (3.7)	High
Tallaght – Tymon (North and South)	22 (8.0)	1,879 (5.3)	High
Total	**146 (52.3)**	**14,794 (42.0)**	
Tallaght – Glenview	11 (4.0)	876 (2.5)	Low
Tallaght – Kilnamanagh	9 (3.3)	3,097 (8.8)	Low
Tallaght – Kiltipper	38 (13.9)	9,503 (27)	Low
Tallaght – Kingswood	13 (4.7)	1,499 (4.3)	Low
Tallaght – Oldbawn	18 (6.6)	1,583 (4.5)	Low
Tallaght – Springfield	39 (14.2)	3,831 (10.9)	Low
Total	**128 (46.7)**	**20,389 (58.0)**	

*Total households in the 13 EDs is 35,183 according to CSO Census 2022 data

Sampling

The 2024 study closely followed the original sampling process used in the 2001 study (Appendix C).[43] Cluster sampling was employed with 30 clusters of seven households selected from each of the low and high deprivation areas, giving the required number of 420 households. However, to account for expected low response rates, hesitancy in completing the survey, or derelict houses, an additional eight households were included, bringing the total number of households per cluster to 15, providing alternative options for survey responses. These additional household addresses were held back by the research team and not released to the market research company It turned out that it was not necessary to release these addresses to the market research company and the sample remained the original 420 households.

All addresses were taken from GeoDirectory of occupied and non-derelict residential buildings as early as 2024. In some cases, apartment blocks were included, resulting in clusters with more than 14 addresses since apartment blocks may share the same coordinates. According to the electoral register, there are 14,794 households in high deprivation and 20,389 in low deprivation in the 13 electoral divisions.

The 13 Electoral Division's in the survey area were partitioned into 390 clusters, each of 15 households. There were 420 households that accounted for the primary 7 households to be invited to participate, followed by supplementary 180 households which received the first round of invitation to participate, and replacements were drawn from the remaining households when necessary.

Fieldwork and data collection

Data collection took place between May and September 2024. The selected households in each cluster were sent an invitation letter (Appendix D) outlining the purpose of the study, the topics that the survey would cover, how their house had been randomly selected and letting them know that a researcher from the market research company would be calling to the home. Households were informed that their participation was voluntary and that they were free to withdraw from the research at any time (Appendix E). Households were given the opportunity to contact the research project research assistant with questions or to indicate that they did not wish to take part in the research. If a household declined the invitation to participate, the market research company were informed, and the address was subsequently removed from the sampling cluster. As a part of their quality control processes, the market research company conducted follow-up checks with respondents to confirm that interviews were completed properly and to ensure data integrity (Appendix F).

Statistical methods

Data were entered for all available completed surveys and the resulting dataset cleaned for any errors. A total of four datasets were compiled - two to assist in the processing of data relating to variables at the household and individual levels and two for questions relating to identical data from the original study in 2001 and HANA 2014 data. Frequency distributions were performed for all variables to identify discordant values and to ensure data followed logical checks. Statistical analysis was carried out in Excel, IBM SPSS version 27 (IBM Corp., Armonk, NY) and Stata MP 18 (Statacorp LLC, College Station, TX).

The frequency distribution for each variable was described in both the household and individual datasets. Binary logistic regression models were developed to determine which variables best predicted key outcomes, such as, chronic illness, waiting to receive treatment, use of TUH Emergency Department, satisfaction with GP services and digital competency. Exact 95.0% confidence intervals were calculated for proportions of binary variables and for regression adjusted odds ratios.

For ease of reading, some key results have been displayed visually as figures to highlight findings under the executive summary section.

Communications

In advance of data collection, a communications strategy was agreed upon with all organisations involved in the project to overcome survey fatigue and reduce participant reluctance, particularly in the context of COVID-19. The strategy aimed to build trust and engagement by emphasizing the value of the research and the impact on the community. General practitioners in the Tallaght area were informed of the study by letter and were asked to display posters in their practice (Appendix G). Short video vignettes were recorded through the Communications team from Tallaght University Hospital showcasing the project with locally known community members, such as local a school principal, TUH consultant, and project partners conveying the project launch. Information posters were displayed in areas of high footfall, such as, community centres, local libraries, shops, primary care centres and on public notice boards within key community locations (Appendix H and I). Radio adverts were also recorded and played in the local major shopping centre “The Square” to build engagement in the community. Each stakeholder involved in the project played a pivotal role in building awareness in the community of the project’s launch. Social media was used to enhance engagement and reach across stakeholder social media channels. The local press informed the community about the survey (Appendix J). The research team also engaged in various community information pop-ups in

The Square Shopping Centre in Tallaght, local libraries and in community centres to inform and engage the public (e.g., information session for Men's Health Week in Tallaght library).

Data collection instrument

The original survey from 2001 was updated and expanded on in 2014 and has been revised again for this third round to better assess current health needs and provide valuable insights for project stakeholders like the HSE, SDCC, SDCP and TUH. New questions were added to reflect the evolving landscape of health and wellbeing needs in Tallaght, to focus on 'whole health', which includes physical, behavioural, and socio-economic wellbeing. New topics such as debt, digital literacy, food access, air quality, dental care and access, and teenage mental health, were included for the first time. The survey instrument was designed and finalised in November 2023. The survey consisted of the following (see Appendix A).

Open ended questions

Respondents were asked several open-ended questions to gather in-depth insights into various aspects of their experiences and perceptions. These questions included identifying the top three positive and negative things about living in Tallaght, the reasons for stress experienced by individuals, and concerns respondents have regarding their teenagers' socialisation. Additional questions sought opinions on the benefits of Tallaght University Hospital to the local community and suggestions for its improvement. Respondents were asked about their reasons for not being registered with a GP, their healthcare access methods, and what healthcare services are needed in the Tallaght community. They were asked what measures would encourage more walking and cycling in the area as a part of South Dublin County Council's climate change strategy. The open-ended responses were analysed thematically, with coding and triangulation used to ensure accuracy and consistency in the analysis.

Household demographics

The questions sourced from the CSO Census cover a broad range of demographic and socio-economic topics. These include personal identifiers and background information, such as "What age are you?"[51] and ethnic diversity with questions like "What is your ethnic group/background?"[52] and language use, including "Do you speak a language other than English or Irish at home?".[53] Additionally, the survey addresses aspects of education and employment, asking "What is your highest level of education attained?"[54] and "What is your current employment status?".[55]
We deviated from the CSO Census in terms of asking about gender and included a more contemporary way of conceptualising gender.

Daily living

The survey question, "How often do you feel cold in your own home because you are trying to save on energy bills?" is part of research conducted by Amárach Research for the Department of the Environment, Climate & Communications.[56] Additionally, the question "Do you own a car?" is also sourced from the Central Statistics Office (CSO).[57]

Physical activity

Four questions assessed respondents' levels of physical activity. These questions were used in the Survey of Lifestyle Attitudes and Nutrition in Ireland (SLAN).[58]
The questions asked in SLAN were adapted from the International Physical Activity Questionnaire (IPAQ).[59] In the 2024 HANA survey, the IPAQ scoring were used to categorise respondents into different levels of activity: inactive, minimally active, and Health Enhancing Physical Activity (HEPA active). These classifications were based on whether respondents achieved the recommended levels of physical activity necessary for protective health benefits. To better understand these activity levels, different categories of exercise were defined; Strenuous exercise was described as exercise in which your 'heart beats rapidly'. For example, running, jogging, football, vigorous swimming; moderate exercise was described as exercise that was 'not exhausting'. For example, fast walking, tennis, easy swimming, easy cycling and heavy gardening; mild exercise was described as exercise that takes 'minimal effort'. For example, yoga, easy walking, golf, light gardening. Respondents were also asked to indicate on how many days, if any, in an average week they walked for 30 minutes or more.

Health status

In the section on health status, questions such as "How would you rate your health in general?" are sourced from the CSO Census.[60-61] Questions related to chronic illness and disability are taken from the Central Statistics Office (CSO).[62] Questions on smoking and substance use, such as "How many people in your household smoke?" "During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?" "During your last attempt to give up,

did you use any help, such as products, medication, or quit support services?" and "Which of the following substances do people in your household use?" are derived from the CSO, Healthy Ireland, and the Irish National Drug and Alcohol Survey.[63-65] The question "How often do you feel lonely?" is assessed using the UCLA Loneliness Scale and CSO-SILC.[66] Additionally, questions about psychological or emotional conditions specifically around teenagers, including "Does X have a psychological or emotional condition?" "If yes, since when has X had this condition?" "Is X hampered in his/her daily activities by this condition or difficulty?" and "Has this condition been diagnosed by a professional?" are taken from the Growing Up in Ireland (GUI) study.[67]

General practice and healthcare services
The following questions were originally sourced from an NHS survey in the UK, which unfortunately has since been removed and is no longer accessible for reference. The questions include: "Have you heard of 'social prescribing services' before completing this survey?" "How did you hear about social prescribing services?" "If you have availed of social prescribing, did you find it helpful?" "Did it link you with a local service/activity?" "Overall, how satisfied are you with your experience of using social prescribing services?" and "What might stop you using a social prescribing service/ activity?"

Personal and community characteristics
Social trust, an indicator of social capital, was assessed using a method adapted from the World Health Organization (WHO) which drew on a question from the European Quality of Life Study to evaluate individual social trust.[20] The question asked: "Generally speaking, would you say that most people can be trusted, or that you can't be too careful in dealing with people?" Participants rated their response on a scale from one to ten, where one denotes "you can't be too careful" and ten signifies "most people can be trusted."

Asset mapping
Asset mapping is the process of creating an inventory of community strengths.[34] It includes both physical assets (such as parks, community centres and churches) and personal assets (such as skills, experience and knowledge).[34] This process helps identify these assets and highlight connection between them, as well as how they relate to the community and can be accessed. More than compiling an inventory list, asset mapping fosters relationships and encourages connections between individuals, communities and organisations.[34,38]

Data were compiled using existing local directories and through interviews with local service providers and community partners. This inventory of health and wellbeing assets was later used during household interviews (Appendix K-M). Respondents were asked to assess which items they considered to be assets, as well as explore their relationship with these resources. Questions addressed how assets were used, why they were or were not considered assets, and the reason behind their usage. The information gathered was used to develop a geographic map of health and wellbeing assets in the Tallaght community using geographic information system (GIS). GIS is a tool that manages spatial data by integrating digital data, computer hardware and software. It allows for the visualisation, analysis, and identification of spatial relationships, patterns and trends in map form. Asset mapping through GIS has proven to be a valuable planning tool, facilitating decision-making processes for stakeholders such as local councils and policymakers by visually communicating important information.[68]

Research ethical approval and data protection approval

Household members were initially contacted via letter, providing information about the study and allowing them a seven-day period where they could contact the market research company or the project research assistant to opt-out or to ask clarification questions about the research. Informed consent was obtained from interviewees, with respondents' signing consent forms, which were collected by the market research company and delivered to Trinity College Dublin.

This study received approval from both the Faculty of Health Sciences Research Ethics Committee and the Data Protection Office at Trinity College Dublin. Confidentiality was a priority, with risk minimisation strategies in place to protect participants' information. Consent forms will be destroyed seven years after the study concludes, and the study data will be archived after the analysis and publication of related research.

Part 2 - Results from HANA 2024

2.1. Response rate

Of the 420 households invited to participate in the survey, a total of 274 households agreed to be interviewed. This resulted in a response rate of 65.2%. In previous rounds, the response rate was 81.6% in 2014 (N=343/420) and 81.9% (N=344/420) in the 2001 health needs assessments.

The analysis focuses on information collected from the 274 respondents' who took part in the survey. Respondents also provided details about 755 individuals living in these households, including themselves.

The respondents were the person responsible for managing the households' welfare and health. In rental households, this was usually the person who paid the bills or whose name was on the rental agreement.

The number of respondents vary per question, as not every respondent answered every question, and some questions allowed for multiple responses.

2.2. Demographic details

Demographic details of individuals living in the participating households.

Respondents provided details on the demographic composition of individuals living in the household.

Table 2 Demographic details for individuals living in the participating households as reported by the respondent.

Indicator	Number (%)
Relationship to the respondent (N=474/481; 98.5%) *	
Child	247 (52.1)
Spouse	168 (35.4)
Not related	19 (4.0)
Parent	18 (3.8)
Other (i.e., sibling, friend, in-law)	16 (3.4)
Grandchild	5 (1.2)
Gender (N= 748/755; 99.1%)	
Female	383 (51.2)
Male	360 (48.1)
Prefer not to say	~
Age (N=743/755; 98.4%)	
0-9	101 (13.6)
10-19	102 (13.6)
20-29	69 (9.3)
30-39	111 (14.9)
40-49	148 (19.9)
50-64	109 (14.7)
65+	103 (13.9)

Note: The 274 respondents were deducted from the denominator for this question as it could only be answered in relation to the other members of the household (274 less than 755 = 481).
*Participants could select more than one answer, so the total number of "yes" responses exceeds N.
~ denotes 5 or fewer cases reported.

Among the 755 total responses given about individuals in the participating households, respondents reported on the relationships of 474 individuals (N=474/481; 98.5%). Of these, 52.1% (N=247/474) were children of the respondent, 35.4% (N=168/474) were spouses, and 4.0% (N=19/474) were not related to the respondent. Smaller percentages included parents (3.8%; N=18/474), other relatives such as siblings or in-laws (3.4%; N=16/474), and grandchildren (1.2%; N=5/474).

The gender distribution was balanced, with 51.2% (N=383/748) identified as female and 48.1% (N=360/748) as male (N=748/755; 99.1%). The age distribution was varied, with the largest group aged 40-49 years (19.9%; N=148/743), followed by those aged 30-39 (14.9%; N=111/743), 50-64 (14.7%; N=109/743 and 65+ (13.9%, N=103/743).

Table 3 Household characteristics as reported by the respondent.

Characteristics	Number (%)
Number of years living in household (grouped) (N= 274/274; 100.0%)	
0-10	106 (38.7)
11-20	57 (20.8)
21-30	35 (12.8)
31-50	59 (21.5)
51+	17 (6.2)
Number of people living in each household (N= 272/274; 99.3%)	
1	55 (20.2)
2 to 4	184 (67.6)
5 to 9	33 (12.1)
Average	1.91
Median	2
Range	2
Household occupancy status (N=274/274; 100.0%)	
Outright owner	104 (38.0)
Mortgage	73 (26.6)
Renting from or rent paid by Health Board/County Council	49 (17.9)
Renting privately	38 (13.9)
Tenant purchasing plan	9 (3.3)
Don't know	~
Current employment status (N= 738/755; 97.7%)*	
Working full time	305 (41.3)
In education	199 (26.9)
Retired	92 (12.5)
Working part time	54 (7.3)
In home	37 (5.0)
Unemployed	27 (2.6)
Ill/unable to work	22 (2.9)

*Participants could select more than one option.
~ denotes 5 or fewer cases reported.

Among the 274 respondents, 38.7% (N=106/274) had lived in their current household for 0-10 years, while 21.5% (N=59/274) had resided there for 31-50 years. The remaining residents were distributed across 11-20 years (20.8%; N=57/274), 21-30 years (12.8%; N=35/274), and over 51 years (6.2%; N=17/274).

In terms of household size, most respondents (67.6%; N=184/272) lived in households with two to four people with an average of 1.91 persons and a median of 2. Whereas the national CSO Census 2022 showed the average household size being 2.74 persons.[4] Smaller percentages lived alone (20.2%; N=55/272) or in larger households of five to nine people (12.1%; N=33/272).

As for household occupancy status, 38.0% (N=104/274) of respondents owned their home outright, while 26.6% (N=73/274) were paying a mortgage. Additionally, 17.9% (N=49/274) were renting from or had rent covered by the Health Board/County Council, 13.9% (N=38/274) rented privately, and 3.3% (N=9/274) were participating in a tenant purchasing plan.

Regarding employment status (97.7%; N=738/755), 41.3% (N=305/738) were working full-time, 26.9% (N=199/738) were in education, and 12.5% (N=92/738) were retired. Smaller percentages included part-time workers (7.3%; N=54/738), individuals working in the home (5.0%; N=37/738), the unemployed (2.6%; N=27/738), and those unable to work due to illness or disability (2.9%; N=22/738).

Demographic and socio-economic characteristics of the respondent

The respondent provided details relating to their own demographic and socio-economic circumstances.

Table 4 Demographic and socio-economic characteristics of the respondent.

Indicator	Number (%)
Gender (N= 274/274; (100.0%)	
Female	184 (67.2)
Male	90 (32.8)
Age (N=274/274; 100.0%)	
18-34	39 (14.3)
35-49	107 (39.1)
50-64	63 (23.0)
65+	64 (23.7)
Ethnic background (N= 274/274; 100.0%)	
White	248 (90.5)
Asian or Asian Irish	15 (5.5)
Black or Black Irish	9 (3.3)
Other, including mixed group/background	~
Do you speak a language other than English or Irish at home? (N=274/274; 100.0%)	
Yes	47 (17.2)
No	227 (82.8)
Proficiency in English (N= 47/274; 17.2 %)^	
Very well	40 (11.6)
Well	7 (2.0)
Marital status (N= 274/274; 100.0%)	
Married (first marriage)	137 (50.0)
Single (never married or never in a same sex civil partnership)	71 (25.9)
Widowed	24 (8.8)
Cohabitating	17 (6.2)
Divorced	12 (4.4)
Separated	9 (3.3)
Re-married	~
In a registered same-sex civil partnership	~

Indicator	Number (%)
Highest level of education (N= 274/274; 100.0%)	
Degree, professional qualification, or both	70 (25.5)
Leaving certificate, A level and technical training	56 (20.4)
Non degree qualification (diploma, certificate)	54 (19.7)
Junior or intermediate certificate, technical/vocational training	46 (16.8)
Postgraduate qualification	25 (9.1)
Primary education or less	23 (8.4)
Current employment status (N= 274/274; 100.0%)*	
Working full time	119 (43.4)
Retired	60 (21.9)
Working part time	39 (14.2)
Working in the home	26 (9.5)
Unemployed	16 (5.8)
Ill/unable to work	10 (3.6)
In education	5 (1.8)
Unpaid voluntary work	/
Work Placement Experience Programme	~
Car ownership (N=274/274; 100.0%)	
Yes	206 (75.2)
No	68 (24.8)
Level of health cover (N=274/274; 100.0%)*	
Private medical insurance	99 (36.1)
Medical card/GMS	96 (35.0)
Neither medical card nor private insurance	67 (24.5)
Doctor visit card	30 (10.9)
Don't know	~

*Participants could select more than one option.
~ denotes 5 or fewer cases reported.
/ denotes zero responses reported.
^ Footnote 1: This data is relative to English proficient in households. Of the 47 respondents (N=47/274) who reported speaking a language other than English or Irish at home, 11.6% (N=40.47) felt very proficient in English and 2.0% (N=7/47) felt proficient. This may reflect the need for good English to participate in the survey.

Among the 274 respondents, 67.2% (N=184/274) identified as female, and 32.8% (N=90/274) identified as male. The age distribution showed that 39.1% (N=107/274) were between 35 and 49 years, with 23.7% (N=64/274) aged 65 and over. In terms of ethnic background, 90.5% (N=248/274) identified as White or White Irish, while smaller groups identified as Asian or Asian Irish (5.5%; N=15/274) and Black or Black Irish (3.3%; N=9/274). Additionally, 17.2% (N=47/274) of respondents reported speaking a language other than English or Irish at home, with 11.6% (N=40/274) of these individuals indicating they spoke English "very well."

Regarding marital status, 50.0% (N=137/274) were married, 25.9% (N=71/274) were single, and 8.8% (N=24/274) were widowed. Educational attainment among respondents was varied; 25.5% (N=70/274) held a degree or professional qualification, 20.4% (N=56/274) had completed a Leaving Certificate or equivalent, and 9.1% (N=25/274) had a postgraduate qualification.

In terms of employment status, 43.4% (N=119/274) were working full-time, 21.9% (N=60/274) were retired, and 14.2% (N=39/274) worked part-time. Additionally, 9.5% (N=26/274) were working in the home, while smaller percentages were unemployed (5.8%; N=16/274) or unable to work due to illness or disability (3.6%; N=10/274). A small group, 1.8% (N=5/274), were currently in education.

Respondents reported a high level of car ownership, with 75.2% (N=206/274) owning a car, while 24.8% (N=68/274) did not. Among the 274 respondents, 36.1% (N=99/274) reported having private medical insurance, while 35.0% (N=96/274) had a medical card/GMS. Additionally, 24.5% (N=67/274) had neither medical card nor private insurance, and 10.9% (N=30/274) had a doctor visit card.

2.3. Quality of life

Top three 'good things' about living in Tallaght

Respondents were asked to list the top three 'good things' about living in Tallaght. It should be noted that respondents could provide more than one 'good thing' from each category. Respondents provided free text responses and categories were created.

Table 5 Respondents' opinions on the top three 'good things' about living in Tallaght.

Indicator	Number (%)
What are the top three good things about living in Tallaght?* (N=238/274; 86.9%)	
Amenities (e.g., The Square, shops, sports facilities, the library, schools)	173 (72.7)
Community spirit (e.g., great neighbours, sense of community, diversity)	146 (61.3)
Location (e.g., proximity to other locations, close to mountains and parks, quiet area)	113 (47.4)
Public transport (e.g., good public transport links, the Luas, and accessibility to city centre)	110 (46.2)
Other (e.g., area has good public services, clean, more affordable to live)	41 (17.2)
Tallaght University Hospital and nearby healthcare services	35 (14.7)
Intergenerational (e.g., living near family)	18 (7.6)

* Participant could provide more than one answer.

A total of 238 out of 274 respondents (86.9%) responded to the question about the top three 'good things' about living in Tallaght (Table 5). The most frequently cited benefit was the availability of amenities in the area, which includes The Square shopping centre, sports facilities, community centres, schools, and libraries (72.7%; N=173/238).

The second most common response was the strong sense of community spirit, with respondents noting positive neighbour relations, diversity, and overall community connection (61.3%; N=146/238).

The third highly regarded aspect was Tallaght's location (47.4%; N=113/238), with residents appreciating its proximity to natural spaces such as mountains and parks, as well as its relatively quiet surroundings.

Other valued aspects included public transport options like the Luas and accessible links to the city centre (46.2%; N=110/238). Additionally, respondents mentioned good public services and affordability (17.2%; N=41/238), healthcare access including Tallaght University Hospital (TUH) (14.7%; N=35/238), and the intergenerational community aspect (7.6%; N=18/238), which allows for family proximity within the area.

Top three 'bad things' about living in Tallaght

Respondents were asked to list the top three 'bad things' about living in Tallaght. It should be noted that respondents could list more than one 'bad thing' from each category. Respondents provided free text responses and categories were created.

Table 6 Respondents' opinions on the top three 'bad things' about living in Tallaght.

Indicator	Number (%)
What are the top three bad things about living in Tallaght?* (N=234/274; 85.4%)	
Antisocial behaviour and feelings of not being safe (e.g., gangs of teenagers, racism, not safe at night)	168 (71.7)
Lack of amenities (e.g., litter, lack of amenities for teenagers, healthcare and community services, council maintenance)	143 (61.1)
Crime and lack of Gardaí (e.g., theft, vandalism, no Gardaí presence)	77 (32.8)
Drugs and alcohol (e.g., drug dealing and consumption in the area)	66 (28.2)
Transport and traffic (e.g., more reliable bus services, extend the Luas, too much traffic)	51 (21.8)
Population density (e.g., overcrowded, litter)	26 (11.1)
None	26 (11.1)
Other (e.g., high cost of living, lack of community)	25 (10.7)
Bad reputation (e.g., negatively viewed and portrayed in media)	21 (8.9)
Poverty (e.g., poor areas)	19 (8.1)

* Participant could provide more than one answer.

When asked about the top ‘bad things’ about living in Tallaght, 234 out of 274 respondents (85.4%) responded. The most frequently cited concern was antisocial behaviour and feelings of insecurity, where respondents highlighted issues such as gangs of teenagers, racism, and general safety concerns, particularly at night (71.7%; N=168/234).

The second most common concern was lack of amenities (61.1%; N=143/234), with respondents mentioning litter, limited facilities for teenagers, inadequate healthcare and community services, and insufficient council maintenance.

Crime and a perceived lack of Gardaí presence was the third top issue identified (32.8%; N=77/234), with respondents citing theft, vandalism, and a low visible Gardaí presence as contributing factors.

Concerns about drug and alcohol prevalence (28.2%; N=66/234) were also notable, followed by transport and traffic issues (21.8%; N=51/234), with calls for more reliable bus services, an extension of the Luas, and reduced congestion.

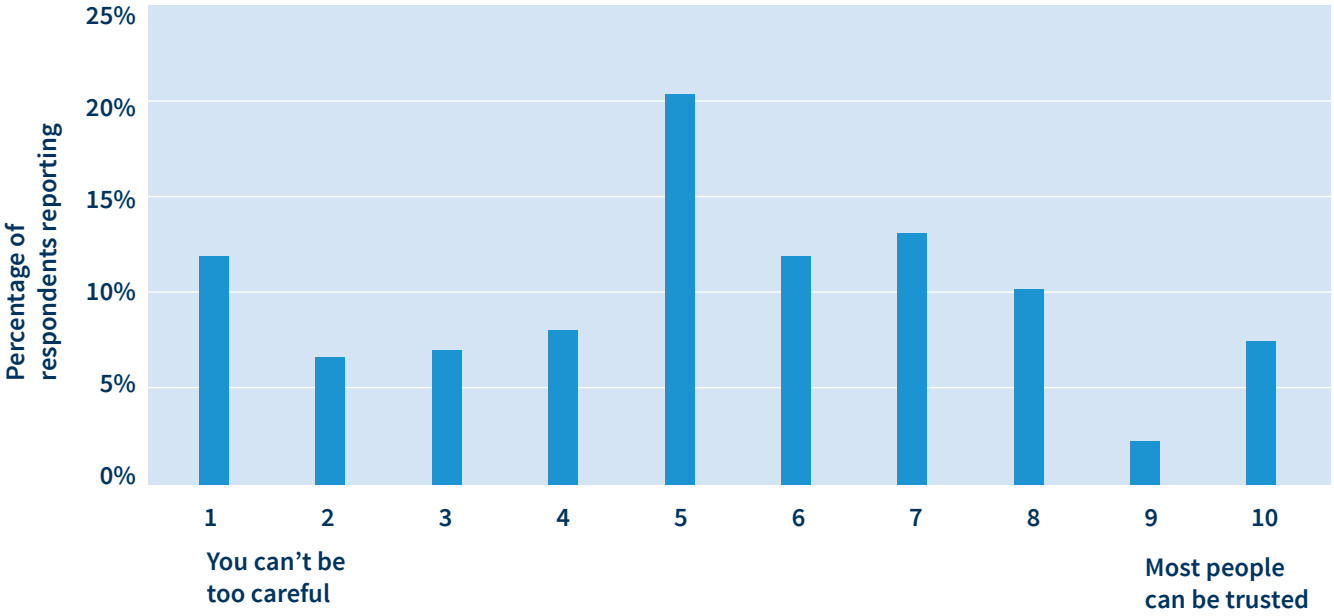
Population density (11.1%; N=26/234) and concerns over overcrowding were also noted, while an equal number of respondents (11.1%; N=26/234) reported no significant ‘bad things’ about living in Tallaght.

Other issues included the high cost of living and perceived lack of community (10.7%; N=25/234), while poverty and socio-economic concerns were mentioned by a smaller group (8.1%; N=19/234), reflecting perceptions of disadvantaged areas within Tallaght.

Social capital

Social capital is measured through an indicator of individual degree of trust. Respondents in each household were asked 'Generally speaking, would you say that most people can be trusted or that you can't be too careful in dealing with people?' (100.0%; N= 274/274). This was rated on a scale of one to ten, where one is 'you can't be too careful' and ten is 'most people can be trusted' (Figure 10). This question was asked in both the 2012 EU Quality of Life Survey, the 2014 round of HANA and the 2024 round of HANA research.

Figure 10 Reported level of trust among Respondents'



The results indicate a wide range of level of trust levels amongst respondents. The largest proportion of respondents (20.4%, N=56/271) rated their trust level at a neural level (5). A combined 33.5% (N=92/274) of respondents expressed lower levels of trust (scores one to four), while 44.8% (N=103/274) of respondents reported higher levels of trust. Notably, 7.3% (N=20/274) reported the highest level of trust (score of ten).

Table 7 Characteristics of home life and quality of life as reported by the respondent.

Indicator	Number (%)
Community volunteering in neighbourhoods (N=267/274; 97.44%)	
Yes	26 (9.7)
No	241 (90.2)
Can use applications/programmes without help on mobile phone, computer or other electronic device (i.e., Zoom) (N=273/274; 99.6%)	
Strongly Disagree	34 (12.4)
Disagree	23 (8.4)
Neutral	15 (5.5)
Agree	73 (26.6)
Strongly Agree	128 (46.7)
Can use video chat without help on mobile phone, computer or other electronic device (N=272/274; 99.3%)	
Strongly Disagree	26 (9.6)
Disagree	20 (7.3)
Neutral	11 (4.0)
Agree	80 (29.2)
Strongly Agree	125 (45.6)
Can solve basic technical issues without help (N=274/274; 100%)	
Strongly Disagree	32 (11.7)
Disagree	29 (10.6)
Neutral	26 (9.5)
Agree	76 (27.7)
Strongly Agree	111 (40.5)
Easy access to supermarket or shop with fresh fruit, vegetables and meat (N=274/274; 100%)	
Yes	268 (97.8)
No	6 (2.2)
Rating of local air quality (N=271/274; 98.9%)	
Very good	76 (28.0)
Good	136 (50.2)
Fair	41 (15.1)
Poor	12 (4.4)
Very poor	7 (2.6)

Indicator	Number (%)
Personal worry about debt (N=271/274; 98.9%)	
All of the time	53 (19.3)
Sometimes	95 (34.7)
Rarely, such as only for certain occasions	30 (10.9)
Almost never	93 (33.9)
Number of people in your area worried about debt (N=215/274; 78.5%)	
Everyone	27 (9.9)
Most people	98 (35.8)
Some people	65 (23.7)
Very few people or none	25 (9.1)
If there are people in your area with debt problems, where do they go for advice? (N=274/274; 100%)	
Don't know	112 (40.9)
MABS the Monetary Advice and Budgeting Service	83 (30.3)
Family or friends	79 (28.8)
Citizens Information	57 (20.8)
Other (e.g., St Vincent de Paul, credit union, bank)	20 (7.3)
Insolvency Service Ireland (IS)	8 (2.9)
How often do you feel cold in your own home because you are trying to save on energy bills? (N=273/274; 99.6%)	
All of the time	19 (6.9)
At different times during the day	25 (9.1)
Occasionally during the week	55 (20.1)
Rarely, only if it's ever cold outside	76 (27.7)
Almost never	98 (35.8)
Put off healthcare because of cost (N=269/274; 98.2%)	
Yes	85 (31.0)
No	184 (67.2)

Among surveyed respondents (N=267/274), 9.7% (26/267) reported participating in community volunteering within their neighbourhoods.

Most respondents felt confident using applications and programmes on electronic devices, with 73.3% (N=201/273) either agreeing or strongly agreeing; specifically, 46.7% (N=128/273) strongly agreed. Similarly, 74.8% (N=205/272) were comfortable using video chat, with 45.6% (N=125/272) strongly agreeing. In contrast, when it came to solving basic technical issues, 22.3% (N=61/274) expressed difficulty, either disagreeing or strongly disagreeing with the statement.

Access to fresh food was widely available, with 97.8% (N=268/274) of respondents reporting easy access to supermarkets or shops offering fresh produce. Regarding local air quality, 49.6% (N=136/271) rated it as “good,” while 27.7% (N=76/271) rated it “very good.”

Personal financial concerns were significant among respondents, with 34.7% (N=95/271) reporting they worried about debt “sometimes,” and 19.3% (N=53/271) worrying “all of the time.” Community perceptions of debt were also notable; 35.8% (N=98/215) believed that “most people” in their area were worried about debt, while 9.9% (N=27/215) thought that “everyone” was affected. When it came to seeking financial advice, 40.9% (N=112/274) were unsure where to turn, and 30.3% (N=83/274) identified the Monetary Advice and Budgeting Service (MABS) as a source.

Energy costs posed challenges, with 6.9% (N=19/273) reporting they felt cold “all of the time” to save on energy bills, and 27.7% (N=76/273) feeling cold “rarely,” only when it was very cold outside. Healthcare was another area impacted by costs, with 31% (N=85/269) delaying healthcare due to financial constraints, while 67.2% (N=184/269) did not.

2.4. Health & wellbeing assets

Maps

An updated list of local services and amenities relating to healthcare, community facilities and sports clubs and hobby facilities was created by the research team. These inventories were compiled from directories from sources including South Dublin County Council, South Dublin County Partnership, the Health Atlas HSE Service Directory, the Health Service Executive, Children and Young People's Services Committee (CYPSYC) and other local organisations. The inventories were also reviewed by key people working within the areas of community and healthcare. For a complete line listing of all of the services and facilities that were identified and plotted refer to Appendices I-K.

The purpose of the inventories was threefold. First, respondents were presented with laminated copies of the inventories to assist them in answering questions in relation to utilisation of services within the area of Tallaght and as to whether they perceived these services to be an asset. Second, the inventories were used to plot services and facilities within the study area onto a series of maps. Third, this also showed the areas of deficit and the areas where there is a high concentration of services, to help guide future service planning.

The maps were developed based on the 13 electoral divisions (EDs) as per the CSO Census 2022. EDs are the smallest legally defined administrative areas in Ireland for which Small Area Population Statistics are published from the CSO Census 2022. The format of the maps allows for the plotting of the known services and facilities within the 13 electoral divisions. This process was undertaken using GIS software (see Method section).

It is quite typical that within an ED there may be a number of smaller neighbourhoods with their own names that are familiar to residents. For example, Brookfield is a neighbourhood within the ED of Fettercairn.

It should be noted that within the EDs there may be both residential and non-residential areas. For example, in the north of the ED of Fettercairn is a quarry.

Some ED boundaries follow roads and public transport structures. For example, the Luas track forms the boundary to the north of the ED of Springfield and the south of Belgard. The N81 makes up the northern boundary of the ED of Oldbawn.

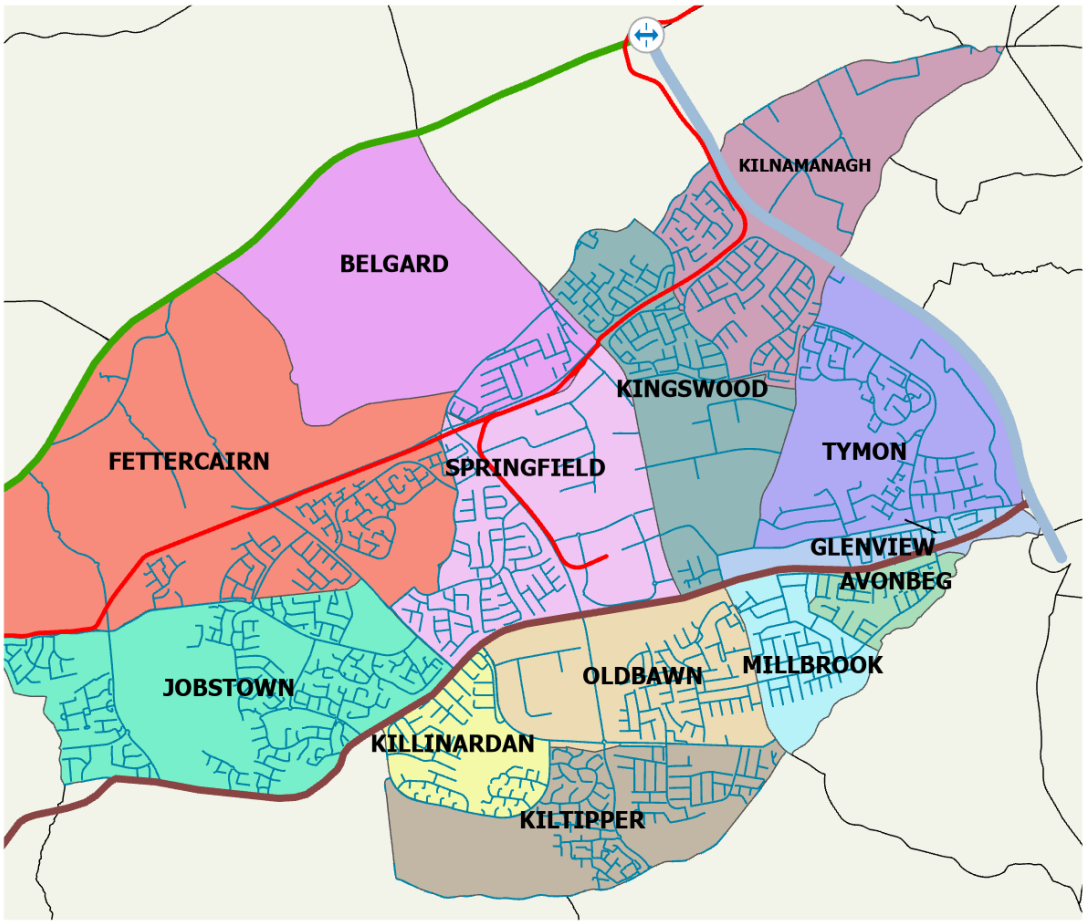
Some facilities and services are co-located within the same building or site. For example, there are three Addiction type services within the Glenabbey building on

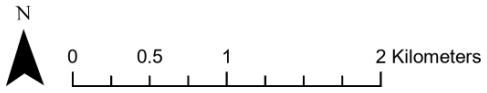
the Belgard Road – the Youth Drug and Alcohol Service, HSE Community Drug Team and HSE Community Alcohol Services. To facilitate easy reading of the map, this location was given one Addiction services symbol rather than three. HSE services have been differentiated from private services in the maps to provide clarity.

Some facilities or services are plotted just outside of the ED boundary. This can occur due to the longitude and latitude of the service not falling entirely within the ED. Nevertheless, these services are considered locally to be available to the population of the area and part of that area. Rather than delete these services and facilities we retained them for completeness. For example, Foróige in the Foróige, Árd Mór Neighbourhood Centre is in Fortunestown, Saggart, but due to its geographic coordinates, it is plotted just outside the boundary of Brookfield.

The sources of the maps were developed through data obtained from the Central Statistics Office, the Health Intelligence Unit (HSE) and ArcGISHub.

Map 1 The 13 Tallaght Electoral Divisions included in HANA 2024.





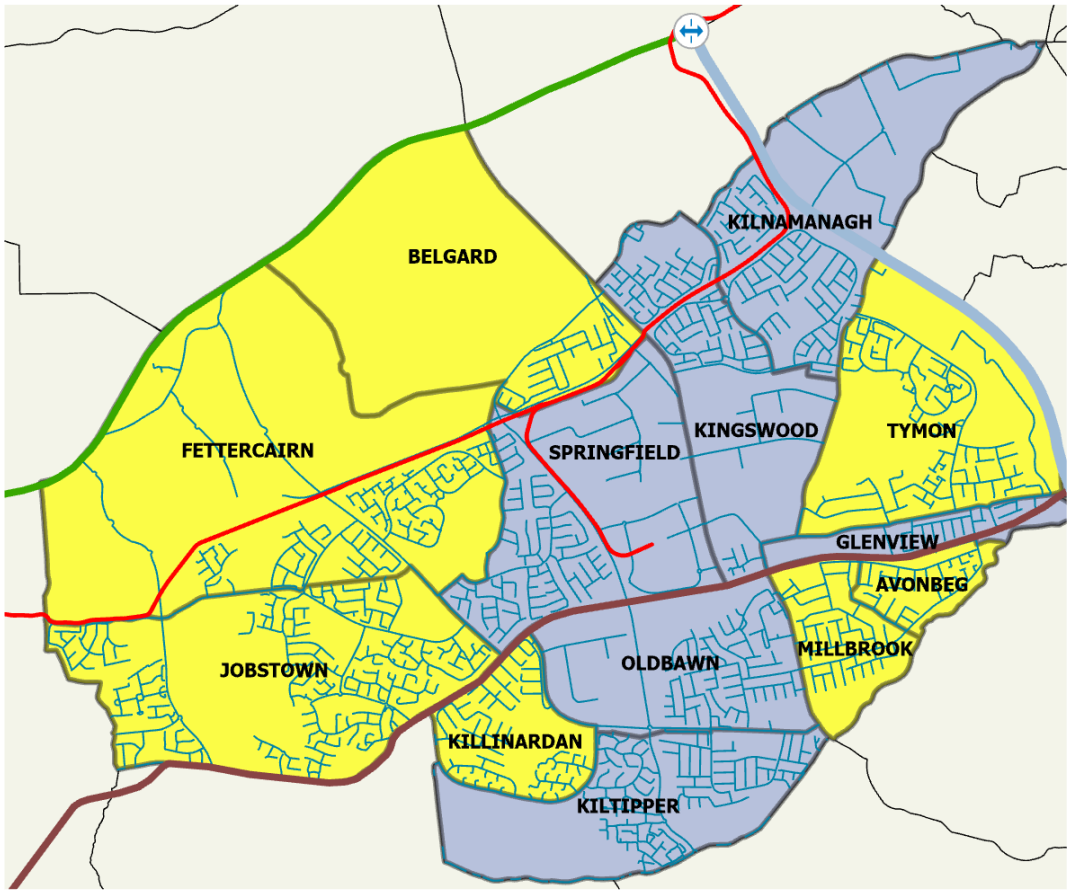
Legend

Tallaght Electoral Divisions (CSO 2022)

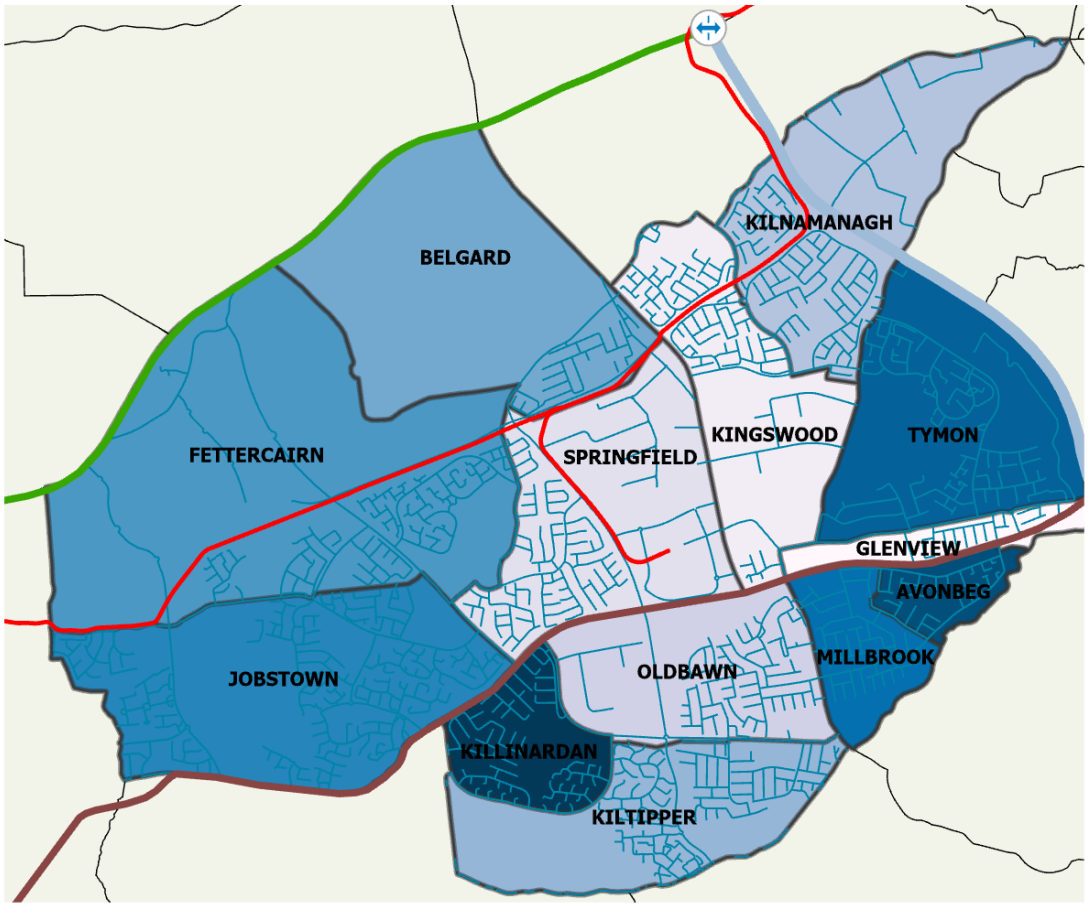
- AVONBEG
- BELGARD
- FETTERCAIRN
- GLENVIEW
- JOBSTOWN
- KILLINARDAN
- KILNAMANAGH
- KILTIPPER
- KINGSWOOD
- MILLBROOK
- OLDBAWN
- SPRINGFIELD
- TYMON

- Electoral Divisions 2022
- Red Cow Interchange
- LUAS (red line)
- M50 - Motorway
- N7 - National Primary Road
- N81 - National Secondary Road
- Tallaght Local Roads

Map 2 Tallaght Electoral Divisions by level of deprivation.



Map 3 Tallaght Electoral Divisions by scale of deprivation.



N

0 0.5 1 2 Kilometers

Legend

- Red Cow Interchange
- LUAS (red line)
- M50 - Motorway
- N7 - National Primary Road
- N81 - National Secondary Road
- Tallaght Local Roads
- Electoral Divisions (CSO 2022)

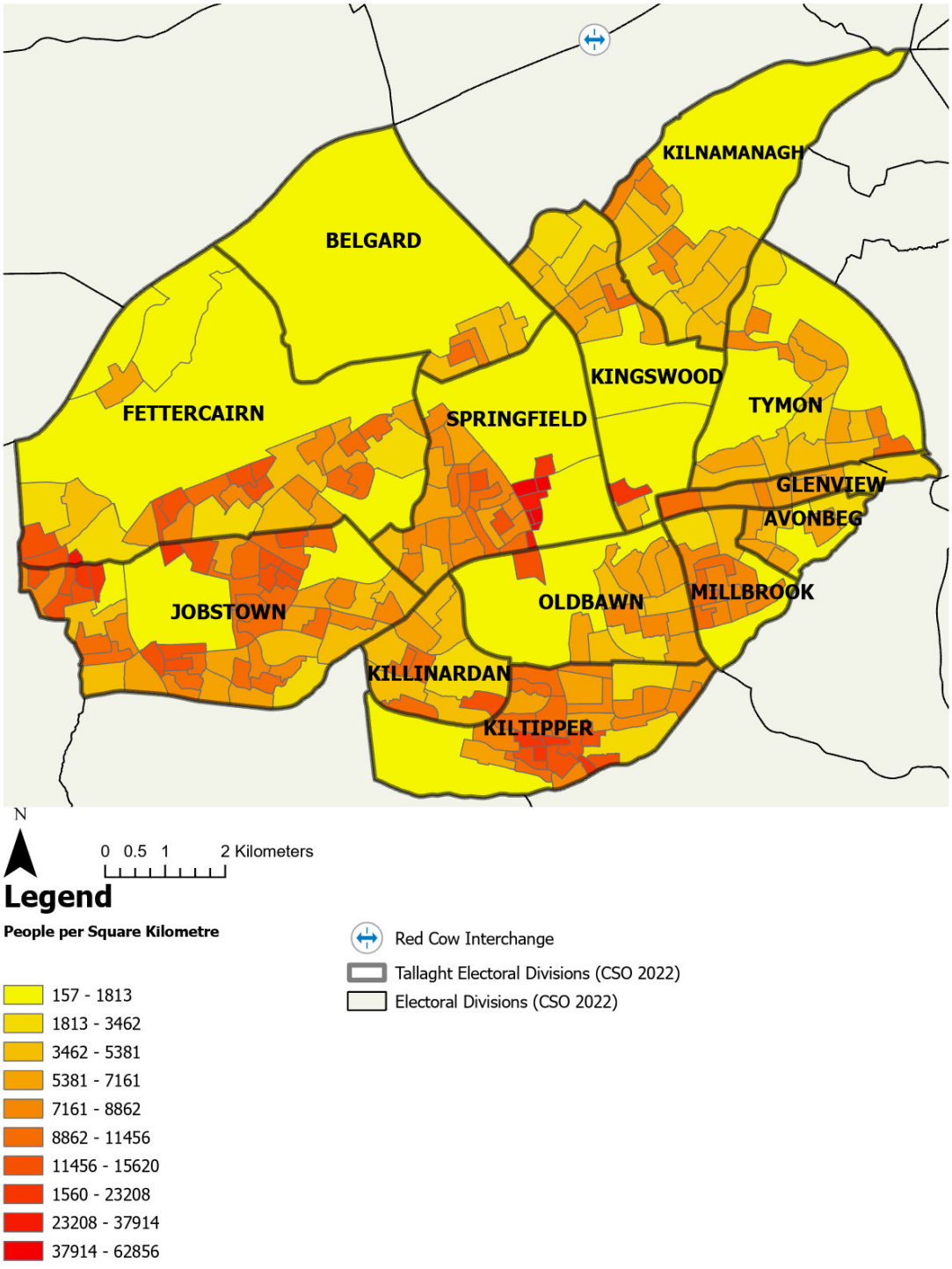
Deprivation Scale

1 = Most Deprived

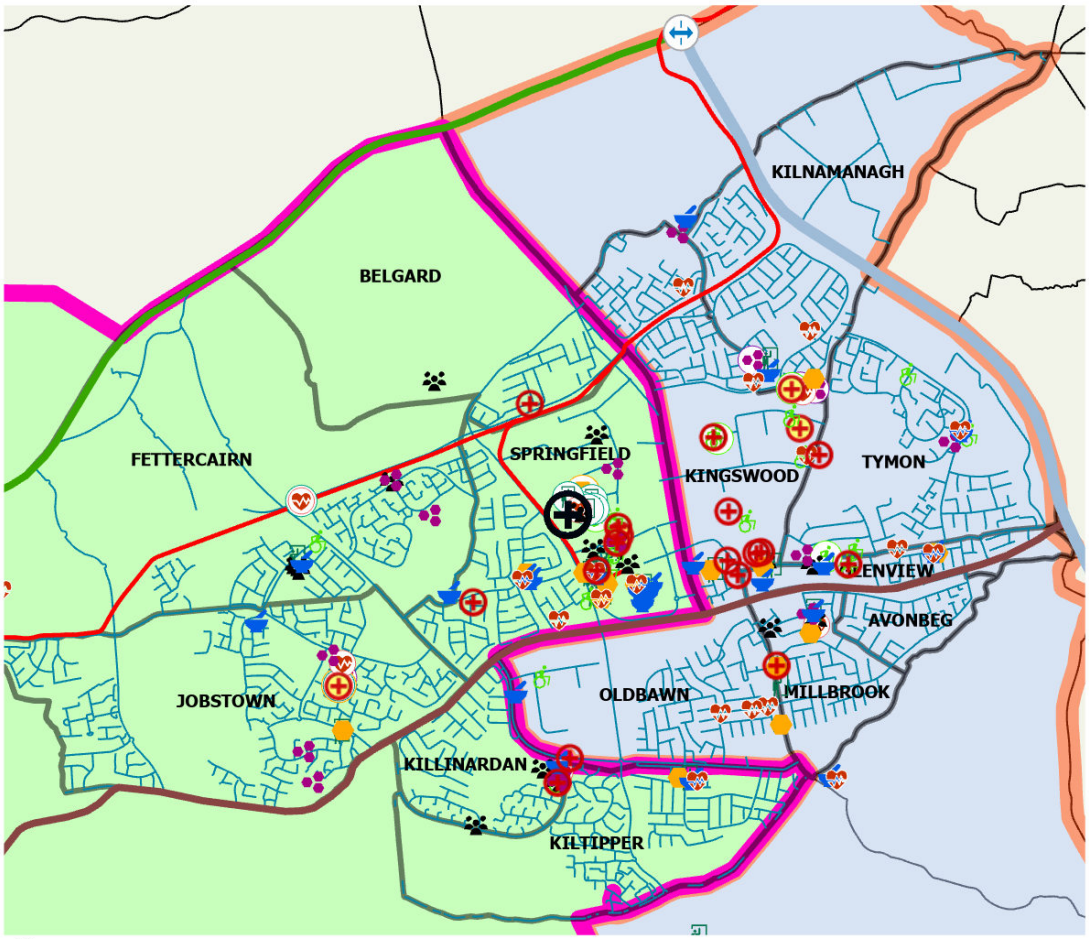
13 = Least Deprived

1
2
3
4
5
6
7
8
9
10
11
12
13

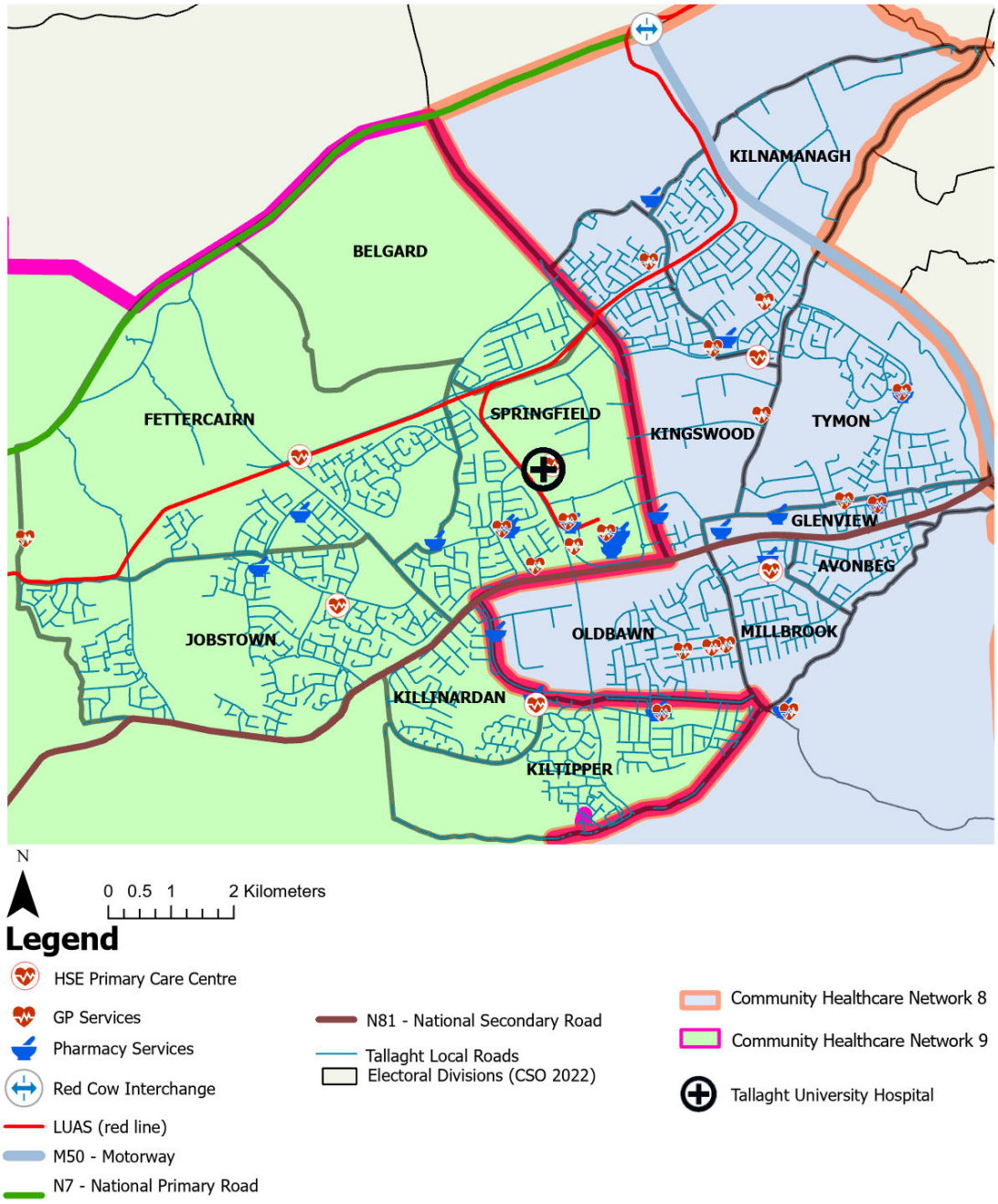
Map 4 Population density of Small Areas in Tallaght.



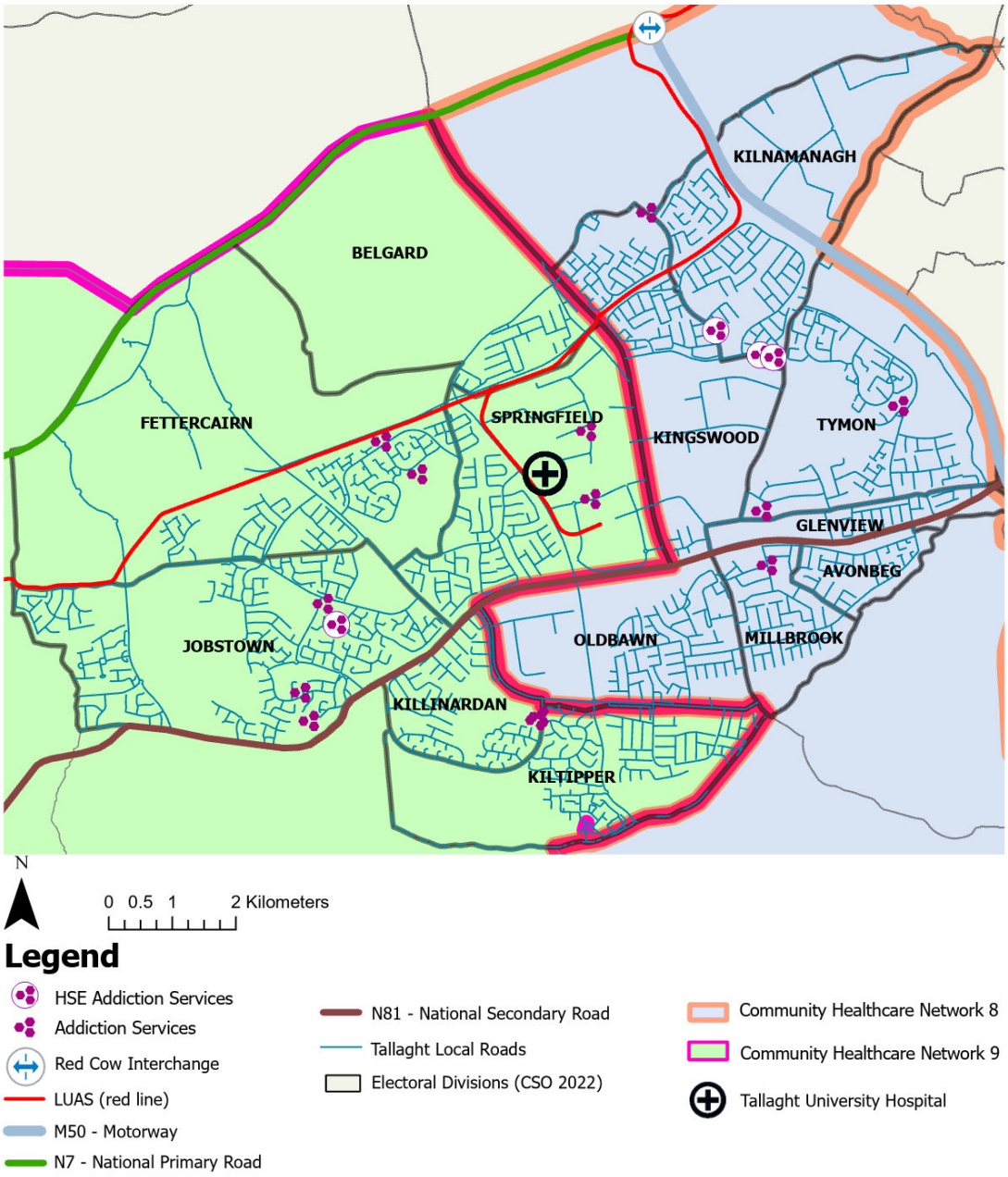
Map 5 Total health services and facilities in the 13 Electoral Divisions of Tallaght.



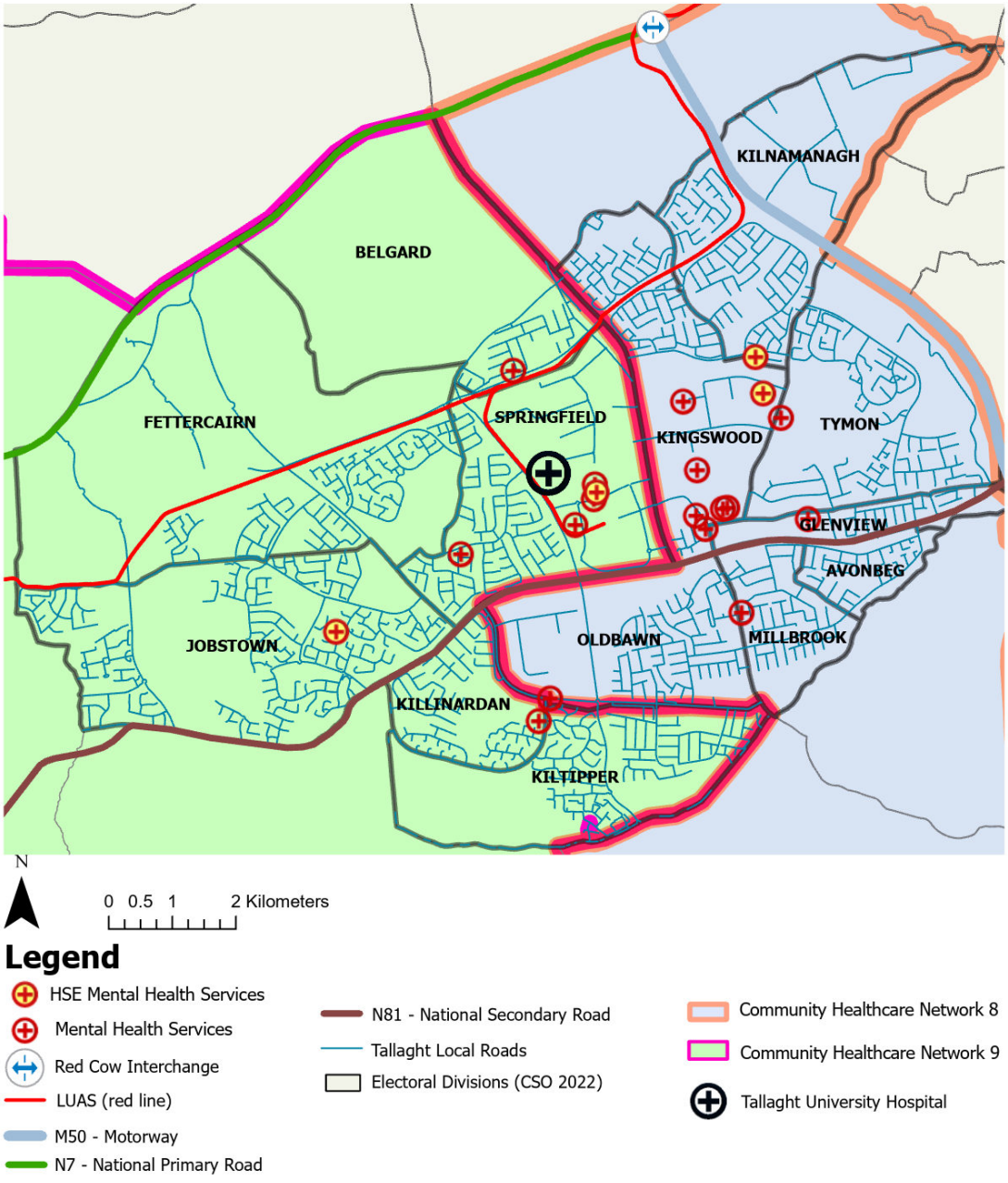
Map 6 GP and pharmacy services in the 13 Electoral Divisions of Tallaght.



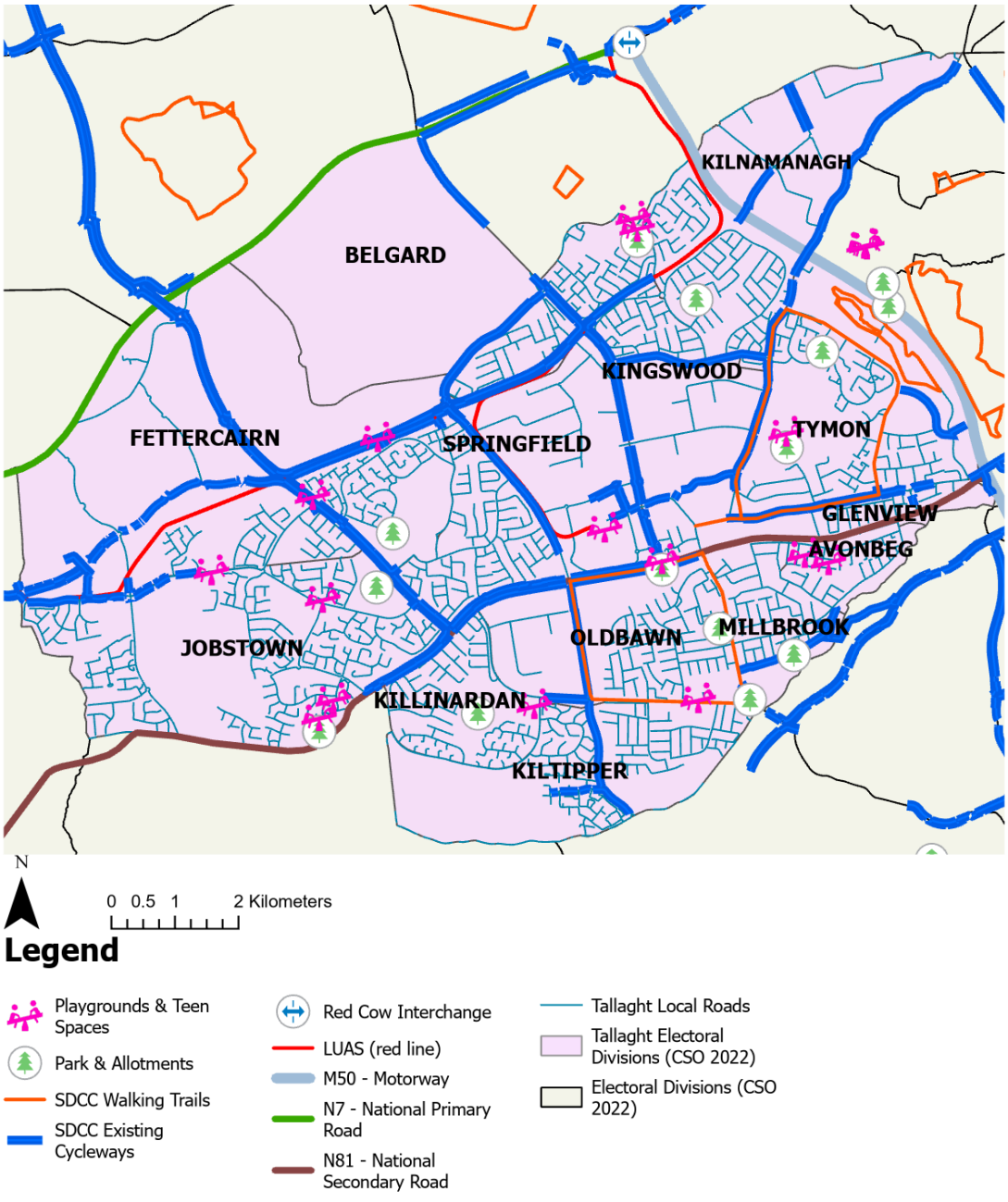
Map 7 Addiction services in the 13 Electoral Divisions of Tallaght.



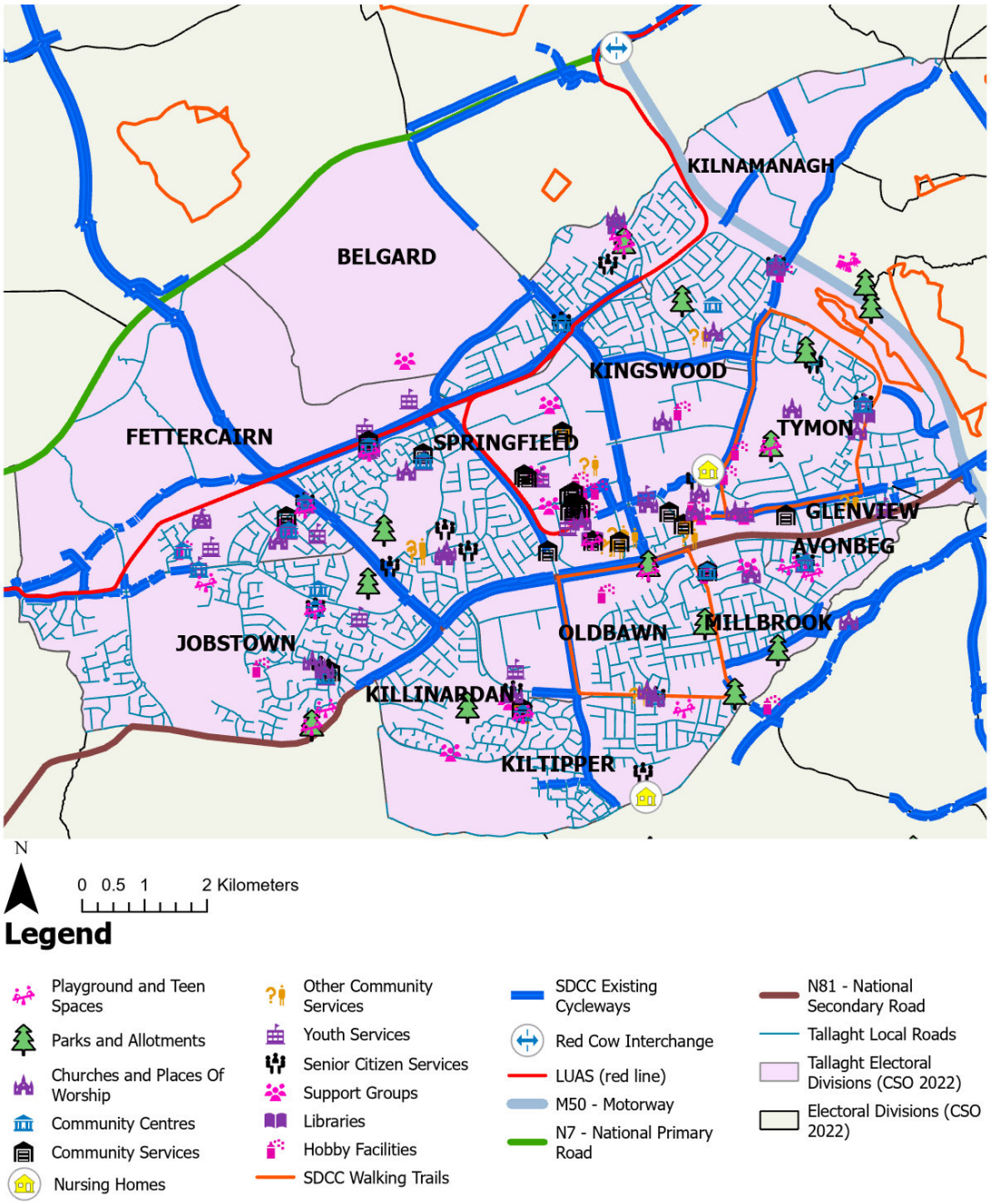
Map 8 Mental healthcare services in the 13 Electoral Divisions of Tallaght.



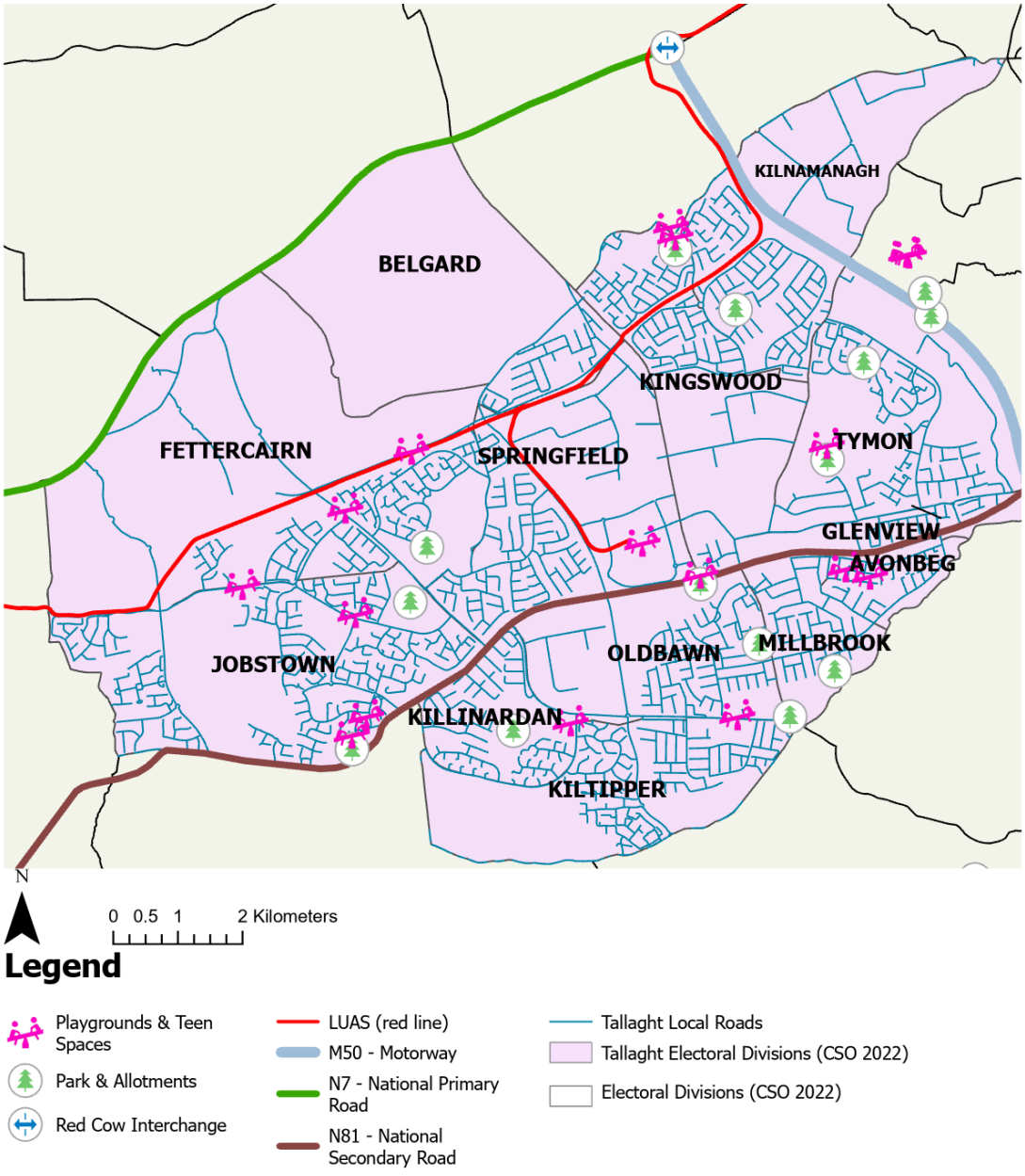
Map 9 Tallaght parks and public recreational spaces in the 13 Electoral Divisions of Tallaght.



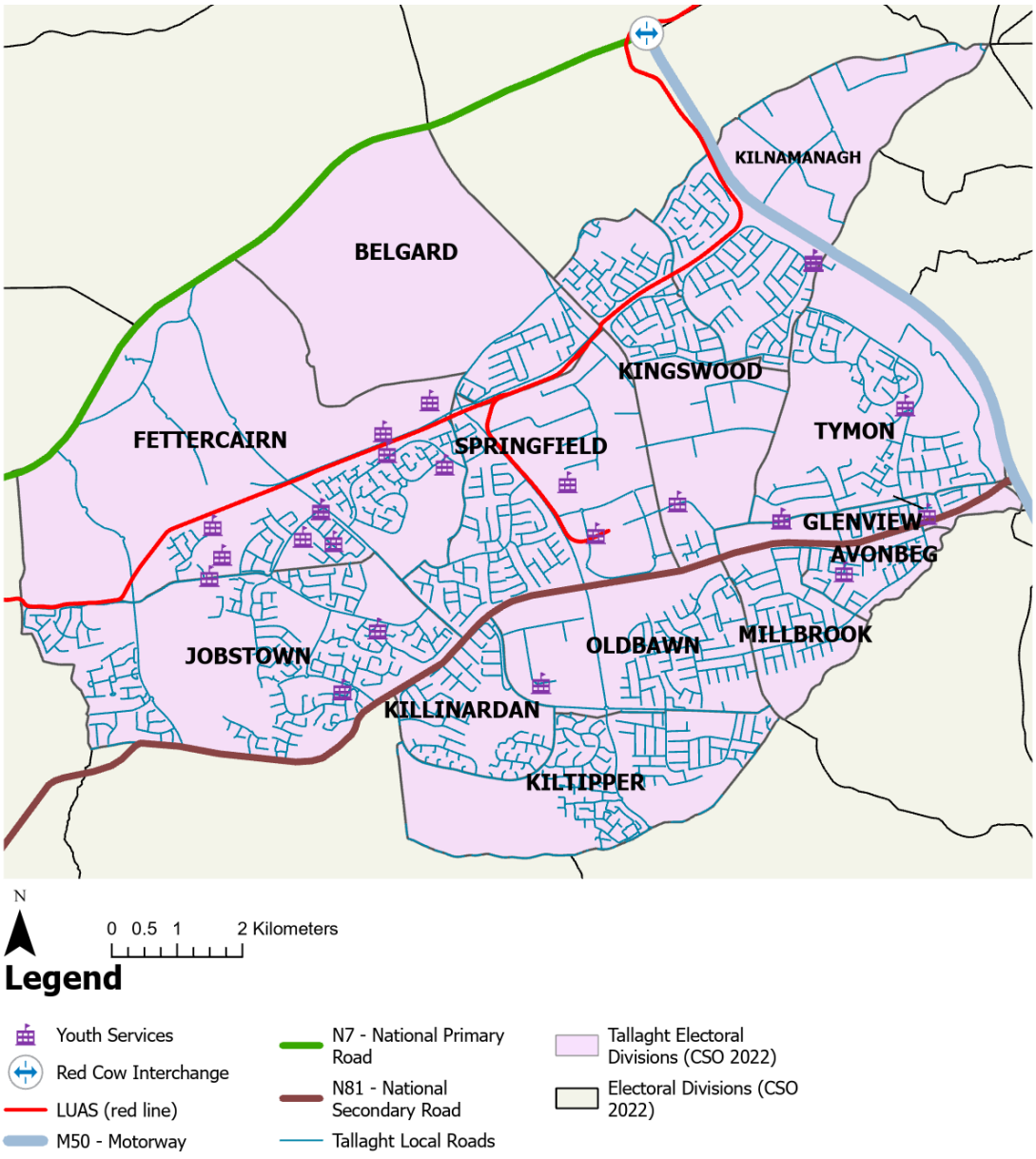
Map 10 Total Tallaght community services and facilities in the 13 Electoral Divisions of Tallaght.



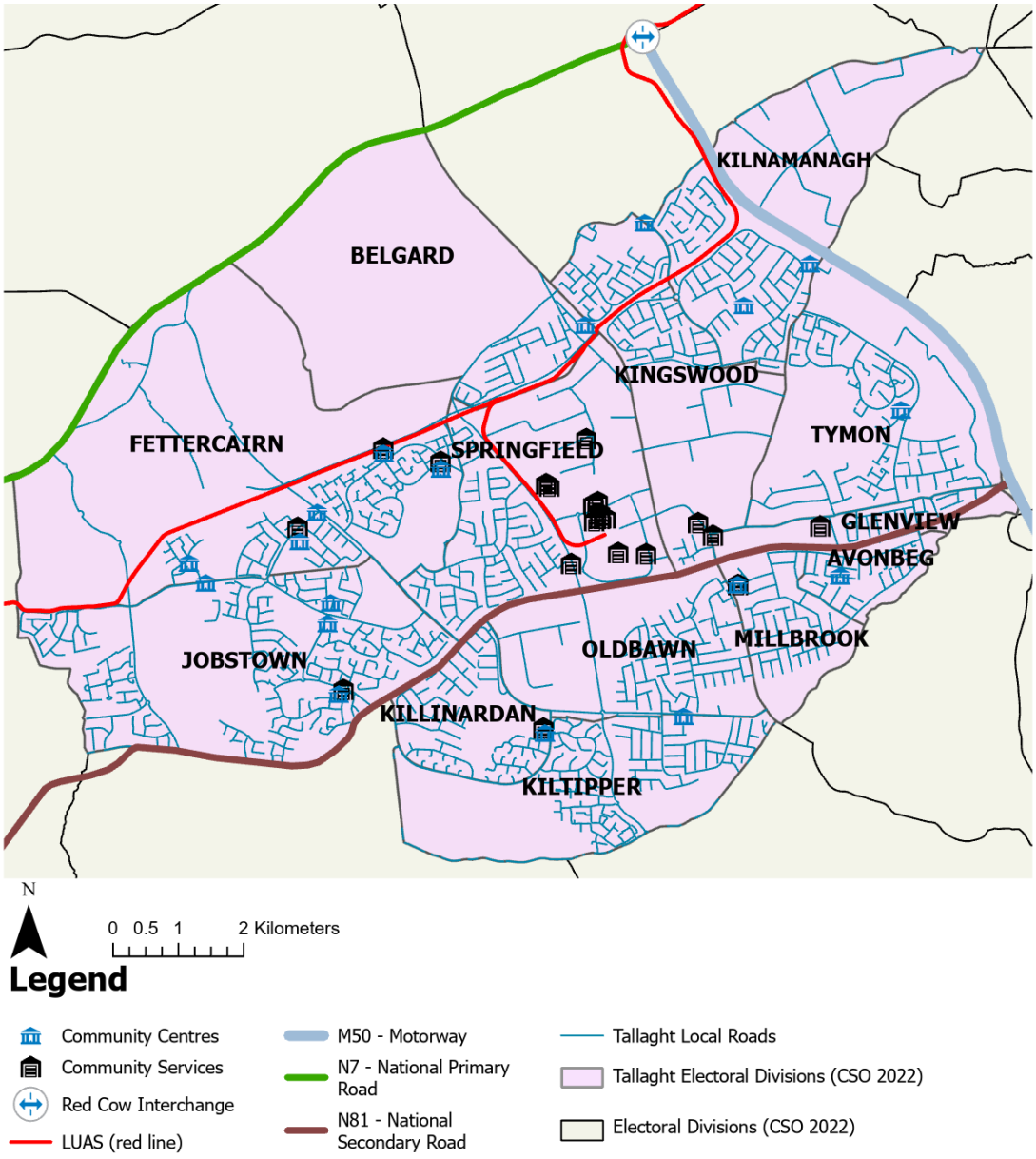
Map 11 Parks, playgrounds, and teen spaces in the 13 Electoral Divisions of Tallaght.



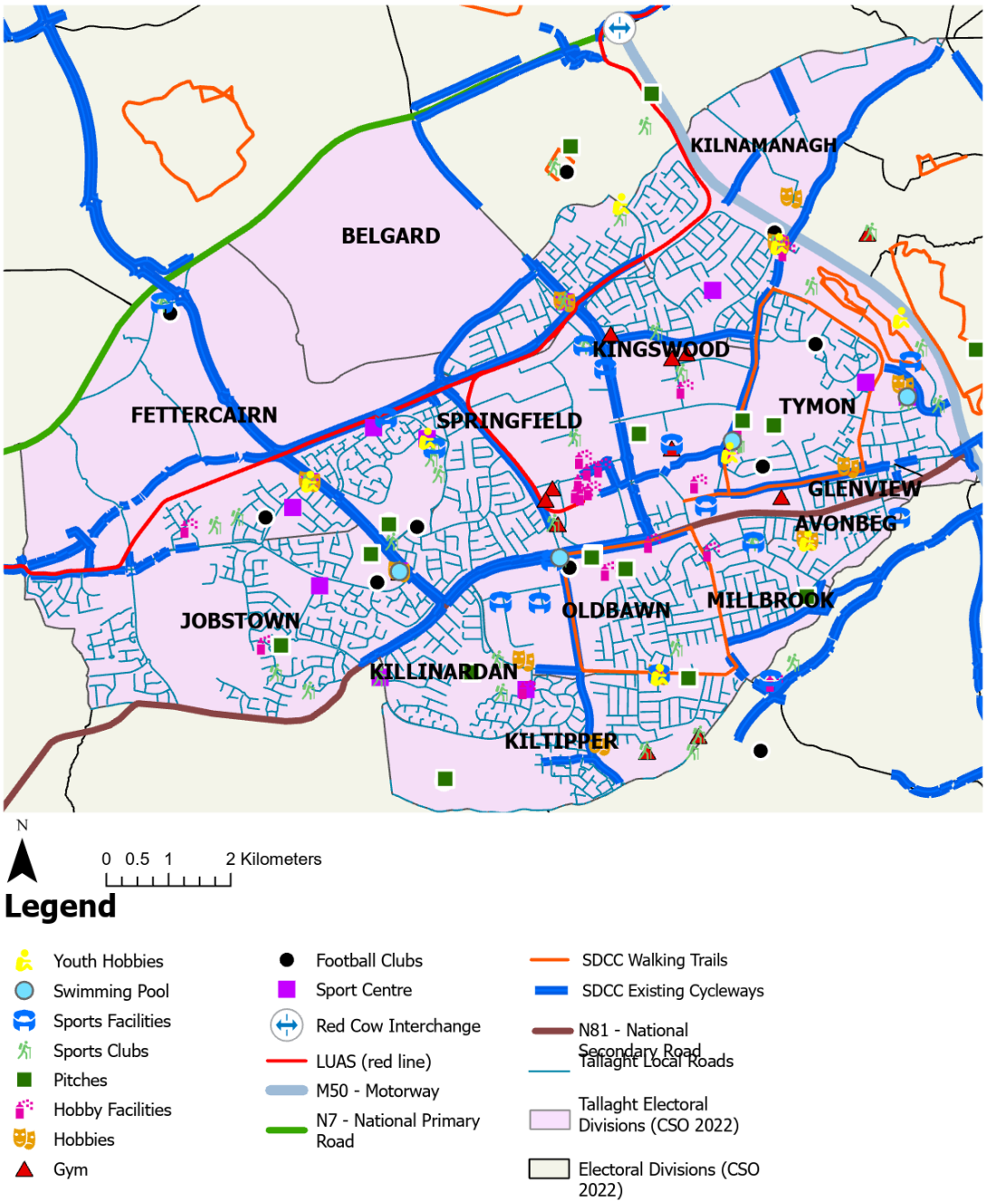
Map 12 Youth services in the 13 Electoral Divisions of Tallaght.



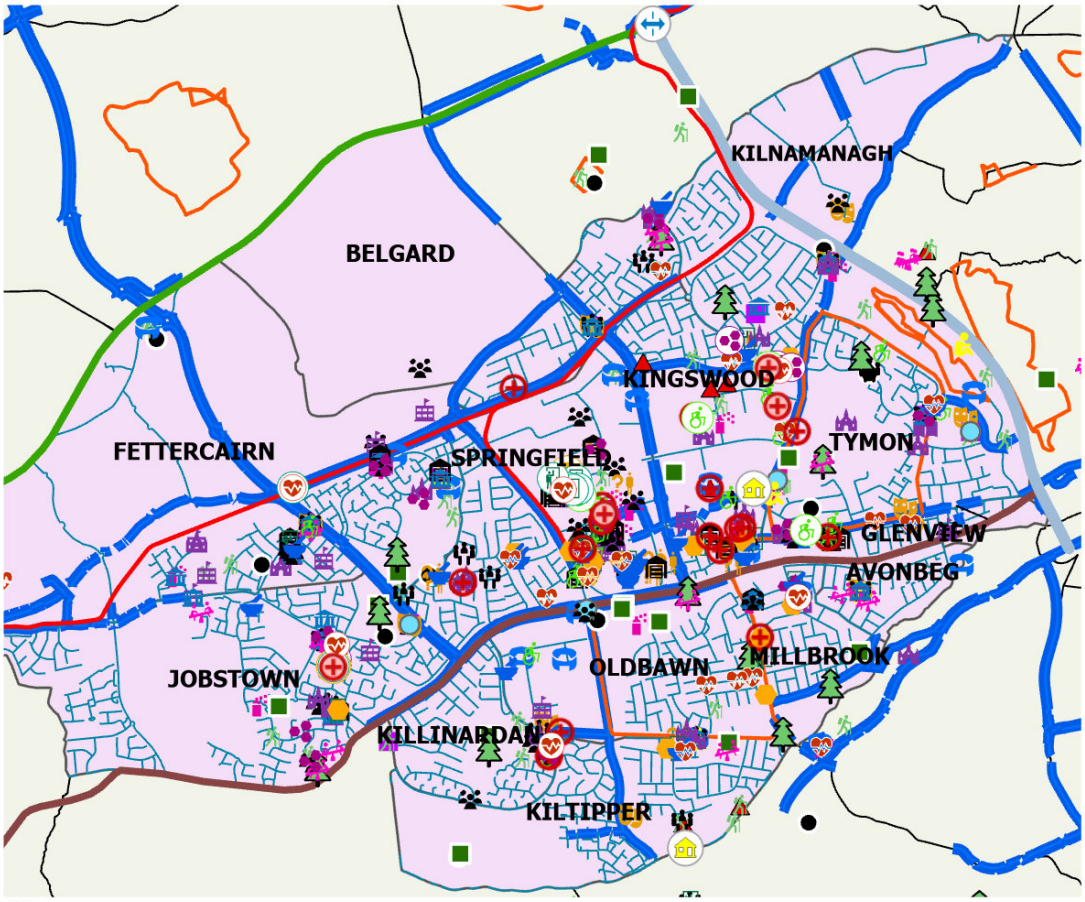
Map 13 Community centres and services in the 13 Electoral Divisions of Tallaght.



Map 14 Sports clubs and hobby facilities in the 13 Electoral Divisions of Tallaght.



Map 15 Total assets in the 13 Electoral Divisions of Tallaght.



Legend

HSE Healthcare Services

- HSE Mental Health Services
- HSE Primary Care Centre
- HSE Other Primary Care Services
- HSE Dental Services
- HSE Addiction Services

Healthcare Services

- Mental Health Services
- GP Services
- Pharmacy Services
- Addiction Services
- Dental Services
- Disability Support Services
- Support Groups
- Other Healthcare

Community Features

- Nursing Homes
- Playground and Teen Spaces
- Parks and Allotments
- Churches and Places Of Worship
- Community Centres
- Community Services
- Other Community Services
- Youth Services
- Senior Citizen Services
- Support Groups
- Libraries
- Other Primary Services
- Transport Services
- Community Support Groups
- Services For Children

Sports and Hobby Feature

- Youth Hobbies
- Swimming Pool
- Sports Facilities
- Sports Clubs
- Pitches
- Hobby Facilities
- Hobbies
- Gym
- Football Clubs
- Sport Centre

Transport

- Red Cow Interchange
- LUAS (red line)
- M50 - Motorway
- N7 - National Primary Road
- N81 - National Secondary Road
- SDCC Walking Trails
- SDCC Existing Cycleways
- Tallaght Local Roads

Administrative

- Tallaght Electoral Divisions (CSO 2022)
- Electoral Divisions (CSO 2022)

Participants were asked to report about their utilisation of services and facilities within Tallaght and whether they considered these to be an asset.

Table 8 Respondents' reported utilisation of community facilities in Tallaght in the past 12 months and whether the services were considered as an asset.

Asset Category Number (%)	Respondents who used services in the past 12 months	Locations where services were used		Frequency which services were used (in Tallaght)		Respondents who considered services an asset (in Tallaght)	
Public transport services (N=273/274; 99.6%)	N=231/274 (84.3)	In Tallaght Both inside and outside of Tallaght Outside of Tallaght	126/231(58.9) 86/231 (37.2) 9/231 (3.9)	Daily Weekly Monthly Bimonthly Once or twice	60/222 (27) 81/222 (36.5) 50/222 (22.5) 14/222 (6.3) 16/222 (7.2)	Yes No	217/222(97.7) ~
Parks and allotments (N=273/274; 99.6%)	N=223/274 (81.2)	In Tallaght Both inside and outside of Tallaght Outside of Tallaght	141/223 (63.2) 64/223 (28.7) 17/223 (7.6)	Daily Weekly Monthly Bimonthly Once or twice	67/205 (32.7) 99/205 (48.3) 26/205 (12.7) 5/205 (2.5) 8/205 (3.9)	Yes No	205/205(100.0) /
Playgrounds and Teen spaces (N=273/274 (99.6%)	N=125/274 (45.6)	In Tallaght Both inside and outside of Tallaght Outside of Tallaght	78/125 (62.4) 34/125 (27.2) 13/125 (10.4)	Daily Weekly Monthly Bimonthly Once or twice	22/112 (19.6) 60/112 (53.6) 22/112 (19.6) 6/112 (5.4) ~	Yes No	111/112(99.1) ~
Community centres (N=269/274; 98.2%)	N=73/274 (26.6)	In Tallaght Both inside and outside of Tallaght Outside of Tallaght	63/73 (86.3) 4/73 (5.5) 5/73 (6.8)	Daily Weekly Monthly Bimonthly Once or twice	4/67 (6.3) 40/67 (59.7) 14/67 (20.9) ~ 7/67 (10.4)	Yes No	67/67 (100.0) /

Asset Category Number (%)	Respondents who used services in the past 12 months	Locations where services were used		Frequency which services were used (in Tallaght)		Respondents who considered services an asset (in Tallaght)	
Community services (N=262/274; 95.6%)	N=44/274 (16.1)	In Tallaght Both inside and outside of Tallaght Outside of Tallaght	41/44 (93.2) ~ ~	Daily Weekly Monthly Bimonthly Once or twice	~ 24/42 (57.1) 7/42 (16.7) ~ 7/42 (16.7)	Yes No	41/42 (97.6) ~
Churches / Places of worship (N=271/274; 98.9%)	N=146/274(53.5)	In Tallaght Both inside and outside of Tallaght Outside of Tallaght	118/146(43.1) 10/146 (6.8) 18/146(12.3)	Daily Weekly Monthly Bimonthly Once or twice	7/128 (5.5) 56/128 (43.8) 23/128 (18.0) 14/128 (10.9) 27/128 (21.1)	Yes No	120/128(93.8) ~
Youth services (N=270/274; 98.5%)	N=18/274 (6.6)	In Tallaght Both inside and outside of Tallaght Outside of Tallaght	16/18(88.9) / ~	Daily Weekly Monthly Bimonthly Once or twice	~ 11/16 (68.8) ~ / /	Yes No	16/16(100.0) /
Support groups (N=271/274; 98.9%)	N=17/274(6.2)	In Tallaght Both inside and outside of Tallaght Outside of Tallaght	12/17(70.6) / 5/17(29.4)	Daily Weekly Monthly Bimonthly Once or twice	~ 8/12(8.3) ~ ~ ~	Yes No	12/12(100.0) /
Senior citizen services (N=271/274; 98.9%)	N=11/274 (4.0)	In Tallaght Both inside and outside of Tallaght Outside of Tallaght	11/274 (4.0) / /	Daily Weekly Monthly Bimonthly Once or twice	~ 6/11(54.5) ~ ~ ~	Yes No	11/11 (100.0) /
Libraries (N=271/274; 98.9%)	N=120/274 (43.8)	In Tallaght Both inside and outside of Tallaght Outside of Tallaght	110/120 (91.7) ~ 6/120 (5.0)	Daily Weekly Monthly Bimonthly Once or twice	5/114(4.4) 31/1114(27.2) 52/114(19.0) 11/114(9.6) 15/114(13.2)	Yes No	114/114(100.0) /

Asset Category Number (%)	Respondents who used services in the past 12 months	Locations where services were used		Frequency which services were used (in Tallaght)		Respondents who considered services an asset (in Tallaght)	
Services for children under 5 (N=272/274; 99.3%)	N=25/274 (9.1)	In Tallaght Both inside and outside of Tallaght Outside of Tallaght	21/25(84.0) ~ ~	Daily Weekly Monthly Bimonthly Once or twice	~ 12/22(54.5) ~ ~ ~	Yes No	18/22(81.8) ~
Disability services (N=271/274; 98.9%)	N=12/274 (6.2)	In Tallaght Both inside and outside of Tallaght Outside of Tallaght	14/17(82.4) ~ ~	Daily Weekly Monthly Bimonthly Once or twice	~ ~ 6/15(40.0) ~ ~	Yes No	12/15(4.4) ~
Other (N=258/274; 94.2%)	N=12/274 (4.4)	In Tallaght Both inside and outside of Tallaght Outside of Tallaght	12/12(100.0) / /	Daily Weekly Monthly Bimonthly Once or twice	~ ~ ~ ~ 5/12(41.7)	Yes No	11/12 (91.7) ~

~ denotes 5 or fewer cases reported.

/ denotes zero responses reported.

Public transport services were the most widely used, with 84.3% (N=231/274) of respondents reporting usage. Most users (58.9%; N=126/231) used public transport within Tallaght, while 37.2% (N=86/231) accessed services both inside and outside the area. In terms of frequency, 36.5% (N=81/222) used public transport weekly, and 27.0% (N=60/222) used it daily. A strong majority (97.6%; N=217/222) considered public transport a valuable community asset.

Parks and allotments were the second most utilised service, with 81.2% (N=223/274) of respondents visiting these spaces. Most visits occurred within Tallaght (63.2%; N=141/223), and 28.7% (N=64/223) accessed parks both inside and outside Tallaght. Parks were visited frequently, with 48.3% (N=99/205) visiting weekly and 32.7% (N=67/205) visiting daily. All respondents who used parks and allotments viewed them as beneficial to the community (100.0%; N=205/205).

Playgrounds and Teen Spaces were utilised by 45.6% (N=125/274) of respondents, with the majority (62.4%; N=78/125) accessing them primarily within Tallaght.

Weekly visits were most common, reported by 53.6% (N=60/112) of users, followed by daily visits at 19.6% (N=22/112). Nearly all respondents who used these spaces valued them as a community asset (99.1%; N=111/112).

Community centres were used by 26.6% (N=73/274) of respondents, with 86.3% (N=63/73) accessing these services within Tallaght. Weekly visits were reported by 59.7% (N=40/67) of users. Although community centre usage was lower compared to other facilities, every respondent who used these centres considered them a valuable asset (100.0%; N=67/67).

For other services, including youth services, support groups, senior citizen services, and disability services, fewer than 10.0% of respondents reported usage over the past 12 months. However, for each of these services, those who used them considered them valuable assets, with user satisfaction ratings between 93.8% and 100.0%.

Table 9 Respondents' reported utilisation of sport and hobby facilities in Tallaght in the past 12 months and whether the services were considered as an asset.

Ranked in order of decreasing rate of utilisation.

Asset Category Number (%)	Respondents who used services in the past 12 months	Locations where services were used		Frequency which services were used (in Tallaght)		Respondents who considered services an asset (in Tallaght)	
Sports clubs and facilities (N=270/274; 98.5%)	N=107/274 (39.1)	In Tallaght Both inside and outside of Tallaght Outside of Tallaght	81/107 (29.6) 12/107 (11.2) 14/107 (13.1)	Daily Weekly Monthly Bimonthly Once or twice	15/93 (16.1) 66/93 (71.0) 10/93 (10.8) / ~	Yes No	91/93 (97.8) ~
Hobby facilities (N=271/274; 98.9%)	N=74/274 (27.0)	In Tallaght Both inside and outside of Tallaght Outside of Tallaght	60/74 (81.1) 5/74 (12.2) 9/74 (12.2)	Daily Weekly Monthly Bimonthly Once or twice	9/65 (13.8) 43/65 (66.2) 10/65 (15.4) ~ ~	Yes No	64/65 (98.5) ~

In the past 12 months, 39.1% (N=107/274) of respondents reported using sports clubs and facilities. Among these users, the majority (29.6%; N=81/107) accessed these services within Tallaght, while 11.2% (N=12/107) used facilities both inside and outside Tallaght, and 13.1% (N=14/107) exclusively outside Tallaght. The most common usage frequency was weekly (71.0%; N=66/93), followed by daily (16.1%; N=15/93) and monthly (10.8%; N=10/93) visits. Overall, 97.8% (N=91/93) of respondents who utilised sports clubs and facilities viewed them as a valuable community asset.

In comparison, 27.0% (N=74/274) of respondents reported using hobby facilities over the past year. Most respondents (81.1%; N=60/74) accessed these services within Tallaght, while 12.2% (N=9/74) used facilities exclusively outside Tallaght, and another 12.2% (N=5/74) used them both inside and outside the area. Weekly usage was again the most frequent (66.2%; N=43/65), followed by monthly (15.4%; N=10/65) and daily use (13.8%; N=9/65). Overall, 98.5% (N=64/65) of facility users reported that hobby facilities were a valuable asset to the community.

Table 10 Respondents' perspectives on personal and community characteristics in Tallaght.

Indicator	Number (%)
South Dublin County Council is exploring measures to increase walking and cycling in Tallaght. What strategies do you think are necessary to achieve this? (N=179/274; 63.5%)*	
Don't know	96 (53.6)
Cycling infrastructure improvements (e.g., more cycle lanes, connecting existing cycle lanes, bike rental schemes)	78 (43.6)
Safety and security (e.g., make it safer to walk with more lighting, greater Gardaí presence)	39 (21.8)
Community engagement initiatives (e.g., more clubs for adults and teenagers, promoting local events/programmes, community bike rental schemes)	25 (13.9)
No action needed	21 (11.7)
Other (e.g., reliance on cars, traffic congestion with cycling lanes and road works)	15 (8.4)
Footpaths, green spaces and road infrastructure (e.g., fix footpaths, more walkways)	12 (6.7)
Public transport improvement (e.g., more frequent and reliable bus routes)	11 (6.1)

Indicator	Number (%)
Where do you think this needs to happen? (N=155/274; 82.1%)*	
General/all over Tallaght	82 (32.2)
Other (e.g., investment, public transport connectivity needs to happen first)	24 (9.4)
Specific areas (e.g., Tallaght to Dublin city centre, connecting Tallaght with suburbs such as Saggart and Citywest)	24 (9.4)
Public spaces (e.g., parks, community centres, in the village)	12 (4.7)
No action needed	8 (3.1)
School areas	5 (1.9)
Would you like to see more Active Travel Infrastructure (e.g., walking paths and cycling lanes) put in within Tallaght? (N=247/274; 90.1%)	
Yes	111 (40.5)
No	136 (49.6)
Where would you like to see them put? (N=85/274; 31.0%)*	
General/all over Tallaght	43 (50.5)
Specific areas (e.g., Tallaght to Dublin city centre, connecting Tallaght with suburbs such as Saggart and Citywest)	24 (28.2)
Public spaces	7 (8.2)
School areas	~
Other (e.g., comments on walking)	6 (7.1)
No action needed	~
Does concern about anti-social behaviour impact your decision to walk or cycle in certain areas of Tallaght? (N=268/274; 97.8%)	
Yes	216 (80.6)
No	52 (19.4)
Do you think that SDCC is good at providing healthy recreation opportunities for the community in Tallaght? (N=274/274; 100.0%)	
Yes	132 (48.2)
No	94 (34.3)
Don't know	48 (17.5)
Why not? (N=86/274; 31.4%)*	
Lack of amenities for children and teenagers	24 (27.9)
Calls for more action from SDCC	13 (15.1)
Anti-social behaviour and safety concerns	10 (11.6)
Lack of community facilities and engagement	10 (11.6)
Lack of focus in certain areas (e.g., Jobstown and Fettercairn)	10 (11.6)
Insufficient funding for local services	9 (10.4)
Lack of accessible information	8 (9.3)
Poor maintenance of public spaces and amenities	5 (5.8)

* Participant could provide more than one answer
~ denotes 5 or fewer cases reported.

When asked about strategies to increase walking and cycling in Tallaght (N=179/274), 53.6% (N=96/179) of respondents were uncertain about specific strategies, while 43.6% (N=78/179) suggested improvements to cycling infrastructure, such as adding more cycle lanes, connecting existing routes, and introducing bike rental schemes. Additionally, 21.8% (N=39/179) recommended increased safety and security measures, such as enhanced lighting and greater Gardaí presence, to make walking more appealing. Community engagement initiatives, including more clubs, local events, and community bike rentals, were proposed by 13.9% (N=25/179) of respondents, while 11.7% (N=21/179) felt that no further action was necessary. Other suggestions included addressing car dependency and traffic congestion (8.4%; N=15/179), improving footpaths and green spaces (6.7%; N=12/179), and enhancing public transport services (6.1%; N=11/179).

When considering locations for these improvements (N=155/274), 52.9% (N=82/155) suggested general improvements across Tallaght, while 15.5% (N=24/155) highlighted specific routes, such as those linking Tallaght with Dublin city centre and nearby suburbs like Saggart and Citywest. Interest in additional active travel infrastructure was mixed, with 40.5% (N=111/247) supporting it and 49.6% (N=136/247) opposing further development in this area. Anti-social behaviour was cited as a significant deterrent to walking and cycling, with 80.6% (N=216/268) of respondents reporting that safety concerns impacted their decisions.

Regarding South Dublin County Council's (SDCC) role in providing recreational opportunities, responses were divided: 48.2% (N=132/274) believed SDCC was effective, while 34.3% (94/274) disagreed, and 17.5% (N=8/274) were unsure. Reasons for dissatisfaction included a lack of amenities for children and teenagers (27.9%; N=24/86), calls for more SDCC action (15.1%; N=13/86), anti-social behaviour concerns (11.6%; N=10/86), and limited community facilities, especially in certain areas like Jobstown and Fettercairn (11.6%; N=10/86). Other concerns included insufficient funding for local services (10.4%; N=9/86), poor maintenance of public spaces (5.8%; N=5/86), and limited access to information about available amenities (9.3%; N=8/86).

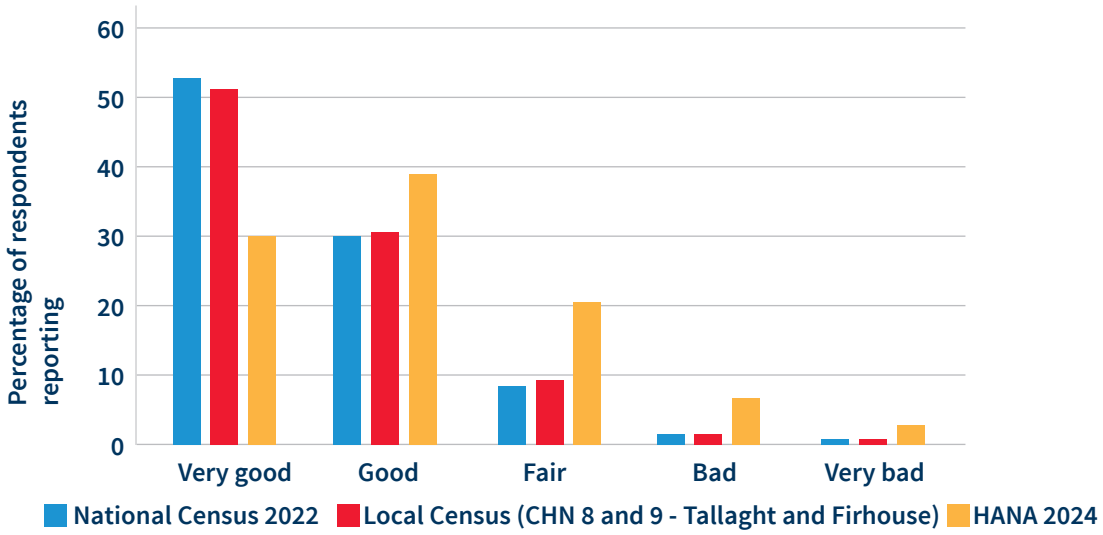
2.5. Physical and social wellbeing

Health status was used to identify health problems in the Tallaght area as a marker for the health needs of the population.

Self-reported rating of health status of respondent

Respondents were asked to indicate their self-reported health status on a five-item scale. This scale is identical to the scale used in the 2022 national Census for Ireland.[60-61]

Figure 11 Self-reported rating of health status of respondents in the CSO Census 2022, Local Census 2022 (CHN 8 and 9) and HANA Survey 2024.



Note: In the HANA 2024 research, this question was asked only of respondents. In contrast, the CSO Census 2022 data gathers responses from all individuals in the household. Similarly, the HSE have carried out a population profile for the community healthcare networks covering Tallaght and Firhouse (CHN 8 and 9)[61] The population comparison includes the CSO Census 2022 (N= 5,149,139), local Census 2022 data covering CHN 8 and 9 (N=45,566) and the HANA Survey 2024 (N = 273/274, 99.6%).

The comparison shows that self-reported health status among respondents in Tallaght appears lower than the national and local average. In the 2024 HANA survey, 30.3% (N=83/273) of respondents rated their health as “very good,” compared to 53.2% (N=2,738,965/5,149,139) in the CSO Census 2022.[60] Similarly, 51.7% (N=23,575/45,566) of respondents within CHN 8 and 9 reported their health as ‘very good’.[61]

Additionally, 20.2% (N=55/273) of respondents in Tallaght rated their health as "fair," significantly higher than the 8.6% (N=442,824/5,149,139) recorded nationally and locally (9.3%; N=4,238/45,566). These findings suggest that respondents in Tallaght may be experiencing poorer health outcomes than the general population in Ireland.

Table 11 Respondents' reported household waiting list status.

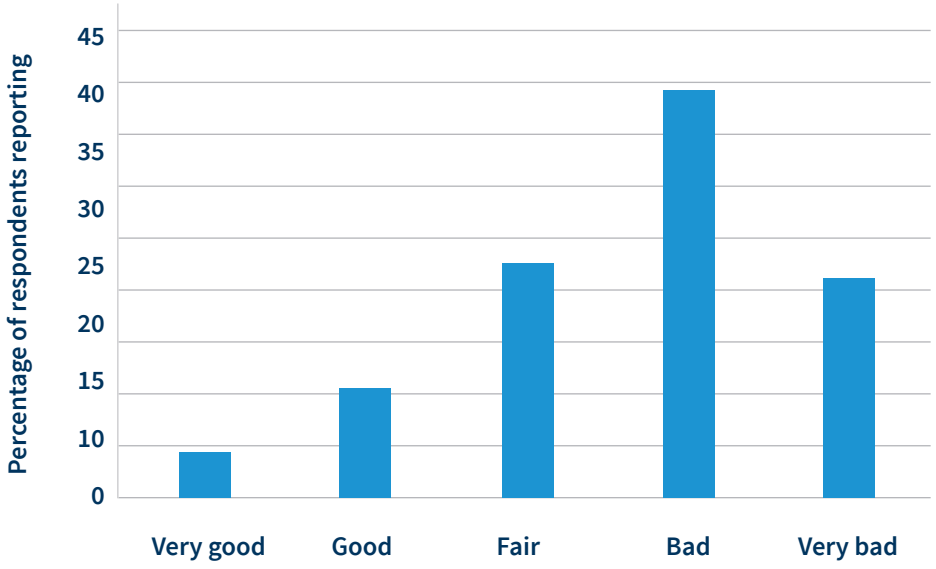
Indicator	Number (%)
Household members on waiting list for assessment or diagnosis (N=268/274; 97.8%)	
0	126 (47.0)
1-2	80 (29.8)
3-4	~

~ denotes 5 or fewer cases reported.

In terms of household waiting lists for assessments or diagnoses (N=268/274; 97.8%), nearly half of the households (47.0%; N=126/268) reported having no members on a waiting list. However, 29.8% (N=80/268) indicated that one to two household members were awaiting assessment or diagnosis.

Dental health

Figure 12 Self-reported rating of dental health of respondents.



Respondents were asked to rate their dental/oral health on a scale from "very bad" to "very good." Among the respondents, 99.6% (N=273/274) answered this question. The majority (83.9%; N=229/273) reported their dental health as either "fair," "good," or "very good."

Table 12 Respondents' reported dental health status and access to care.

Indicator	Number (%)
Need for dental treatment if visiting tomorrow (N=274/274; 100.0%)	
Yes	135 (49.3)
No	130 (47.4)
Don't know	9 (3.3)
Frequency of dental or oral pain in households in the last four months (N=274/274; 100.0%)	
Never	153 (55.8)
Hardly ever	33 (12.0)
Occasionally	57 (20.8)
Often	17 (6.2)
Very often	10 (3.6)
Don't know	~
Access and preference of dental care services (N=274/274; 100%)	
I primarily accessed private dental care services	135 (49.3)
I primarily accessed public dental care services	87 (31.8)
I did not access any dental care services	36 (13.1)
I accessed both public and private dental care services equally	11 (4.0)
Don't know	5 (1.8)
Why did you not access any dental care services? (N=36/274; 13.1%)	
I wanted to access dental care services but faced barriers due to costs	12 (33.3)
I wanted to access dental care services but faced barriers due to a dentist being unavailable	~
Number of dentist visits in the last 2 years (N=226/274; 82.5%)	
0 times	40 (14.6)
1-2 times	111 (49.1)
3-4 times	52 (23.0)
5-6 times	12 (5.3)
7 or more times	11 (4.8)
Visited GP for dental issues due to a lack of dentist access (N=274/274; (100.0%)	
Yes	12 (4.4)
No	260 (94.9)
Don't know	~

~ denotes 5 or fewer cases reported.

Among respondents, 49.3% (N=135/274) indicated they would need dental treatment if they visited a dentist tomorrow, while 47.4% (N=130/274) felt they would not, and 3.3% (N=9/274) were unsure. In terms of recent dental pain, 55.8% (N=153/274) reported experiencing no pain in the last four months, while 30.6% (N=84/274) reported occasional to frequent pain ("occasionally," "often," or "very often").

Regarding access to dental care services, 49.3% (N=135/274) primarily used private dental care, 31.8% (N=87/274) accessed public services, and 13.1% (N=36/274) did not access any dental services, mainly due to cost barriers (33.3%; N=12/36).

For frequency of dental visits over the past two years (N=226/274; 82.5%), the most common response was one to two visits (49.1%; N=111/226), while 14.6% (N=40/226) reported no dental visits. Additionally, only 4.4% (N=12/274) visited a GP for dental issues when they lacked access to a dentist.

Physical activity

Respondents were asked about how much physical activity they engaged in.

Table 13 Respondents' reported physical activity in the 2024 HANA Survey.

Indicator	Weekly Frequency	2024 HANA Survey Number (%)
Strenuous exercise (e.g., running, jogging, hurling, football).	**N=255/274 (93.4)**	
	None	165 (64.7)
	Less than five	75 (29.4)
	More than five	15 (5.8)
Moderate exercise (e.g., fast walking, tennis, easy cycling).	**N=256/274 (93.4)**	
	None	112 (43.7)
	Less than five	104 (40.6)
	More than five40	(15.6)
Mild exercise (e.g., yoga, golf, easy walking, bowling).	**N=258/274 (94.2)**	
	None	68 (26.3)
	Less than five	118 (45.7)
	More than five	72 (27.9)
Walking 30 minutes or more	**N=267/274 (97.4)**	
	None	47 (17.6)
	Less than five	96 (35.9)
	More than five	124 (46.6)

Results highlighted varying levels of physical activity among respondents. For strenuous exercise, 64.7% (N=165/255) of respondents reported no participation, while 29.4% (N=75/255) engaged in such activities less than five times a week, and only 5.8% (N=15/255) exercised more than five times weekly. Moderate exercise, which includes activities like fast walking or tennis, showed slightly better engagement; 43.7% (N=112/256) of respondents reported no participation, while 40.6% (N=104/256) exercised less than five times a week, and 15.6% (N=40/256) participated more frequently. Mild exercise, including yoga and light walking, was more common, with 26.3% (N=68/258) of respondents reporting no participation, 45.7% (N=118/258) engaging less than five times weekly, and 27.9% (N=72/258) exercising more than five times a week. Walking for 30 minutes or more was the most prevalent activity with 46.6% (N=124/267) walked for 30 minutes or more on more than five occasions weekly; however, 17.6% (N=47/267) of respondents reported no walking, 35.9% (N=96/267) walked less than five times a week.

Smoking and vaping habits

Respondents were asked to indicate how many people in the household smoke or vape and how many people less than 18 years of age in the household smoke.

Figure 13 Respondents' reported household prevalence of smoking in the household.

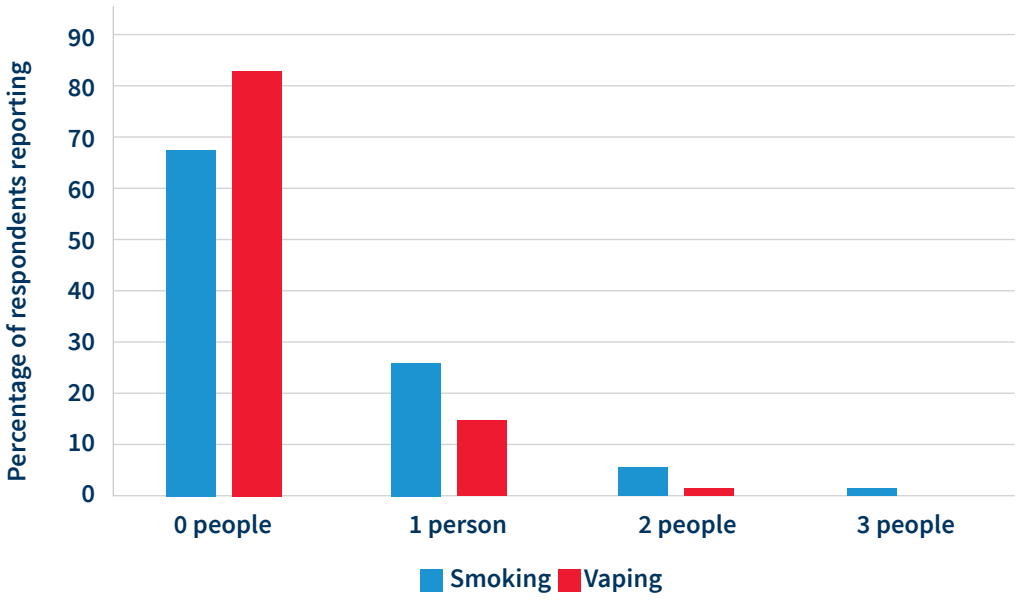


Table 14 Respondents' reported prevalence of smoking habits and cessation efforts.

Indicator	Number (%)
Do you smoke?* (N=87/274; 31.8%)	
Yes	56 (64.4)
No	31 (35.6)
Tried to stop smoking for one day in the past 12 months (N=56/274; 20.6%)	
Yes	23 (41.1)
No	33 (58.9)
Help used to quit smoking (products, medication, quit support services) (N=23/274; 8.4%)	
No help used, attempted to quit "cold turkey"	14 (60.9)
Nicotine patches, gum, lozenges, spray	5 (21.7)

*If the respondent did not smoke, the above questions were not completed.

Among the 31.8% (N=87/274) of respondents who reported on smoking in the household, 64.4% (N=56/87) identified as current smokers, while 35.6% (N=31/87) did not smoke.

Of the respondents who smoked (N=56/274; 20.6%), 41.1% (N=23/56) had tried to quit smoking for at least one day in the past 12 months, while 58.9% (N=33/56) had not made such an attempt. For those who attempted to quit (N=23/274; 8.4%), the majority (60.9%; N=14/23) reported trying to quit "cold turkey," while 21.7% (N=5/23) used nicotine patches, gum, lozenges, or sprays.

Responses were minimal or absent regarding the use of other smoking cessation aids, such as Varenicline/Champix or Bupropion/Zyban (prescribed medications), acupuncture, the Smoker's Quitline, online resources (e.g., www.quit.ie, www.facebook.com/HSEquit), e-cigarettes, or other support options.

Substance use in households

Table 15 Respondents' reported prevalence of substance use in the household.

Indicator	Number (%)
Which of the following substances do people in your household use?* (N=274/274; 100.0%)	
Alcohol	190 (69.3)
Pain medication (e.g., soluble Solpadine or Maxilief)	134 (48.9)
Sedatives not prescribed by a doctor (e.g., Valium, Xanax)	6 (2.2)
Cocaine/Crack cocaine	~
Ecstasy	~
Ketamine	/
Heroin	~
Oxycodone	~
Illegal/street methadone	/
Cannabis	7 (2.6)
Weed	8 (2.9)
Nitrous oxide	~
None	45 (16.5)
Other	~

* Participant could select more than one answer
~ denotes 5 or fewer cases reported.
/ denotes zero responses reported.

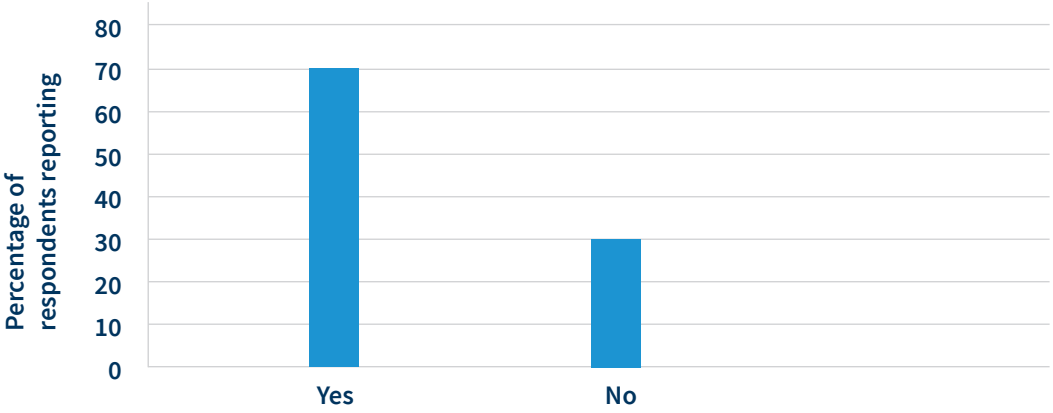
Respondents were asked to report any substance use within their households. All respondents (N=274/274; 100.0%) answered this question. The most commonly reported substance was alcohol, with 69.3% (N=190/274) of households indicating its use. This was followed by pain medications, such as soluble Solpadine or Maxilief, at 48.9% (N=134/274). A smaller percentage reported no substance use in the household (16.5%; N=45/274).

Among other substances, 5.5% (N=15/274) reported cannabis or weed use, with 2.6% (N=7/274) reporting cannabis and 2.9% (N=8/274) specifically reporting weed. Use of sedatives not prescribed by a doctor, such as Valium or Xanax, was reported by 2.2% (N=6/274). Minimal responses were recorded for substances such as cocaine, ecstasy, heroin, and nitrous oxide, with five or fewer cases for each, which are not specified here to maintain confidentiality.

Stress and loneliness

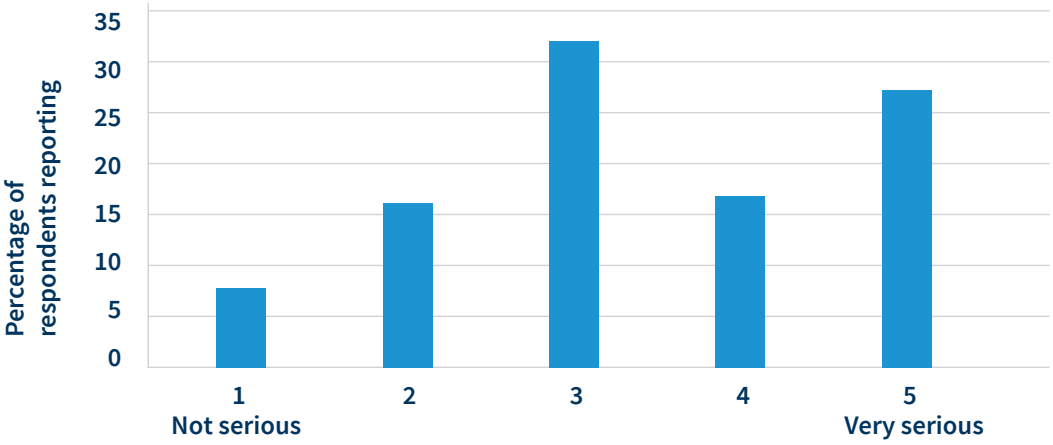
Respondents were asked whether they experienced stress in the 12 months prior to the survey.

Figure 14 Respondents' reported experience of stress in the past 12 months prior to the survey.



Respondents were asked whether they had experienced stress in the 12 months prior to the survey, with 99.3% (N=272/274) responding to this question. The majority, 69.1% (N=188/272), reported experiencing stress during this period, while 30.1% (N=82/272) indicated they had not.

Figure 15 Rating of seriousness of reported stress experienced in the past 12 months by respondents.



Respondents were asked to rate the seriousness of their self-reported stress over the past 12 months on a scale from one (not serious) to five (very serious), with 98.9% (N=271/274) responding. The largest group of respondents (31.7%; N=86/271) rated their stress at a neutral level of three. Additionally, 16.9% (N=46/271) reported more serious stress at a level of four, and 26.9% (N=73/271) rated their stress as very serious at level 5.

Table 16 Respondents' reported experience of stress and loneliness in the past 12 months.

Indicator	Number (%)
Reason for stress+ (N= 181/274; 66.1%)**	
Family	75 (41.4)
Work/Unemployment/Study	33 (18.2)
Finances	30 (16.6)
Illness	29 (16.0)
Other (e.g., life, housing)	14 (7.7)
Symptoms experienced as a result of stress* (N=189/274; 68.9%)	
Anxiety	129 (68.3)
Sleeplessness	127 (67.2)
Annoyed	97 (51.3)
Depression	57 (30.2)
Eating too much	55 (29.1)
Illness	46 (24.3)
Eating too little	44 (23.3)
Smoking more	33 (17.5)
Aggressive	29 (15.3)
Taking more drugs/alcohol	19 (10.1)
None	12 (6.3)
Actions taken as a result of stress* (N= 189/274; 68.9%)	
Talked to friends/relatives	114 (60.3)
Visited GP	61 (32.3)
None	41 (21.7)
Visited counsellor/psychiatrist/psychologist	34 (18.0)
Taken prescription medication	33 (17.5)
Visited church	30 (15.9)
Online resources	17 (9.0)
Peer support groups	12 (6.3)
Other (e.g., exercising or mindfulness)	8 (4.2)
Frequency of feeling lonely (N=274/274; 100.0%)	
Hardly ever or never	163 (59.5)
Some of the time	80 (29.2)
Often	27 (9.9)
Don't know	~

+ Reason for stress was collapsed to five categories to allow for sensible comparisons.
* Participant could select more than one answer
**Participant could provide more than one answer
~ denotes 5 or fewer cases reported.

Among the 274 respondents, 66.1% (N=181/274) reported experiencing stress over the past 12 months, of these 43.9% experienced 'serious stress' The primary sources of stress were family-related issues (41.3%; N=75/181), followed by work, unemployment, or study concerns (18.2%; N=33/181), financial stress (16.6%; N=30/181), and illness (16.0%; N=29/181).

Regarding symptoms associated with stress (N=189/274; 68.9%), the most commonly reported symptoms were anxiety (68.3%; N=129/189), sleeplessness (67.2%; N=127/189) and feeling annoyed (51.3%; N=97/189). Additional symptoms included depression (30.2%; N=57/189) and changes in eating habits, with 29.1% (N=55/189) eating more and 23.3% (N=44/189) eating less. A smaller proportion reported physical illness due to stress (24.3%; N=46/189) and increased smoking (17.5%; N=33/189).

In response to stress, 60.3% (N=114/189) of respondents talked to friends or relatives, while 32.3% (N=61/189) visited a GP. However, 21.7% (N=41/189) reported taking no action. Other responses included visiting a counsellor, psychiatrist, or psychologist (18.0%; N=34/189) and taking prescription medication (17.5%; N=33/189).

Regarding loneliness, 59.5% (N=163/274) reported feeling lonely "hardly ever" or "never". However, 29.2% (N=80/274) reported feeling lonely "some of the time", and 9.9% (N=27/274) reported feeling lonely "often".

Teenage behaviour and family dynamics

Respondents were asked to indicate their experience of dealing with teenagers.

Table 17 Respondents' reported relationship with teenagers in the household.

Indicator	Number (%)
Worry about teenagers socialising (N= 79/79; 100.0%)	
Yes	38 (48.1)
No	41 (51.8)
Reason for worrying about teenagers socialising* (N= 37/37; 100.0%)	
Bullying and peer pressure	14 (37.8)
Behaviour/attitude of their own teenager	10 (27.0)
Safety about their environment and who they are with	8 (21.6)
Concerns about neighbourhood anti-social behaviour of others	5 (13.5)

Indicator	Number (%)
Happy with teenagers' friends (N= 79/79; 100.0%)	
Yes	69 (77.5)
No	6 (7.6)
Don't know their friends	~
Experienced problematic attitude or behaviour in the past 12 months (N= 79/79; 100.0%)	
Yes	18 (22.7)
No	61 (77.2)
Teenagers have a psychological or emotional conditions (N=64/64; 100.0%)	
Yes	8 (12.5)
No	40 (62.5)
Don't know	6 (9.4)
Duration of teenagers psychological or emotional condition (N=11/11; 100.0%)	
6 months or less	~
1 year or less	~
1-2 years	~
More than 2 years	6 (54.5)
Don't know	~
Teenagers' daily life affected by this condition of difficulty (N=11/11; 100.0%)	
Yes, severely	~
Yes to some extent	6 (54.5)
No	~
Condition diagnosed by a professional (N=11/11/; 100.0%)	
Yes	8 (72.3)
No	~

~ denotes 5 or fewer cases reported.
*Participant could provide more than one answer.

Among the 79 respondents (N=79/274; 28.8%) who responded to questions about their relationship with teenagers in the household, 48.1% (N=38/79) expressed worry about their teenagers socialising, while 51.8% (N=41/79) reported no concerns. For those who worried, the main reasons included bullying and peer pressure (37.8%; N=14/37), concerns about their teenager's behaviour or attitude (27.0%; N=10/37), safety concerns regarding the environment and peers (21.6%; N=8/37), and neighbourhood anti-social behaviour (13.5%; N=5/37). Most respondents (77.5%; N=69/79) were satisfied with their teenager's friends, while 7.6% (N=6/79) were not.

When asked about problematic attitudes or behaviours in the past year, 22.7% (N=18/79) of respondents reported experiencing issues, while 77.2% (N=61/79) had not observed problematic behaviour. For teenagers with psychological or emotional conditions (N=64/79; 81.0%), 12.5% (N=8/64) of respondents reported a diagnosed condition, while 62.5% (N=40/64) reported none, and 9.4% (N=6/64) were unsure. Among those with a diagnosed condition (N=11/11; 100.0%), over half (54.5%; N=6/11) indicated the condition had persisted for more than two years, and 54.5% (N=6/11) noted that it affected daily life to some extent. Additionally, 72.3% (N=8/11) of cases had been professionally diagnosed.

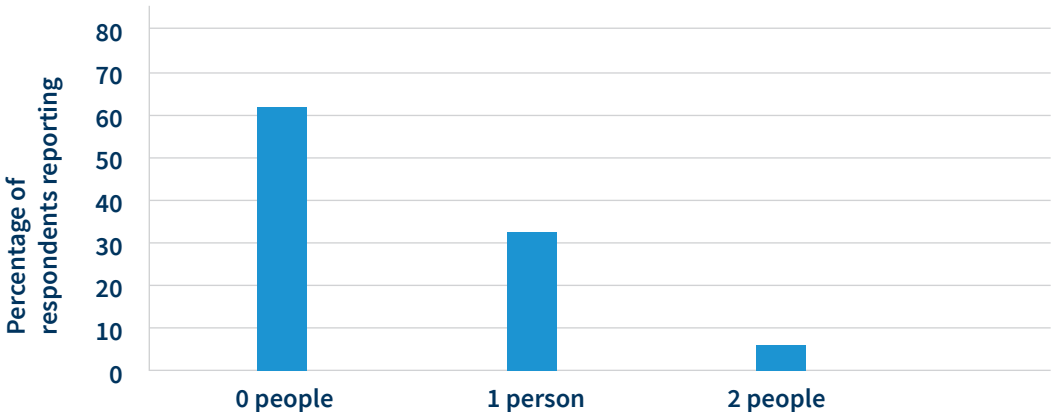
Additional questions around the most problematic behaviour experienced and the sources of help for teen behaviour in the past 12 months was asked. The response rate to this particular question was low and from what was reported we know that a total of 38.9% (N=7/18) did not seek help for their teenager's behaviour.

Chronic illness & disability

Prevalence of chronic illness at the household level

Respondents were asked how many people in their household had a chronic illness, defined as an illness that is ongoing or recurs frequently, requiring medical treatment. Examples provided included heart disease, diabetes, cancer, respiratory illness, gastrointestinal disease, and depression (Appendix N).

Figure 16 Respondents' reported prevalence of chronic illness for members in the household.



Among the respondents, 94.5% (N=259/274) answered this question. Most respondents (62.5%; N=162/259) reported that no one in their household had a chronic illness. For those households reporting chronic illness, the most common prevalence level was one affected individual (32.0%; N=83/259), but there was a small percentage of households reporting two individuals with a chronic illness (5.4%, N=14/259). A total of N=111/259 (42.9%) respondents reported on individuals in the household having a chronic illness.

Prevalence of chronic illness at the individual level

Respondents were asked to indicate how many and what types of chronic illnesses individuals living in their household had.

Table 18 Respondents' reported type of chronic illness for individuals in the household and associated care practices.

Indicator	Number (%)
Does this person have a chronic illness? (N=259/274; 94.5%)	
Yes	111 (42.9)
No	162 (62.5)
Type of chronic illness* reported (N=111/111; 100.0%)	
Neurological	21 (18.9)
Heart disease	17 (15.3)
Diabetes	16 (14.4)
Respiratory	16 (14.4)
Gastrointestinal disease	11 (9.9)
Cancer	11 (9.9)
Arthritis	11 (9.9)
Orthopaedic	10 (9.0)
Other	10 (9.0)
Immunological	9 (8.1)
Kidney	7 (6.3)
Mental health and addiction	6 (5.4)

*Participant could provide more than one answer

Among the 259 respondents who responded, 42.9% (N=111/259) reported at least one household member with a chronic illness, while 62.5% (N=162/259) reported no chronic illness in the household.

For those households with reported chronic illnesses, the most reported conditions were neurological illnesses (18.9%; N=21/111), heart disease (15.3%; N=17/111), diabetes (14.4%; N=16/111), and respiratory illnesses (14.4%; N=16/111). Other reported conditions included gastrointestinal disease (9.9%; N=11/111), cancer (9.9%; N=11/111), arthritis (9.9%; N=11/111), orthopaedic issues (9.0%; N=10/111), immunological conditions (8.1%; N=9/111), kidney disease (6.3%; N=7/111), and mental health or addiction issues (5.4%; N=6/111).

Care and utilisation of healthcare services related to a chronic illness

Respondents were asked questions relating to those reported as having a chronic illness. Specifically, questions were asked about the chronic disease management and healthcare utilisation of these individuals.

Table 19 Respondents' reported healthcare utilisation for individuals with chronic illness.

Indicator	Number (%)
Healthcare received at home (N=111/274; 40.5%)	
Yes	12 (10.8)
No	99 (89.2)
Number of times visited by public health nurse in the last 3 months (N=10/111; 9.0%)	
1-2 times	8 (80.0)
3-4 times	~
Number of times visited by a GP in the last 3 months (N=72/111; 64.8%)	
1-2 times	40 (55.5)
3-4 times	21 (29.2)
5-6 times	6 (8.3)
7 or more times	5 (6.9)
Reason of this/these visits by a GP* (N=39/111; 35.1%)	
Repeat prescription	29 (74.9)
Medical check up	21 (53.8)
Sudden illness	~
Advice	10 (25.6)
Other (e.g., blood tests)	5 (12.8)
Attendance at Tallaght University Hospital in the last 3 months (N=109/111; 98.2%)	
Yes	48 (43.2)
No	61 (54.9)
On a waiting list for services (N=106/111; 95.5%)	
Yes	35 (33.0)
No	71 (66.0)
Attendance at a 'chronic disease management hub' or 'chronic disease management programme' (N=107/111; 96.4%)	
Yes	16 (15.0)
No	91 (85.0)

~ denotes 5 or fewer cases reported.
* Participant could select more than one answer

Among respondents with household members who have chronic illnesses (N=111/274; 40.5%), only 10.8% (N=12/111) reported receiving healthcare at home, while 89.2% (N=99/111) did not receive any home-based care. Only 9.0% (N=10/111) of respondents reported being visited by a public health nurse in the last 3 months.

In terms of GP visits over the past three months, 64.8% (N=72/111) of respondents reported at least one household member with a chronic illness visiting a GP. Of these, 55.5% (N=40/72) reported one to two visits, 29.2% (N=21/72) had three to four visits, and smaller groups had five to six visits (8.3%; N=6/72) or seven or more visits (6.9%; N=5/72).

Regarding the reasons for GP visits (N=39/111; 35.1%), 74.9% (N=29/39) indicated visits were for repeat prescriptions, 53.8% (N=21/39) for medical check-ups, and 25.6% (N=10/39) for advice. A small number (12.8%; N=5/39) mentioned other reasons such as blood tests.

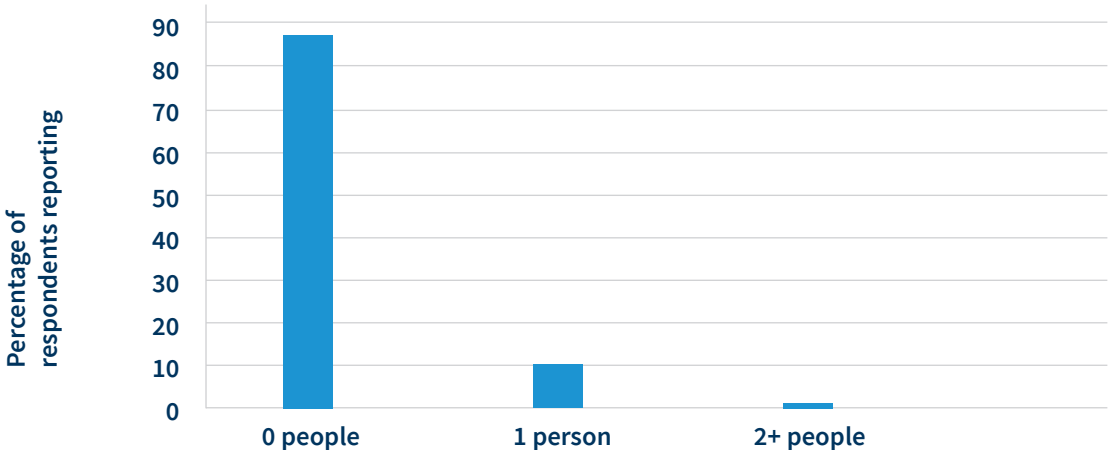
In the last three months, 43.2% (N=48/109) of respondents reported household members attending Tallaght University Hospital, while 54.9% (N=61/109) did not. For waiting lists, 33.0% (N=35/106) of respondents indicated that a household member was on a waiting list for services, while 66.0% (N=71/106) were not.

When asked about participation in a ‘chronic disease management hub’ or ‘chronic disease management programme’ (N=107/111; 96.4%), only 15.0% (N=16/107) reported attendance, while 85.0% (N=91/107) did not participate.

Disability

Respondents were asked to indicate how many people in their household, if any, were in receipt of a disability allowance. Disability allowance is a means tested weekly allowance paid to a person with a disability over the age of 16 years. To qualify for disability, allowance a person must have an injury, disease or physical disability that has continued for at least one year.

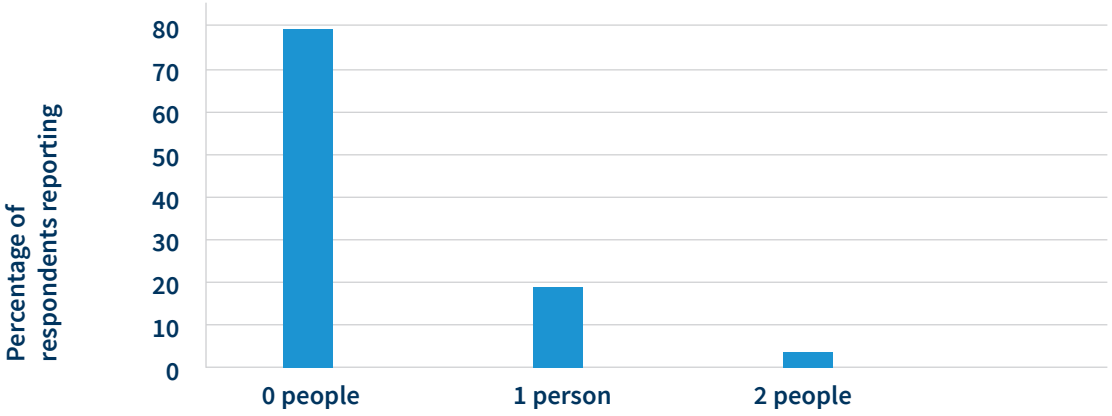
Figure 17 Distribution of the number of people in receipt of disability allowance.



Respondents were asked how many people in their household, if any, were in receipt of disability allowance. A total of 97.4% (N=267/274) of households responded to this question. The majority (86.5%; N=231/267) reported that no one in the household was receiving disability allowance, while 10.5% (N=28/267) indicated that one household member was in receipt of this allowance.

Chronic illness and disability

Figure 18 Distribution of individuals in household with a chronic illness and a disability.



Respondents were asked how many people in their household had both a chronic illness and a disability. A total of 97.4% (N=267/274) of households responded. Most respondents (77.6%; N=207/267) reported that no one in the household had both conditions. However, 18.7% (N=50/267) indicated that one household member had both a chronic illness and a disability, while 3.7% (N=10/267) reported that two people in the household were affected.

2.6. Experience of Tallaght University Hospital

Respondents were asked to provide their opinion on their experience relating to Tallaght University Hospital, Tallaght University Hospital Emergency Department services and waiting lists for Tallaght University Hospital.

Table 20 Utilisation of Tallaght University Hospital (excluding the Emergency Department) for tests or treatment in the previous 12 months.

Indicator	Number (%)
Attended Tallaght University Hospital for tests or treatments in TUH in the past 12 months (N=266/274; 97.1%)	
Yes	125 (46.9)
No	141 (53.0)
Reason for attending TUH*	
Clinical investigations (e.g., blood tests & diagnostic tests)	34 (27.2)
Other (e.g., dermatology, audiology)	16 (12.8)
Skeletal and Muscular Issues	16 (12.8)
Heart and Circulatory Issues	15 (12)
Gastrointestinal issues	14 (11.2)
Kidneys and Urological Issues	12 (9.6)
Neurological (e.g., memory clinic)	11 (8.8)
Respiratory and Chest Issues	7 (5.6)
Pain clinic	7 (5.6)
Cancer and related treatments	5 (4)
Diabetes	~
Source of referral (N= 125/274; 45.6%)	
GP	84 (67.2)
Self-referral	26 (20.8)
Hospital doctor	15 (12.0)

*Participant could provide more than one answer
~ denotes 5 or fewer cases reported.

Respondents were asked if any household members had attended Tallaght University Hospital (TUH) for tests or treatment (excluding the Emergency Department) in the past 12 months. Among respondents, 97.1% (N=266/274) answered this question, with 46.9% (N=125/266) reporting attendance a significant increase from 2014, which was 22.7% (N=244/1077); 53.0% (N=141/266) indicating no visits to TUH for these services.

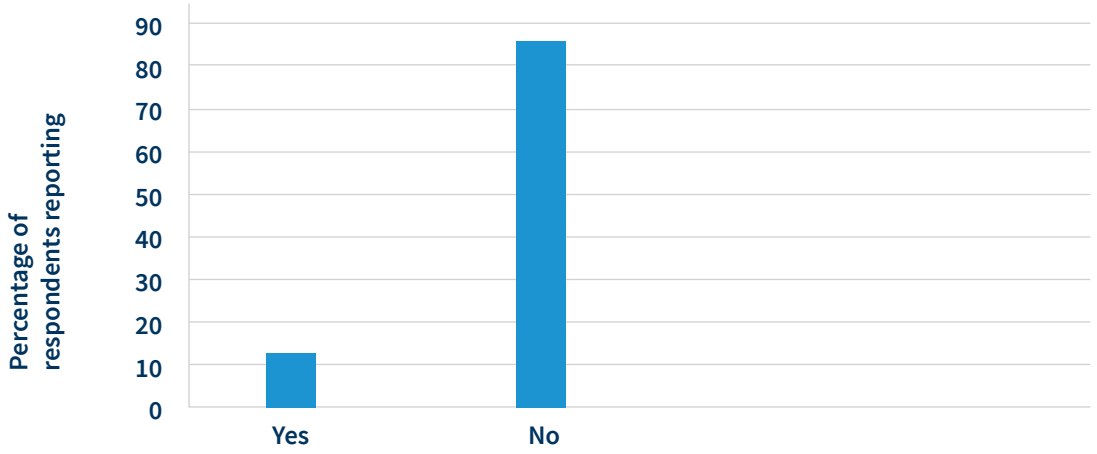
For those who attended TUH (46.9%; N=125/266), the main reasons for attendance included clinical investigations such as blood tests and diagnostic tests (27.2%; N=34/125), other reasons (e.g., dermatology, audiology) (12.8%; N=16/125), skeletal and muscular issues (12.8%; N=16/125), heart and circulatory issues (12.0%; N=15/125), and gastrointestinal issues (11.2%; N=14/125). Other reported reasons were kidneys and urological issues (9.6%; N=12/125), neurological issues (e.g., memory clinic) (8.8%; N=11/125), respiratory and chest issues (5.6%; N=7/125), pain management (5.6%; N=7/125), and cancer-related treatments (4.0%; N=5/125). For conditions with five or fewer cases, such as diabetes, specific numbers are not provided to maintain confidentiality.

Regarding the source of referral (N=125), most attendees were referred by a GP (67.2%; N=84/125), followed by self-referrals (20.8%; N=26/125), and hospital doctors (12.0%; N=15/125).

Tallaght University Hospital waiting lists

Respondents were asked to indicate how many people within the household, including themselves, were currently on a waiting list to receive treatment in Tallaght University Hospital.

Figure 19 Respondents reported number of household members being on a waiting list in Tallaght University Hospital.



Respondents were asked if their household experienced any unmet healthcare needs in the past 12 months due to waiting lists at Tallaght University Hospital (TUH). A total of 98.2% (N=269/274) responded to this question. Most respondents, 85.1% (N=229/269), reported no unmet healthcare needs related to TUH waiting lists, while 13.0% (N=35/269) reported a member in the household being on a waiting list.

Satisfaction with Tallaght University Hospital and impact of the hospital on the community

Respondents who used Tallaght University Hospital in the previous 12 months were asked about how satisfied they were with the tests or treatment they received.

Table 21 Satisfaction with Tallaght University Hospital (excluding the Emergency Department) for tests or treatment in the past 12 months.

Indicator	Number (%)
Satisfaction rating with TUH (N= 124/274; 45.6%)*	
Dissatisfied (rated 1-3)	40 (32.2)
Satisfied (4-6)	84 (67.2)
Main reasons of dissatisfaction with TUH+	
Long waiting times	34 (85.0)
Poor communication from staff	20 (50.0)
Speed of care too slow	20 (50.0)
Poor quality of care	19 (47.5)
Hospital environment	9 (22.5)
Hospital safety	7 (17.5)
Lack of friendliness/respect/compassion provided by staff	6 (15.0)
Hospital cleanliness	6 (15.0)
Speed of care too quick	~
Other	~
Main reasons of satisfaction with TUH+	
Quality of care	65 (77.4)
Friendliness/respect/compassion provided by staff	64 (76.2)
Good communication from staff	50 (58.8)
Speed of care	44 (51.7)
Hospital environment	38 (44.7)
Hospital cleanliness	37 (43.5)
Hospital Safety	32 (37.6)
Short waiting times	25 (29.2)
Other	~
Would recommend TUH to a friend/family member (N= 125/274; 45.6%)	
Yes	86 (68.8)
No	24 (19.2)
Don't know	15 (12.0)

*This question was on a scale from 1-6 where scores closer to 1 mean 'dissatisfied' and scores closer to 6 indicate 'satisfaction'. These scores were then grouped 1-3 as being dissatisfied and 4-6 as satisfied.
+ Participants could select more than one answer.
~ denotes 5 or fewer cases reported.

Among the respondents who reported their satisfaction with Tallaght University Hospital (TUH) services (N=124/274; 45.6%), 67.2% (N=84/124) were satisfied, giving a satisfaction rating of four to six, while 32.2% (N=40/124) were dissatisfied, with ratings of one to three.

Among those dissatisfied (32.2%; N=40/124), the primary reasons included long waiting times (85.0%; N=34/40), poor communication from staff (50.0%; N=20/40), slow speed of care (50.0%; N=20/40), and poor quality of care (47.5%; N=19/40). Other factors were the hospital environment (22.5%; N=9/40), hospital safety (17.5%; N=7/40), lack of friendliness, respect, or compassion from staff (15.0%; N=6/40), and hospital cleanliness (15.0%; N=6/40).

Among those satisfied (67.2%; N=84/124), the most commonly cited reasons included the quality of care (77.3%; N=65/84), friendliness, respect, and compassion provided by staff (76.2%; N=64/84), good communication from staff (58.8%; N=50/84), speed of care (51.7%; N=44/84), hospital environment (44.7%; N=38/84), hospital cleanliness (43.5%; N=37/84), and hospital safety (37.6%; N=32/84). Short waiting times were also noted by 29.2% (N=25/84) of satisfied respondents.

When asked if they would recommend TUH to a friend or family member (N=125/274; 45.6%), 68.8% (N=86/125) responded “Yes,” 19.2% (N=24/125) said “No,” and 12.0% (N=15/125) were uncertain.

Respondents who used Tallaght University Hospital in the past 12 months were asked about the impact of TUH on the surrounding community.

Table 22 Respondents’ opinions on Tallaght University Hospital and its impact on the surrounding community.

Indicator	Number (%)
Is TUH beneficial to the surrounding community? (N= 274/274; 100.0%)	
Yes	246 (89.8)
No	18 (6.6)
Don’t know	10 (3.6)
If yes, why?*	
Location and Proximity	175 (71.1)
Service Quality	50 (20.3)
Community and Population Need	35 (14.2)
Quality of Staff and Care Provided	30 (12.2)
Range of Services	25 (10.2)
Emergency Services	20 (8.1)
Employment and Economic Impact	10 (4.1)

*Participant could provide more than one answer

Among respondents, 100.0% (N=274/274) responded when asked whether TUH is beneficial to the surrounding community. The majority, 89.8% (N=246/274), indicated "Yes," while 6.6% (N=18/274) responded "No," and 3.6% (N=10/274) were uncertain.

For those who viewed TUH as beneficial (N=246), the primary reasons included its convenient location and proximity (71.1%; N=175/246), service quality (20.3%; N=50/246), addressing community and population needs (14.2%; N=35/246), and the quality of staff and care provided (12.2%; N=30/246). Additional reasons mentioned were the range of services offered (10.2%; N=25/246), availability of emergency services (8.1%; N=20/246), and its positive employment and economic impact on the community (4.1%; N=10/246).

Tallaght University Hospital community involvement and improvements

Respondents were asked if they would like to be involved in changes made and how TUH could be improved. Free text answers were recorded and then analysed to identify categories.

Table 23 Respondents' opinions on improvements and involvement in Tallaght University Hospital.

Indicator	Number (%)
Would you like to be more involved in the decisions TUH makes in changing and improving its services? (N= 274/274; 100.0%)	
Yes	40 (14.6)
Yes, but unsure what difference it would make	73 (26.6)
No	149 (54.4)
Don't know	12 (4.4)
How can TUH improve the service it provides?* (N = 199/274; 72.6%)	
Reduce Waiting times	78 (39.2)
More staff	63 (31.6)
Improve Communication with patients	20 (10.1)
Emergency Department concerns (e.g., understaffed and long wait times)	19 (9.5)
Other (e.g., nothing needed, use another hospital)	15 (7.5)
Provide more services	14 (7.0)
Facility Cleanliness and Maintenance	8 (4.0)
Parking and Accessibility	8 (4.0)

*Participant could provide more than one answer
~ denotes 5 or fewer cases reported.

When asked about involvement in decision-making at TUH (N=274/274; 100.0%), 14.6% (N=40/274) expressed interest in being more involved, 26.6% (N=73/274) wanted involvement but were uncertain of its impact, 54.4% (N=149/274) preferred no involvement, and 4.4% (N=12/274) were unsure.

Among the respondents, 72.6% (N=199/274) provided suggestions on how TUH could improve its services. The most cited improvements included reducing waiting times (39.2%; N=78/199), hiring more staff (31.6%; N=63/199), and enhancing communication with patients (10.1%; N=20/199). Other concerns included understaffing and long wait times in the Emergency Department (9.5%; N=19/199), adding more services (7.0%; N=14/199), improving facility cleanliness and maintenance (4.0%; N=8/199), and addressing parking and accessibility issues (4.0%; N=8/199). Additionally, 7.5% (N=15/199) of respondents felt no improvements were needed or suggested using another hospital.

Tallaght University Hospital Emergency Department

Respondents were asked their frequency of use of Tallaght University Hospital Emergency Department services, the reason for attending, the source of referral and how long they waited before attending the Emergency Department.

Table 24 Respondents' reported experience with service utilisation in Tallaght University Hospital Emergency Department in the past 12 months.

Indicator	Number (%)
Attended Tallaght University Hospital Emergency Department (N=271/274; 98.9%)	
Yes	95 (34.7)
No	176 (64.2)
Don't know	~
Source of referral (N= 95/95; 100%)	
Self-referral	48 (50.5)
GP referral	27 (28.4)
Came in by ambulance	18 (18.9)
Other	~

Indicator	Number (%)
If self-referral, why did you/they not go to see another healthcare professional, such as your GP beforehand? (N= 48/48; 100.0%)	
'Out-of-hours'	21 (43.8)
GP was not available	15 (21.3)
GP too expensive	~
GP didn't have access to same test (e.g., x-ray)	~
Other (e.g., severity of illness/injury)	8 (16.7)
How long were you/they sick before attending TUH Emergency Department (N= 95/95; 100.0%)	
<24 hours	54 (56.8)
1-2 days	18 (18.9)
3-7 days	11 (11.6)
1-2 weeks	~
2-4 months	~
>2 months	~
Reason for attendance*	
Other (e.g., general pain)	23 (24.2)
Respiratory and breathing issues	12 (12.6)
Stomach and digestive issues	12 (12.6)
Fractures and broken bones	9 (9.5)
Head injury	8 (8.4)
Heart issues	7 (7.4)
Fall	6 (6.3)
Chronic conditions	6 (6.3)
Infection and sepsis	5 (5.3)
Allergic reactions and rashes	~

~denotes 5 or fewer cases reported.
*Participant could provide more than one answer.

Respondents were asked about their household's utilisation of Tallaght University Hospital (TUH) Emergency Department over the past 12 months. Among respondents (98.9%; N=271/274), 34.7% (N=95/271) reported attending the Emergency Department, while 64.2% (N=176/271) did not. For those who attended (34.7%; N=95/271), the primary sources of referral were self-referral (50.5%; N=48/95), GP referral (28.4%; N=27/95) and arriving by ambulance (18.9%; N=18/95).

Of those who self-referred (N=48), the main reasons included needing an out-of-hours service (43.8%; N=21/48) and GP unavailability (21.3%; N=10/48). Cost of GP visits and lack of access to specific tests (e.g., x-ray) were also noted by a small number, as well as the severity of illness or injury (16.7%; N=8/48). Most patients were unwell for less than 24 hours before attending the Emergency Department (56.8%; N=54/95), while others waited one to two days (18.9%; N=18/95) or three to seven days (11.6%; N=11/95). The primary reasons for Emergency Department attendance included general pain (24.2%; N=23/95), respiratory and breathing issues (12.6%; N=12/95), stomach and digestive issues (12.6%; N=12/95), and fractures and broken bones (9.5%; N=9/95). Other reasons included head injuries (8.4%; N=8/95), heart issues (7.4%; N=7/95), falls (6.3%; N=6/95), chronic conditions (6.3%; N=6/95), infections and sepsis (5.3%; N=5/95), and allergic reactions or rashes (5 or fewer cases, not specified for confidentiality).

Satisfaction with Tallaght University Hospital Emergency Department

Respondents were asked a series of questions relating to satisfaction with Tallaght University Hospital Emergency Department.

Table 25 Satisfaction with Tallaght University Hospital Emergency Department in the past 12 months.

Indicator	Number (%)
Would you recommend TUH Emergency Department to a friend/family member? (N=95/95; 100.0%)	
Yes	43 (45.3)
No	47 (49.5)
Don't know	5 (5.3)
Satisfaction rating with TUH Emergency Department (N= 95/95; 100.0%)*	
Dissatisfied (1-3)	63 (66.3)
Satisfied (4-6)	32 (33.7)
Main reasons of dissatisfaction with TUH Emergency Department+	
Long waiting times	52 (82.5)
Poor communication from staff	34 (54.0)
Speed of care too slow	28 (44.4)
Poor quality of care	27 (42.9)
Hospital cleanliness	15 (23.8)

Indicator	Number (%)
Main reasons of dissatisfaction with TUH Emergency Department+	
Lack of friendliness/respect/compassion provided by staff	14 (22.2)
Hospital environment	14 (22.2)
Hospital safety	14 (22.2)
Other (e.g., mayhem in waiting area; lack of seating)	10 (15.9)
Speed of care too quick	~
Main reasons of satisfaction with TUH Emergency Department+	
Quality of care	24 (75.0)
Friendliness/respect/compassion provided by staff	23 (71.9)
Good communication from staff	16 (50.0)
Hospital environment	15 (46.9)
Hospital cleanliness	15 (46.9)
Speed of care	13 (40.6)
Short waiting times	12 (37.5)
Hospital Safety	9 (28.1)
Other	~

*This question was on a scale from 1-6 where scores closer to 1 mean 'dissatisfied' and scores closer to 6 indicate 'satisfaction'. These scores were then grouped 1-3 as being dissatisfied and 4-6 as satisfied.
+ Participants could select more than one answer.
~denotes 5 or fewer cases reported.

Respondents were asked about their satisfaction with the Tallaght University Hospital (TUH) Emergency Department over the past 12 months. All respondents (N=95/95; 100.0%) answered questions on whether they would recommend the Emergency Department, with 49.5% (N=47/95) stating they would not recommend it, 45.3% (N=43/95) indicating they would, and 5.3% (N=5/95) uncertain.

Satisfaction was measured on a scale from 1-6, with scores grouped as dissatisfied (1-3) or satisfied (4-6). Among respondents, 66.3% (N=63/95) were dissatisfied, while 33.7% (N=32/95) expressed satisfaction.

For those who were dissatisfied (66.3%; N=63/95), the primary issues included long waiting times (82.5%; N=52/63), poor communication from staff (54.0%; N=34/63), and slow speed of care (44.4%; N=28/63). Other concerns involved poor quality of care (42.9%; N=27/63), hospital cleanliness (23.8%; N=15/63), lack of friendliness, respect, or compassion from staff (22.2%; N=14/63), the hospital environment (22.2%; N=14/63), and hospital safety (22.2%; N=14/63).

Among those who were satisfied (33.7%; N=32/95), the main factors for satisfaction included quality of care (75.0%; N=24/32), friendliness and compassion of staff (71.9%; N=23/32), good communication from staff (50.0%; N=16/32), and positive hospital environment and cleanliness (46.9% each; N=15/32). Other factors were speed of care (40.6%; N=13/32) and shorter waiting times (37.5%; N=12/32).

2.7. General practice and 'out-of-hours' services

Table 26 Respondents' reported experience with general practitioner and 'out-of-hours' services.

Indicator	Number (%)
Registered with a GP (N= 274/274; 100.0%)	
Yes	260 (94.9)
No	12 (4.4)
Don't know	~
If no, why not? (N= 12/12; 100.0%)	
On waiting list	~
Currently no medical need to register with GP	~
Accessing GP services elsewhere	~
(e.g., another location in Dublin; out of state)	
If no, how do you access healthcare? (N= 10/12; 83.3%)	
Go to the Emergency Department	~
Access GP services elsewhere	~
(e.g., another location in Dublin; out of state)	
Is your GP within walking distance of your house? (N= 262/274; 95.6%)	
Yes	146 (55.7)
No	114 (43.5)
Don't know	~
When anyone in your household needs 'out-of-hours' doctors services, what do you do?*	
TLC Doc	101 (69.2)
Go to the Emergency Department	71 (25.9)
Depends on the situation	62 (22.6)
NA	23 (8.4)
Other (e.g., use clinics through private medical insurance or telehealth services).	18 (12.3)
House call	~
If you need to see your GP, how long does it take for you to get an appointment? (N= 248/274; 90.5%)	
Less than 3 days	140 (56.4)
Between 4 and 7 days	69 (25.2)
Longer than 8 days	65 (23.7)

~ denotes 5 or fewer cases reported.
*Participant could provide more than one answer

The majority of respondents (94.9%; N=260/274) reported being registered with a GP, while 4.4% (N=12/274) were not registered. Reasons for non-registration included being on a waiting list, no current medical need, or accessing GP services elsewhere, such as in another Dublin location or out of state.

Regarding proximity, 55.7% (N=146/262) of registered respondents indicated their GP was within walking distance, while 43.5% (N=114/262) reported it was not.

When household members required out-of-hours doctor services, most respondents (69.2%; N=101/146) used the TLC Doc service. Others opted to go to the Emergency Department (25.9%; N=71/146), noted it depended on the situation (22.6%; N=62/146), or indicated it was not applicable (8.4%; N=23/146). Some (12.3%; N=18/146) used alternative options, such as private medical insurance clinics or telehealth services.

Among those needing GP appointments (N=248/274; 90.5%), 56.4% (N=140/248) reported they could obtain an appointment within three days, 25.2% (N=69/248) within four to seven days, and 23.7% (N=65/248) waited longer than eight days.

Satisfaction with GP and 'out-of-hours' doctor service options

Table 27 Respondents' reported satisfaction with general practitioner and 'out-of-hours' services.

Indicator	Number (%)
Would you recommend your GP to a friend/family member? (N= 274/274; 100.0%)	
Yes	218 (79.6)
No	34 (12.4)
Don't know	15 (5.5)
Not registered with a GP	7 (2.6)
Satisfaction rating with your GP (N=262/274; 95.6%)*	
Dissatisfied (1-3)	48 (18.3)
Satisfied (4-6)	214 (81.6)
Are you satisfied with your current 'out-of-hours' doctor service options? (N= 274/274; 100.0%)	
Yes	112 (40.9)
No	56 (20.4)
Don't know	106 (38.7)

* This question was on a scale from 1-6 where that scores closer to 1 mean 'dissatisfied' and scores closer to 6 indicate 'satisfaction'. These scores were then grouped 1-3 as being dissatisfied and 4-6 as satisfied.

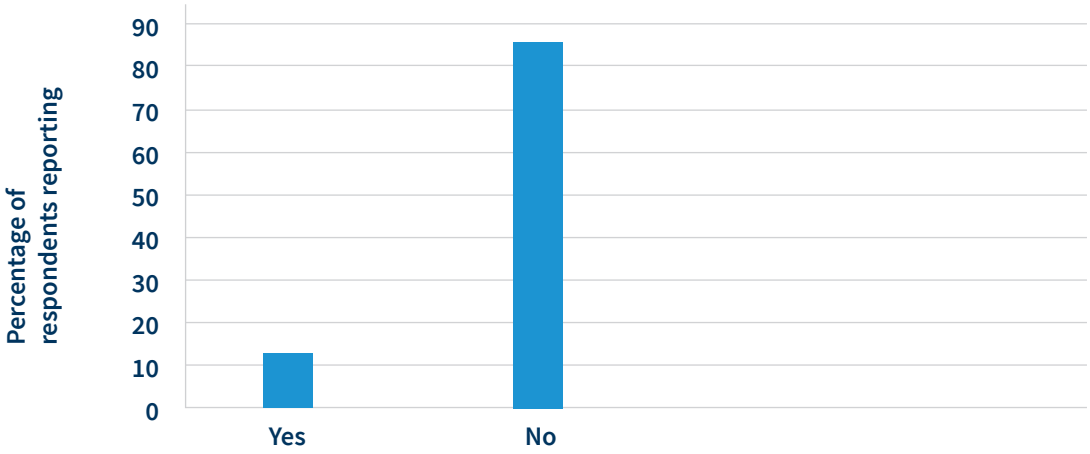
Most respondents (79.6%; N=218/274) indicated they would recommend their GP to a friend or family member, while 12.4% (N=34/274) would not, and 5.5% (N=15/274) were uncertain. A small percentage (2.6%; N=7/274) were not registered with a GP.

Among those who rated their satisfaction with their GP (N=262/274; 95.6%), 81.6% (N=214/262) were satisfied (rating 4-6), and 18.3% (N=48/262) were dissatisfied (rating 1-3).

When asked about satisfaction with current out-of-hours doctor service options (N=274/274; 100.0%), 40.9% (N=112/274) were satisfied, 20.4% (N=56/274) were not satisfied, and 38.7% (N=106/274) were uncertain.

2.8. Social prescribing services

Figure 20 Respondents' awareness of social prescribing services prior to the survey.



A total of N=269/274 (98.2%) respondents answered this question. Of these, a total of 11.7% (N=32/274) had heard of social prescribing before the survey, with the majority (86.5%, N=237/274) reporting that they had never heard of social prescribing.

Table 28 Respondents' reported experience with social prescribing services.

Indicator	Number (%)
How did you hear about social prescribing services? (N=32/274; 11.7%)	
From a friend/colleague	15 (46.9)
Through my GP surgery	6 (18.8)
Other (e.g., word of mouth, work/study in healthcare)	5 (15.6)
Web search	/
From a voluntary organisation	~
Via social media	~
Via a leaflet	~
For those who have availed, was it helpful? (N=274/274; 100.0%)	
Yes	13 (4.7)
No	61 (22.3)
Did not avail of social prescribing	165 (60.2)
Don't know	35 (12.8)
Did it link you with a local service/activity? (N=74/274; 27.0%)	
Yes	11 (14.9)
No	55 (74.3)
Don't know	8 (10.8)
Overall, how satisfied are you as respondent (or for those you care for) with your experience of using social prescribing services? (N=74/274; 27.0%)	
Very dissatisfied	~
Dissatisfied	~
Neutral	~
Satisfied	9 (12.2)
Very satisfied	7 (9.5)
Don't know	51 (68.9)
What might stop you from using a social prescribing service/activity? (N=153/274; 55.8%)	
Other (e.g., did not know about the service or constraints like distance, childcare, time off work).	82 (53.6)
Availability of appointments (long waiting times/ time of appointments)	20 (13.1)
Not being able to refer myself/having to refer through a GP	18 (11.8)
Long travelling distances (if appointments aren't in my local area)	12 (7.8)
Difficulty making an appointment	10 (6.5)
Lack of appropriate transport to the service/activity area	7 (4.6)
Feeling that I would be judged if I used this service/joined this activity	~

~ denotes 5 or fewer cases reported.
/ denotes zero responses reported.

Among respondents, 11.7% (N=32/274) reported having heard of social prescribing services. Of those, 46.9% (N=15/32) learned about it from a friend or colleague, 18.8% (N=6/32) through their GP surgery, and 15.6% (N=5/32) from other sources, such as word of mouth or work/study in healthcare. Few or no respondents reported learning about social prescribing via voluntary organisations, social media, leaflets, or web searches.

For those who availed of social prescribing only 4.7% (N=13/274) found it helpful, while 60.2% (N=165/274) did not avail of the service and 22.3% (N=61/274) were unsure if it was helpful. Of those aware of social prescribing (27.0%, N=74/217), only 14.9% (N=11/74) reported that it linked them to a local service or activity, while 74.3% (N=55/74) said it did not, and 10.8% (N=8/74) were unsure.

Among respondents, 27.0% (N=74/274) reported their satisfaction with social prescribing services. Of those, 12.2% (N=9/74) were satisfied, and 9.5% (N=7/74) were very satisfied. However, a substantial 68.9% (N=51/74) indicated they did not know if they were satisfied with the services received through social prescribing.

When asked about factors that might prevent them from using 'social prescribing' services or activities (55.8%; N=153/274), the most common response was a lack of awareness or constraints like distance, childcare, or work commitments (53.6%; N=82/153). Other barriers included appointment availability (13.1%; N=20/153), needing a GP referral rather than self-referral (11.8%; N=18/153), long travel distances (7.8%; N=12/153), difficulty in making an appointment (6.5%; N=10/153), and lack of appropriate transport (4.6%; N=7/153). A few respondents noted concerns about feeling judged for using such services, although this was reported by fewer than five cases.

2.9. Future health and social care services in Tallaght

Respondents were asked what healthcare services they believed were needed in Tallaght.

Table 29 Respondents' opinions on what health and social care services are needed in Tallaght.

Indicator	Number (%)
What healthcare services are needed in the Tallaght community?* (N=190/274; 69.3%)	
Increase in GP services (e.g., more GP's needed for the area)	46 (24.2)
Mental Health and Addiction Services (e.g., more mental health services for young people; more addiction rehabilitation services)	36 (18.9)
Specialised healthcare services (e.g., more cancer treatment centres)	27 (14.2)
Children's healthcare and special needs (e.g., occupational therapy, speech and language therapy)	24 (12.6)
Hospital infrastructure (e.g., TUH should be more efficient, better organised, more doctors and nurses)	16 (8.4)
Elderly and Homecare Services (e.g., more homecare support to keep people in their homes as they get older)	14 (7.4)
Dentistry and Oral Health (e.g., more dentists in the area)	12 (6.3)
Preventive medicine in the community (e.g., better community care teams for age-related care)	10 (5.3)

*Participant could provide more than one answer

Respondents were asked what healthcare services are needed in Tallaght. A total of 69.3% respondents responded (N=190/274). The most reported healthcare service needed in the community was more GPs in the area and increased services (24.2%, N=46/190), mental health and addition services (18.9%, N=36/190), specialised healthcare services such as cancer treatment centres (14.2%, N=27/190), and children's healthcare and special needs services such as occupational therapy or speech and language therapy (12.6%, N=24/190). Other healthcare and social care services needed are a more organised hospital infrastructure (8.4%, N=16/190), elderly and homecare services (7.4%, N=14/190), dentists (6.3%, N=12/190) and preventive medicine services in the community (5.3%, N=10/190).

Respondents were asked if there was anything missing from these (asset) lists that could be considered an asset to their life in Tallaght.

Table 30 Respondents' opinion of missing assets in Tallaght.

Indicator	Number (%)
What are the missing assets in Tallaght?* (N=122/274; 44.5%)	
No action needed	74 (61.7)
Recreational facilities (e.g., sports clubs, gyms, swimming pools, dog parks)	18 (14.8)
Other (green spaces, communication on local information)	12 (9.8)
Support and education for children (e.g., schools, teen resources, childcare services)	10 (8.2)
Public services and facilities (e.g., Garda stations, libraries)	7 (5.7)
Community support services (e.g., job assistance, community support groups, 'sister sheds')	7 (5.7)
Healthcare services (e.g., teen mental health services, disability services, dentists and GPs)	6 (4.9)
Better transportation routes and greater frequency of public transport options	6 (4.9)
Shopping and dining (e.g., supermarkets and dine-in restaurants)	5 (4.1)

Note: The availability of services is Electoral Division (ED) dependent, as some respondents feel that services are less accessible in certain EDs.

*Respondents could provide more than 1 answer.

Respondents were asked, 'Is there anything missing from these lists which are an asset to your life in Tallaght?' and were shown asset laminates (Appendix K-M).

Most respondents felt no action was needed when asked about missing assets in Tallaght (61.7%, N=74/122), however there was a call for more recreational facilities (14.8%, N=18/122), green spaces and communication from the local council for activities and development in the area (9.8%, N=12/122) as well as supports and education for children (8.2%, N=10/122). Other missing assets were public services and facilities such as An Garda Síochána stations and libraries (5.7%, N=7/122), community support services (5.7%, N=7/122), healthcare services to support teenage mental health and disability services (4.9%, N=6/122), better transportation routes and frequency (N=4.9%, 6/122) and amenities in the area (4.1%, N=5/122).

Part 3 – Comparison Between 2001, 2014 and 2024 Rounds of HANA

3.1 Response rates

The HANA 2024 study achieved a response rate of 65.2% (N=274/420), compared to the 81.6% (N=343/420) response rate in 2014, and a 81.9% (N=344/420) response rate in the 2001 health needs assessment.

3.2 Distribution of the electoral divisions based on level of deprivation.

Table 31 shows an overview of sample and population households across the 13 EDs from 2001, 2014 and 2024, categorising them into low and high deprivation. The reference point for change in deprivation is considered from changes to the deprivation status of an ED when compared to its status in 2001.

Table 31 Distribution of the sample by electoral division based on level of deprivation in 2001, 2014 and 2024.

Electoral Division	Sample households – 2001 Total (%)	Population households – 2001 Total (%)	Sample households – 2014 Total (%)	Population households – 2014 Total (%)	Sample households – 2024 Total (%)	Population households – 2024 Total (%)
Areas of low deprivation in 2001						
Belgard	14 (6.7)	543 (6.8)	21 (10.0)	592 (7.9)	10 (6.0)	1635 (3.6)
Glenview	7 (3.3)	378 (4.7)	21 (10.0)	813 (10.9)	11 (8.6)	2171 (6.0)
Kilnamanagh	42 (20.0)	1451 (18.2)	42 (20.0)	1565 (20.9)	9 (7.0)	4393 (12.2)
Kingswood	35 (16.7)	1186 (14.9)	42 (20.0)	1534 (20.5)	13 (10.2)	4291 (11.9)
Millbrook	35 (16.7)	1267 (15.9)	35 (16.7)	1301 (17.4)	12 (8.2)	3338 (7.4)
Oldbawn	35 (16.7)	1285 (16.1)	49 (23.3)	1678 (22.4)	18 (14.1)	4445 (12.3)
Springfield	42 (20.0)	1863 (23.4)	42 (20.0)	3663 (19.6)	39 (30.5)	11297 (31.4)
Total N (%)	**210 (100)**	**7973 (100)**	**210 (100)**	**7483 (100)**	**146 (52.3)**	**44992 (55.5)**
Areas of high deprivation in 2001						
Avonbeg	7 (3.3)	552 (6.4)	7 (3.3)	654 (3.5)	9 (6.2)	1542 (3.4)
Fettercairn	28 (13.3)	1165 (13.4)	28 (13.3)	2427 (13.0)	31 (21.2)	11335 (25.2)
Jobstown	70 (33.3)	2754 (31.7)	63 (30.0)	5834 (31.2)	53 (36.3)	18125 (40.3)
Killinarden	28 (13.3)	1155 (13.3)	14 (6.7)	1275 (6.8)	9 (6.2)	3878 (8.6)
Kiltipper	35 (16.7)	1392 (16.0)	35 (16.7)	2913 (15.6)	38 (29.7) ¯	9432 (26.2) ¯
Tymon	42 (20.0)	1664 (19.2)	21 (10.0)	1817 (10.3)	22 (15.1)	5138 (11.4)
Total N (%)	**210 (100)**	**8682 (100)**	**210 (100)**	**18683 (100)**	**128 (46.7)**	**36029 (44.5)**

Note: In 2001 survey, the SAHRU deprivation index scores ranged from 1-5, therefore, low deprivation was categorised as 1-3, and high deprivation was categorised as 4-5.[45] In the HANA 2014 survey – the SAHRU deprivation index scores ranged from 1-10, therefore, lower deprivation was categorised as 1-8, definitely high deprivation was categorised at 9-10.[45] In the HANA 2024 survey – the Pobal HP Deprivation Index was used. It is based off the 2022 Census data and categorised deprivation on a scale of 1-20: low deprivation (scores 1-5), medium deprivation (scores 6-14) and high deprivation (Scores 15-20).[2] The data presented is based on 2001 deprivation levels and is compared to population samples from 2001, 2014 and 2024. Any values with an arrow value such as '↑' show a change in deprivation status, where an area has moved from low to high deprivation and a value with '↓' show a change from high to low deprivation between these years.

The table shows the changing demographics of EDs over time, comparing sample and population households from 2001 to 2024 in both low and high deprivation areas.

It highlights a significant increase in total population households – rising from 7,973 in 2001 to 44,992 in 2024 for low deprivation areas and from 8,682 to 36,029 for high deprivation areas. While sample households decreased from 210 in both high and low deprivation categories in 2001 and 2014 to 146 in low deprivation and 128 in high deprivation in 2024. This trend reflects a growing population while also highlighting the challenges of conducting household surveys, marked by participant reluctance, particularly in more deprived areas.

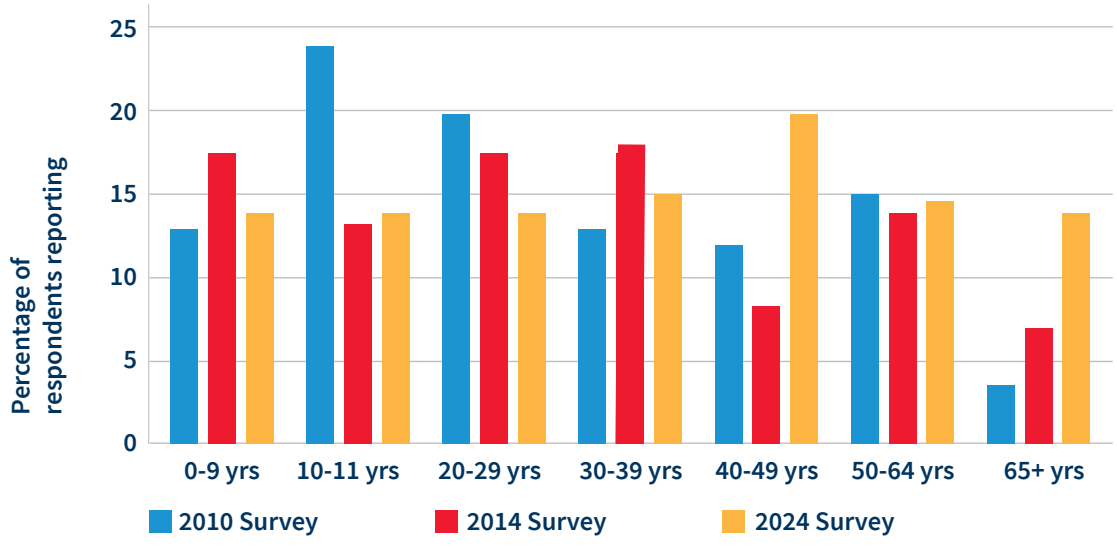
Deprivation status remained low across the three data collection timepoints for Kilnamanagh, Kingswood, Glenview and Old Bawn. Deprivation status remained high across the three data collection timepoints for Avonbeg, Fettercairn, Jobstown, Killinarden, and Tymon. Changes to deprivation occurred for Belgard and Millbrook which went from low to high deprivation between 2001 to 2024. Springfield was an area of low deprivation in 2001, changed to high deprivation in 2014 and returned to low deprivation in 2024. Kiltipper went from an area of high deprivation in 2001 to low deprivation in 2024.

3.3 Demographic details

Demographic profile of all individuals – has it changed between 2001, 2014 and 2024?

There are some significant differences within the demographic and socio-economic characteristics reported for individuals in the households between 2001, 2014 and 2024.

Figure 21 Age Profile Comparison: 2001 Needs Assessment, 2014 HANA Survey, and 2024 HANA Survey.



This data shows how age groups have significantly changed across the years from 2001, 2014 and 2024 (X^2=206.24, p <0.001). Children aged 0-9 years increased from 12.7% (N=167/1,313) in 2001 to 16.7% (N=178/1,065) in 2014 and then declined to 13.6% (N=101/743) by 2024. Teens (10-19 years) also dropped, while young adults (20-29 years) steadily decreased from 19.7% (N=259/1,313) in 2001 to 9.3% (N=69/743) in 2024, indicating that there are fewer younger adults over time. Middle aged groups (30-39 years) fluctuated, with a significant rise in the 40-49 age group from 9.8% (N=104/1,065) in 2014 to 19.9% (N=148/743) in 2024. Adults 50-64 years stayed relatively stable, around 14-15.0% across all years. The older population (65+ years) showed the most dramatic growth, tripling from 3.4% (N=45/1,313) in 2001 to 13.8% (N=103/743) in 2024, indicating a trend towards an older population.

Have household characteristics as reported by the respondent changed between 2001, 2014 and 2024?

Table 32 Changes in key demographic profile of households between 2001, 2014 and 2024.

Indicator	2001 Number (%)	2014 Number (%)	2024 Number (%)	X^2
Number of years in house	**N=340/344 (98.8)**	**N=328/343 (95.6)**	**N=274/274 (100.0)**	**117.35*** **
0-10	122 (35.9)	117 (35.7)	106 (38.7)	
11-20	105 (30.9)	48 (14.6)	57 (20.8)	
21-30	102 (30.0)	63 (19.2)	35 (12.8)	
31+	11 (3.2)	100 (30.5)	76 (27.7)	
Occupancy status*	**N=341/344 (99.1)**	**N=336/343 (98.0)**	**N=274/274 (100.0)**	**55.32*** **
Outright owner	74 (21.7)	113 (33.6)	104 (38.0)	
Renting from or rent paid by county council or tenant purchasing plan	109 (31.9)	104 (31.0)	58 (21.2)	
Mortgage	144 (42.2)	90 (26.8)	73 (26.6)	
Renting privately	14 (4.1)	29 (8.6)	38 (13.9)	
Car ownership	**N=343/344 (99.7)**	**N=321/343 (93.6)**	**N=274/274 (100.0)**	**0.29**
Yes	264 (77.0)	243 (75.7)	206 (75.2)	
No	79 (23.0)	78 (24.3)	68 (24.8)	

- Not included in 2014 study
*Categories were collapsed for sensible comparison to 2001, 2014 and 2024 survey data.

The data from 2001, 2014 and 2024 show significant changes in housing patterns, but little change in car ownership. Over time, more people are staying in their homes longer. The percentage of those living in their homes 0-10 years rose from 35.9% in 2001 to 38.7% in 2024, while fewer people lived in their homes for 11-20 years, 30.9% in 2001, 14.6% in 2014 to 20.8% in 2024. The number of outright homeowners increased from 21.7% in 2001 to 38.0% in 2024, and fewer people were renting from the county council or had mortgages; mortgages went from 42.2% in 2001 to 26.6% in 2024. Additionally, the proportion of people renting privately increased from 4.1% in 2001 to 13.9% in 2024. The Chi-squared test for number of years in house showed a highly significant change ($X^2 = 117.35$, $p < 0.001$), and for occupancy status, it was also significant ($X^2 = 55.32$, $p < 0.001$). However, car ownership remained stable across all three-time points. These trends suggest a shift towards longer homeownership and private rentals, with a steady relationship of car ownership.

Demographic profile of respondents– has it changed between 2001, 2014 and 2024?

Table 33 Changes in key demographic profile of respondents between 2001, 2014 and 2024.

Indicator	2001 Number (%)	2014 Number (%)	2024 Number (%)	X^2
Gender	**N=344/344 (100.0)**	**N=343/343 (100.0)**	**N=274/274 (100.0)**	**77.22*** **
Female	320 (93.0)	237 (69.1)	184 (67.2)	
Male	24 (7.0)	106 (30.9)	90 (32.8)	
Age	**N=341/344 (99.1)**	**N=339/343 (98.8)**	**N=274/274 (100.0)**	**49.65*** **
20-34	80 (23.5)	65 (19.2)	38 (13.9)	
35-49	131 (38.4)	93 (27.4)	107 (29.3)	
50-64	107 (31.4)	113 (33.3)	63 (17.3)	
65+	26 (7.1)	72 (19.7)	65 (17.8)	
Marital status*	**N=344/344 (100.0)**	**N=342/343 (99.7)**	**N=274/274 (100.0)**	**28.51*** **
Married	215 (62.5)	179 (52.3)	137 (50)	
Separated, divorced, widowed	60 (17.4)	72 (21.1)	45 (16.5)	
Single	69 (20.1)	67 (19.6)	71 (25.9)	
Cohabitating	-	24 (7.0)	17 (6.2)	

Indicator	2001 Number (%)	2014 Number (%)	2024 Number (%)	X^2
Highest level of educational attainment	**N=344/344 (100.0)**	**N=337/343 (98.3)**	**N=274/274 (100.0)**	**152.92*** **
Primary education or less	124 (36.0)	90 (26.7)	23 (8.4)	
Junior or intermediate certificate, technical or vocational training	107 (31.1)	75 (22.3)	46 (16.8)	
Leaving certificate, A-level, technical training	49 (14.2)	55 (16.3)	56 (20.4)	
Non-degree qualification	43 (12.5)	69 (20.5)	54 (19.7)	
Degree, professional qualification, both and postgraduate	18 (5.2)	48 (14.3)	95 (34.6)	
Current employment status^	**N=344/344 (100.0)**	**N=342/343 (99.7)**	**N=274/274 (100.0)**	**38.46*** **
Working full time	100 (29.1)	94 (27.5)	119 (43.4)	
Working part tine	86 (25.0)	47 (13.7)	39 (14.2)	
Always in the home or in education	157 (45.6)	201 (58.8)	117 (42.6)	
Level of health cover^^	**N=344/344 (100.0)**	**N=341/343 (99.4)**	**N=274/274 (100.0)**	**113.21*** **
Medical card	111 (32.3)	187 (54.8)	96 (35.0)	
Neither medical card nor private health insurance	120 (34.9)	99 (29)	67 (24.5)	
Private medical insurance	113 (32.8)	47 (13.8)	99 (36.1)	
Doctor visit card	-	8 (2.3)	30 (10.9)	

* Categories were collapsed for comparison to 2001, 2014 and 2024 survey data
*** = $p<0.001$
^ in 2001 study, employment status was categorised differently and cannot be compared
^^ in 2001 study, level of health cover did not include doctor visit card
- not included in 2001 study

For gender, the distribution changed dramatically over time (X^2=77.22, p < 0.001). In 2001, 93.0% of respondents were female, but by 2024, this dropped to 67.2% and the percentage of male respondents increased from 7.0% in 2001 to 32.8% in 2024. In terms of age, significant shifts were observed (X^2=49.65, p < 0.001). The percentage of people in the 20-34 age group dropped from 23.5% in 2001 to 13.9% in 2024. Meanwhile, in the 35–49-year age group remained relatively stable, decreasing slightly from 38.4% in 2001 to 29.3% in 2024. The 50–64-year age group saw an increase from 2001 to 2014 (21.4% to 33.3%) but decreased to 17.3% by 2024. The 65+ years age group saw growth from 7.1% in 2001 to 19.7% in 2014 and has remained high in 2024 at 17.8% in 2024.

Regarding marital status, the percentage of respondents who were married decreased from 62.5% in 2001 to 50.0% in 2024. Meanwhile the number of single respondents increased slightly from 20.1% in 2001 to 25.9% in 2024. The proportion of people who were separated, divorced or widowed remained steady, and cohabitating was a new category introduced in 2014, slightly decreasing from 7.0% to 6.2% in 2024 (X^2=28.51, p < 0.001).

For the highest level of educational attainment, there was a clear shift towards higher qualifications (X^2=152.92, p <0.001). The percentage of respondents with primary education or less significantly decreased from 36.0% in 2001 to 8.4% in 2024. Those with a degree or higher qualification increased from 5.2% in 2001 to 34.6% in 2024, while the percentage of respondents with junior/intermediate certificates and non-degree qualifications showed a modest change.

In terms of employment status, there was a notable increase in respondents reporting working full-time, from 29.1% in 2001 to 43.4% in 2024. The proportion working part time decreased from 25.0% in 2001 to 14.2% in 2024, while those always in the home or in education decreased from 45.6% in 2001 to 42.6% in 2024. The Chi-squared result for employment status was significant (X^2=38.46, p < 0.001), indicating a shift towards full time employment.

As for health cover, the use of medical cards increased significantly from 32.3% in 2001 to 54.8% in 2014, before dropping back to 35.0% in 2024. The percentage with private health insurance decreased from 32.8% in 2001 to 13.8% in 2014 but increased again to 36.1% in 2024. Those with no health coverage decreased from 24.9% in 2001 to 24.5% in 2024. It is important to note that these trends may be influenced by oversampling in areas of higher deprivation, where there is likely a higher reliance of public health services such as medical cards. However, there has been a meaningful shift in health coverage looking towards private health insurance or using public services over time (X^2=113.21, p < 0.001).

3.4 Health status

Table 34 Is there a change in respondent reported physical activity between 2014 and 2024?

Physical activity	Times a week	2014 Number (%)	2024 Number (%)	X^2
Strenuous exercise		N=334/343 (97.4)	N=255/274 (93.4)	23.6***
	None	278 (83.2)	165 (64.7)	
	Less than five	47 (14.1)	75 (29.4)	
	Five or more	9 (2.7)	15 (5.8)	
Moderate exercise		N=337/343 (98.3)	N=256/274 (93.4)	35.1***
	None	192 (57.0)	112 (43.7)	
	Less than five	92 (27.3)	104 (40.6)	
	Five or more	53 (15.7)	40 (15.6)	
Mild exercise		N=338/242 (98.5)	N=258/274 (94.2)	8.2**
	None	119 (35.2)	68 (26.3)	
	Less than five	118 (34.9)	118 (45.7)	
	Five or more	101 (29.9)	72 (27.9)	
Walking 30 minutes or more		N=343/343 (100.0)	N=267/274 (97.4)	7.2*
	None	77 (22.4)	47 (17.6)	
	Less than five	143 (41.7)	96 (35.9)	
	Five or more	123 (35.9)	124 (46.4)	

*p<0.05
**p<0.01
*** = p<0.001

The data reveal significant changes in physical activity levels among respondents between 2014 and 2024, particularly in strenuous and moderate exercise, with smaller shifts in mild exercise and walking habits.

For strenuous exercise (X^2=23.6, $p < 0.001$), the percentage of respondents reporting no participation decreased from 83.2% (N=278/334) in 2014 to 64.7% (N=165/255) in 2024. Meanwhile, the proportion engaging in strenuous exercise less than five times a week rose from 14.1% (N=47/334) to 29.4% (N=75/255). The percentage of those exercising five or more times weekly also increased, from 2.7% (N=9/334) in 2014 to 5.8% (N=15/255) in 2024.

In terms of moderate exercise (X^2=35.1, $p < 0.001$), the proportion of respondents reporting no participation decreased from 57.0% (N=192/337) in 2014 to 43.7% (N=112/256) in 2024. Those exercising less than five times weekly rose from 27.3% (N=92/337) to 40.6% (N=104/256), while participation in moderate exercise five or more times a week remained largely stable, decreasing slightly from 15.7% (N=53/337) to 15.6% (N=40/256).

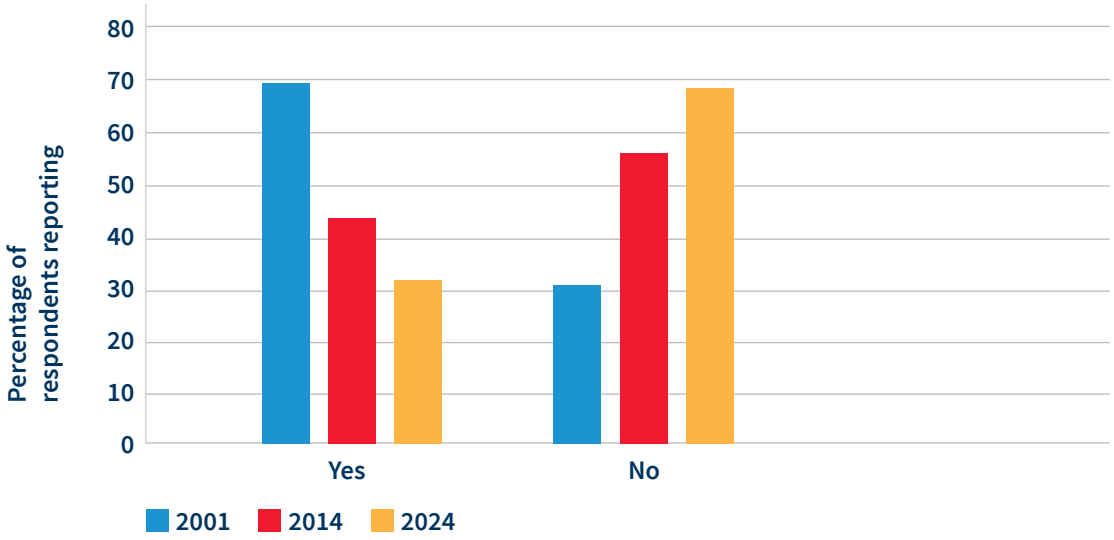
For mild exercise (X^2=8.2, $p < 0.01$), the percentage of respondents reporting no participation dropped from 35.2% (N=119/338) in 2014 to 26.3% (N=68/258) in 2024. Those engaging in mild exercise less than five times a week increased from 34.9% (N=118/338) to 45.7% (N=118/258), while the percentage participating five or more times weekly declined from 29.9% (N=101/338) to 27.9% (N=72/258).

Walking for 30 minutes or more remained the most consistent activity, though participation showed slight declines (X^2=7.2, $p < 0.05$). In 2014, 22.4% (N=77/343) of respondents reported not walking at all, which decreased to 17.6% (N=47/267) in 2024. Those walking less than five times a week dropped from 41.7% (N=143/343) to 35.9% (N=96/267), while the proportion walking five or more times a week increased from 35.9% (N=123/343) to 46.4% (N=124/267).

These findings indicate significant improvements in strenuous and moderate exercise participation among respondents over the ten-year period, with modest but positive changes in mild exercise and walking habits.

Has the proportion of households with a smoker changed between 2001, 2014 and 2024?

Figure 22 Number of households reporting any smokers in 2001, 2014, and 2024.



Numbers of households reporting one or more smoker significantly varied from 2001 (N=238/344; 69.2%), 2014 (N=151/340; 44.4%) and 2024 (N=87/270; 32.2%; X^2=89.03, $p<0.001$). In 2001, there was a large proportion (69.2%) of respondents reporting 1 or more person in the household smoking; this decreased to 44.4% in 2014, and now 32.2% in 2024. There is an inverse in reporting habits in 2024, as more respondents are reporting fewer or no individuals smoking in the household, from 30.8% in 2001, 55.6% in 2014, and 67.8% in 2024.

Was there a change in the proportion of respondents reporting stress and the severity of this stress between 2001, 2014 and 2024?

Table 35 Respondents' reported experience of stress in the previous 12 months in 2001, 2014 and 2024.

Indicator	2001 Number (%)	2014 Number (%)	2024 Number (%)	X^2
Have you experienced stress in the past 12 months?	**N=344/344 (100.0)**	**N=339/343 (98.8)**	**N=272/274 (99.3)**	**7.88***
Yes	204 (59.3)	227 (66.9)	189 (54.9)	
No	140 (40.7)	112 (33.0)	83 (30.3)	
Rating of seriousness of stress	**N=203/204 (99.5)**	**N=225/227 (99.1)**	**N=189/274 (68.9)**	**19.18***
1 (not serious)	33 (16.3)	24 (10.7)	13 (6.9)	
2	39 (19.2)	31 (13.8)	30 (15.9)	
3	62 (30.5)	52 (23.1)	60 (31.7)	
4	30 (14.8)	47 (20.9)	32 (16.9)	
5 (very serious)	39 (19.2)	71 (31.6)	51 (26.9)	
Reason for stress}	**N=197/204 (96.9)**	**N=213/227 (93.8)**	**N=251/274 (91.6)**	**18.29 ****
Family	108 (54.8)	83 (38.9)	70 (38.6)	
Finances	19 (9.6)	44 (20.7)	33 (18.2)	
Illness	37 (18.8)	41 (19.2)	43 (23.7)	
Work/Unemployment/ Study/Other	33 (16.8)	45 (21.1)	35 (13.9)	
Actions taken as a result of stress +	**N=191/204 (93.6)**	**N=227/227 (100.0)**	**N=189/274 (68.9)**	**145.91*****
Talked to friends or relatives	125 (65.4)	114 (50.2)	113 (59.8)	
Visited GP	66 (34.6)	101 (44.5)	61 (32.3)	
Took prescription medication	37 (19.4)	53 (23.2)	33 (17.5)	
Visited counsellor/ psychiatrist/ psychologist	23 (12.0)	39 (17.2)	34 (17.9)	
Visited church	-	32 (14.1)	30 (15.9)	
Alternative medicine	19 (9.9)	-	-	
Other	-	~ (^)	9 (4.8)	
None	-	49 (21.6)	41 (21.9)	

~ denotes 5 or fewer cases reported.
^ percentage not provided to prevent disclosure of small numbers
- Not included as a category in the questionnaire
} Reason for illness was collapsed to four categories to allow for sensible comparisons.
+ Participant could provide more than one answer.
*p<0.05
**p<0.01
*** p<0.001

In examining the experience of stress over the past 12 months, respondents reported rates remained high across all years, though with some variation, and the change over time was found to be statistically significant (X^2=7.88, p<0.05). In 2001, 59.3% reported they had experienced stress, while 40.7% did not. In 2014, the percentage of respondents who reported stress increased with 66.9% reporting stress and 33.0% reporting they did not experience stress. By 2024, the percentage reporting stress dropped to 54.9%, while 30.3% reported not experiencing stress.

When respondents were asked to rate the seriousness of their stress on a scale of 1 (not serious) to 5 (very serious), the distribution shifted significantly across the years (X^2=19.18, p<0.05). In 2001, 19.2% rated their stress as very serious (5), with the largest group 30.5% selecting a moderate rating of 3. By 2014, there was an increase in perceived severity, with 21.6% rating their stress as very serious, while 23.1% rated it as a 3. In 2024, the percentage reporting very serious (5) stress slightly decreased to 26.9%, while the moderate rating was chosen by 31.7%, suggesting some fluctuation in perceived stress severity over time.

The primary reason for stress among respondents also evolved significantly over time (X^2=19.20, p<0.01). In 2001, family related stress was the most reported reason of stress, cited by 54.8% of respondents. By 2014, this number had decreased to 38.9%, with financial concerns rising to 20.7% as a more prominent stressor, up from 9.6% in 2001. In 2024, family stress continued to decrease, as reported by 38.6%, while financial stress remained relatively high at 18.2%. Illness related stress showed a slight increase over time from 18.8% in 2001 to 23.7% in 2024. Other reasons of stress reported were related to work, unemployment, study or other reasons.

In terms of actions taken to manage stress, responses showed a significant distinct pattern over time showing variations in actions taken because of stress (X^2=145.91, p < 0.001). Talking to friends or relatives was the most common action across all years, though the percentage decreased from 64.4% in 2001 to 50.2% in 2014 and rose again to 58.9% in 2024. Visiting a GP became increasingly common, rising from 34.6% in 2001 to 44.5% in 2014, to declining to 32.3% in 2024. Notably, 17.2% of respondents in 2014 and 17.9% in 2024 visited a mental health professional, a notable increase from the 12.0% reported in 2001, suggesting an increasing openness to seeking specialised mental health support. Additionally, visiting church, a new category presented in 2014 remained consistent in 2024, with approximately 15.9% of respondents choosing this action.

Is there a change in respondent reported experience of teenagers between 2001, 2014 and 2024?

Table 36 Respondents' reported experience of teenagers in 2001, 2024 and 2024.

Indicator	2001 Number (%)	2014 Number (%)	2024 Number (%)	X^2
Worrying about teenager socialising	**N=218/218 (100.0)**	**N=95/99 (95.9)**	**N=79/79 (100.0)**	**3.23**
Yes	130 (59.6)	52 (54.7)	38 (48.1)	
No	88 (40.4)	43 (45.3)	41 (51.8)	
Happy with teenagers' friends	**N=218/218 (100.0)**	**N=89/99 (89.9)**	**N=79/79 (100.0)**	**1.69**
Yes	186 (85.3)	70 (78.7)	69 (77.5)	
No	13 (5.9)	19 (21.3)	6 (7.6)	
Teenager displays problematic behaviour	**N=213/218 (97.7)**	**N=89/99 (84.8)**	**N=79/79 (100.0)**	**13.67****
Yes	97 (45.5)	28 (33.3)	18 (22.7)	
No	116 (54.5)	56 (66.7)	61 (77.2)	

**p<0.01

In 2001, 59.6% (N=120/218) of respondents expressed concern about their teenager socialising. Over the years, this worry decreased, with 54.7% (N=52/95) reporting concerns in 2014, and an even further decline in 2024, where only 48.1% (N=38/79) indicated worry. Similarly, there was a slight decrease in the percentage of respondents who were happy with their teenager's friends. In 2001, 85.3% (N=186/218) reported being happy, which dropped to 78.6% (N=70/89) in 2014, and 77.5% (N=69/79) in 2024. However, the most significant change was seen in the perception of problematic behaviours. While there was a steady decline in respondents reporting such behaviours, the most notable shift occurred between 2001, when 45.5% (N=97/213) reported issues, and 2024, when only 22.7% (N=18/79) indicated the same.

Has the proportion of people reporting chronic illness changed between 2001, 2014 and 2024 and has there been any change in the types of chronic illness?

Table 37 Respondents' reported type of chronic illness for each individual with a chronic illness in the household in 2001, 2014 and 2024.

Indicator	2001 Number (%)	2014 Number (%)	2024 Number (%)	X^2
Chronic illness	**N=284/1313 (21.6)**	**N=234/1082 (21.6)**	**N=111/755 (14.7)**	**119.42*** **
Heart disease	67 (23.6)	68 (29.1)	17 (15.3)	
Diabetes	22 (7.7)	30 (12.8)	16 (14.4)	
Respiratory	92 (32.4)	20 (12.4)	16 (14.4)	
Mental health and addiction	14 (4.9)	24 (10.3)	6 (5.4)	
Arthritis	23 (8.1)	17 (7.3)	10 (9.0)	
Chronic Bowel Disease	16 (5.6)	15 (6.4)	11 (9.9)	
Cancer	~ (^)	13 (5.6)	11 (9.9)	
Neurological	14 (4.9)	11 (4.7)	21 (18.9)	
Orthopaedic	14 (4.9)	~ (^)	11 (9.9)	
Other	19 (6.7)	23 (9.7)	10 (9)	

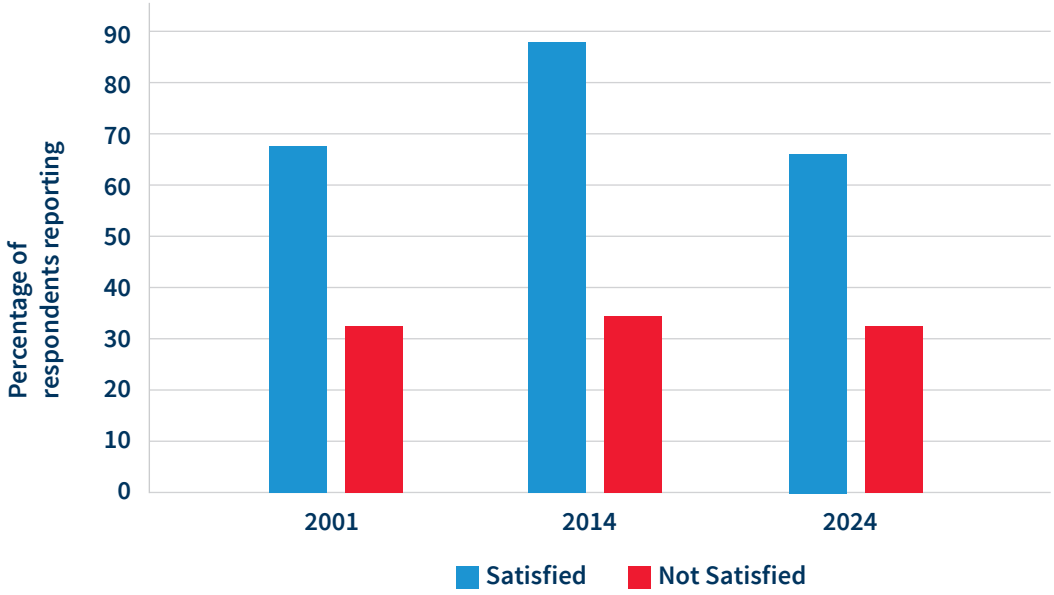
~ denotes 5 or fewer cases reported.
^ percentage not provided to prevent disclosure of small numbers
***p<0.001

Chronic illness among respondents from 2001, 2014 and 2024 has changed significantly (X^2=119.42, p<0.001). The percentage of respondents reporting heart disease decreased from 23.1% in 2001 to 15.3% in 2024. However, more respondents are reporting diabetes in 2024 (14.4% from 7.7% in 2001). Similarly, respiratory conditions saw a notable decrease from 32.4% (N=92/284) in 2001 to 12.4% (N=20/234) in 2014, increasing slightly in 2024 (14.4%; N=16/111). Mental health and addiction saw a significant increase from 4.9% (N=14/284) in 2001 to 10.3% (N=24/234) in 2014, decreasing to 5.4% (N=6/111) in 2024. Arthritis remained consistent across all time points, ranging from 7.3-9.0%. Chronic bowel disease also showed increases, fluctuating between 5.6% (N=16/284) in 2001 to 9.9% (N=11/111) in 2024. Limited numbers regarding respondents reporting cancer were available in 2001, however this has since increased from 5.6% (N=13/234) in 2014 to 9.9% (N=11/111) in 2024.

Neurological conditions saw a substantial increase from 4.9% (N=14/284) in 2001 to 18.9% (N=21/111) in 2024, indicating a significance prevalence of these conditions over the years. In 2024, orthopaedic issues were highlighted as a chronic illness of concern (9.9%; N=11/111), which was not distinctly reported on in previous years, emphasising the need for a broader focus on chronic health conditions, particularly musculoskeletal health among respondents.

Has the proportion of respondents indicating satisfaction with 'out-of-hours' services between 2001, 2014 and 2024 changed?

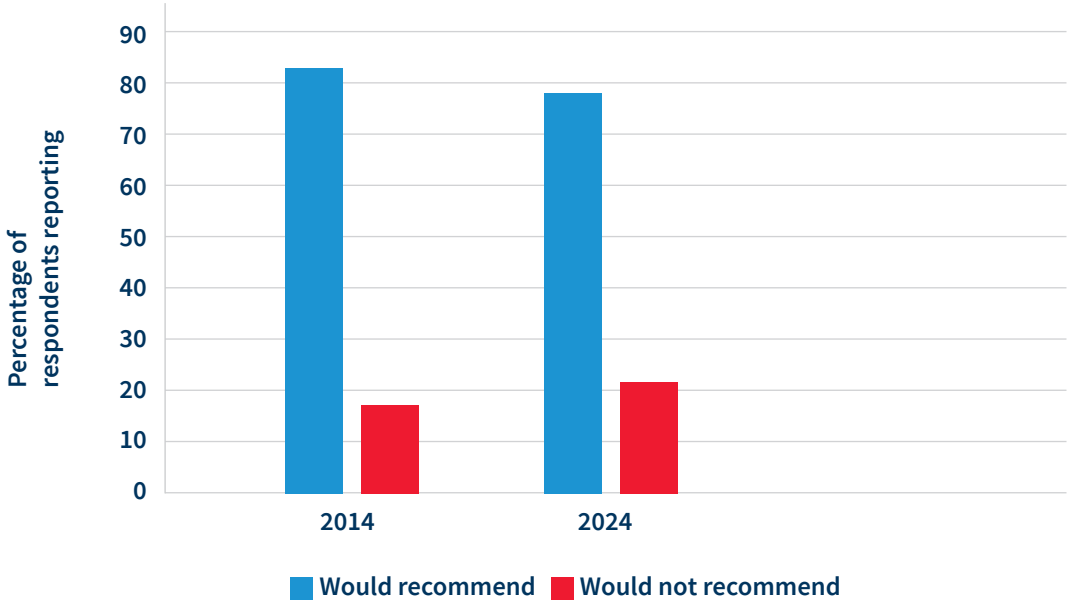
Figure 23 Respondents reported satisfaction of 'out-of-hours' services from 2001, 2014 and 2024



There was no change in the proportion of respondents reporting their satisfaction with 'out-of-hours' services between 2001 (N=176/262; 67.2%), 2014 (N=135/154; 87.7%), and 2024 (N=112/168; 66.7%) (X^2=1.21, p=0.55).

Has the proportion of respondents who would recommend Tallaght University Hospital to a friend or family member changed between 2014 and 2024?

Figure 24 Respondents reported likelihood to recommend Tallaght University Hospital from 2014 and 2024



There was no significant change (p=0.22) between the proportion of respondents who would recommend Tallaght University Hospital to a friend or a family member in 2014 (N=177/211; 83.9%) and 2024 (N=86/110; 78.2%).

Part 4 - Discussion and Conclusion

4.1 Discussion

This third round of the 'Health Assets and Needs Assessment' conducted in 2024 aimed to refresh insights from health assessments conducted in Tallaght in 2001 and 2014. To achieve this, we undertook a large-scale household survey across Tallaght's 13 electoral divisions, reaching out to respondents in 420 randomly selected households. Our approach used a cluster sampling method to ensure geographic and demographic representation, with a market research company conducting interviews in participants' homes. Through these structured conversations, we gathered data to inform evidence-based recommendations for population health. Additionally, we mapped key local assets like healthcare facilities, parks, and recreational spaces, creating a comprehensive asset inventory to highlight Tallaght's available resources for resident wellbeing.

In terms of the response rate of 65.2%, this aligns with other community-based studies, indicating a sufficiently representative sample for robust socio-economic and demographic insights.69-72 The response rate for the HANA study has declined over time, from 81.9% (N=344/420) in 2001 and 81.6% (N=343/420) in 2014 to Round 3 response rate of 65.2% (N=272/420). This trend reflects increasing challenges in engaging participants for surveys, potentially linked to demographic shifts and higher population mobility. While participation has decreased, the study continues to provide representative insights, particularly in areas with high deprivation. This highlights the need for innovative recruitment strategies to maintain robust data collection in future assessments. This study's age distribution of the respondent respondents —dominated by those aged 40-49 years—reflects findings from similar household surveys internationally.[69,72-73] Gender balance, consistent with norms in large-scale demographic surveys supports confidence in the data's representativeness.[73] Reflecting global trends, the variation in employment status (e.g., full-time work at 41.3% (N=305/738) and education at 26.9% (N=199/738)) underscores the importance of tailored community services, as noted in international studies.[74] Such diversity highlights the multi-faceted nature of household needs, where access to educational resources and workforce integration remain essential.[75] Changes in demographic and socio-economic profiles underline significant societal transformations between data collection rounds. The proportion of children (0–9 years) rose from 12.7% (N=167/1,313) in 2001 to 16.7% (N=178/1,065) in 2014 but declined to 13.9% (N=103/743) by 2024, while the older population (65+ years) tripled from 3.4% (N=45/1,313) in 2001 to 13.9% (N=103/743) in 2024. Additionally, housing patterns revealed a shift toward longer homeownership, with outright ownership increasing from N=74/344; 21.7% in 2001 to N=104/274; 38.0% in 2024. These findings indicate an ageing population, requiring increased support for older adults and enhanced housing policies tailored to evolving ownership trends.

The findings from respondents about living in Tallaght reveal a community with both valued assets and notable challenges. Among the most positively regarded aspects are the amenities, with 72.7% of respondents (N=173/238) appreciating resources such as 'The Square' shopping centre, local sports facilities, and libraries. Access to amenities is widely recognised in urban studies as a critical factor in enhancing residents' quality of life, contributing to both physical and social well-being.[76] Moreover, Tallaght's community spirit, noted by 61.3% (N=146/238), aligns with research suggesting that neighbourhood social cohesion can mitigate stress and foster a stronger sense of belonging, an especially valuable asset in urban settings.[77] In terms of location, 47.4% (N=113/238) highlighted the area's proximity to mountains, parks, and other natural spaces, contributing to a quieter living environment. Access to green spaces is associated with mental and physical health benefits, especially in urban environments where such resources are often limited.[78] Public transport was another commonly cited benefit (46.2%; N=110/238), with residents commending the convenience of the Luas and bus links to Dublin city centre. Accessible and reliable public transport is a known factor in urban resilience improving social equity.[79]

On the other hand, respondents identified antisocial behaviour and safety concerns as primary challenges, with 71.7% (N=168/234) citing issues such as gangs, racism, and feeling unsafe at night. Such concerns reflect findings from previous studies, which link perceived safety and social order to residents' mental health and overall life satisfaction.[80] The second concern, lack of amenities (61.1%; N=143/234), includes limited facilities for teenagers and insufficient healthcare services—consistent with urban research showing that inadequate services can hinder community cohesion and create service gaps, particularly in health and youth engagement.[81] Further, 32.8% (N=77/234) identified crime and a lack of visible Gardaí presence, with residents expressing a desire for improved policing to counteract theft and vandalism. These findings underline that public safety is a shared responsibility, requiring a collective, coordinated response from residents, community groups, and agencies. Ensuring safety cannot rest solely on the Gardaí or South Dublin County Council but demands community-based initiatives, education, and improved resources to foster a safer environment for all.

Other challenges presented were around the prevalence of drugs and alcohol in community areas highlighted by 28.2% (N=66/234), coupled with transport and traffic issues (21.8%; N=51/234), suggesting that while Tallaght offers certain logistical conveniences, social issues impact the community's perception of safety and infrastructure. High population density and overcrowding concerns, though less prominent (11.1%; N=26/234), add to these challenges, and the area's reputation is influenced by negative media portrayal, as noted by 8.9% (N=21/234). A collaborative approach to addressing these concerns can foster trust, strengthen social cohesion, and improve quality of life for all residents. These findings reinforce the importance

of multi-level urban policies that address both social and infrastructural factors to foster a balanced, thriving urban environment.[82] Additionally, levels of social capital, as measured by trust, reveal a mixed perception, with 44.8% (N=103/274) indicating higher trust but a notable portion of residents expressing low or neutral trust (33.5% and 20.4%, respectively), reflecting a nuanced community dynamic.

The findings indicate that community volunteering in Tallaght remains relatively low, with only 9.7% of respondents (N=26/267) participating in volunteer activities. Compared nationally, this not only contrasts with research highlighting the positive role of community volunteering in enhancing social cohesion, safety, and overall neighbourhood quality, but also with the highly reported sense of community spirit (61.3%; N=146/238).[83] Low volunteer rates could reflect barriers such as time constraints or limited awareness of volunteer opportunities.[84] With social capital linked to public health and community resilience, efforts to boost volunteer participation may enhance the community's social infrastructure and foster a stronger collective identity.[85]

When considering infrastructure to promote walking and cycling, respondents prioritised improvements in cycling infrastructure (43.6%; N=78/179) and safety measures (21.8%; N=39/179). The high rate of "don't know" responses (53.6%; N=96/179) suggests an opportunity for increased public education around active travel benefits and infrastructure plans, potentially reducing car dependency.[86] Furthermore, 80.6% (N=216/268) cited concerns over anti-social behaviour as a deterrent to walking and cycling. Studies have shown that perceived safety directly impacts active travel uptake, particularly in urban areas.[87] Implementing safety-focused measures, such as improved lighting and community policing, alongside infrastructure investments, may enhance the appeal of active travel options and align with South Dublin County Council's objective of promoting healthy, sustainable transportation options.

Regarding community service utilisation, there was a high usage rates of public services (e.g., public transport at 84.3% (N=231/274) and parks at (81.2% (N=223/274)) resonate with findings that access to such amenities fosters social cohesion and physical activity, as evidenced in European studies.[88] This emphasises the importance of community infrastructure in supporting mental and physical well-being across populations.[89]

Consistent with European data on health inequities where affordability limits access, the 31.5% (N=85/269) of respondents delaying healthcare due to cost reflects the economic uncertainty found worldwide.[90] This underscores the need for affordable, accessible healthcare to mitigate health disparities which is championed by the World Health Organisation[91] and is the primary ambition of current national health policy within Ireland through the implementation of *Sláintecare*.[92]

The health status of respondents in Tallaght, based on self-reported assessments, indicates a marked disparity in health outcomes when compared to national and local averages.[60-61] In the 2024 HANA survey, only 30.3% (N=83/273) of respondents rated their health as "very good" (N=109/273), significantly lower than the national average of 53.2%.[60] This self-assessment suggests that Tallaght's respondents might face health challenges which are not as prevalent in the general population, potentially influenced by socio-economic factors specific to the area. Self-reported health status has been used globally as a key indicator of community health and has been shown to correlate strongly with morbidity and mortality rates.[93-94] This disparity highlights the need for targeted interventions to address health inequalities in areas of lower self-rated health.

Health behaviours showed positive changes, with households reporting one or more smokers decreasing significantly from N=238/344; 69.1% in 2001 to N=87/270; 32.2% in 2024. Physical activity data from the survey suggest that a large proportion of respondents fall below recommended activity levels, with 64.7% reporting no participation in strenuous exercise and 40.9% abstaining from moderate exercise. The inactivity rates in Tallaght align with global trends where socio-economic barriers, including limited time, lack of safe spaces, and health issues, restrict physical activity among lower-income populations.[95] Increasing access to community exercise programmes and safe, well-maintained public spaces may help mitigate inactivity rates and promote better health outcomes in areas like Tallaght, which stands to benefit from such interventions.[96] These findings reflect growing public awareness of health-promoting behaviours but emphasise the need to sustain and expand initiatives targeting lifestyle modifications to reduce preventable diseases.

The data on stress levels among respondents further illustrates the pressures on this group, with 66.1% reporting stress in the previous year, primarily related to family, financial, and health issues. The prevalence of stress and its associated symptoms, including anxiety, sleeplessness, and depression, is consistent with findings from other urban areas facing economic challenges.[97] Chronic stress is widely recognised as a determinant of poor health, influencing both mental and physical wellbeing[98], which could exacerbate the lower self-rated health status observed among respondents in Tallaght.

The results reveal intricate relationships between teenage behaviour and family dynamics, shedding light on the concerns and resilience of respondents. Nearly half of the respondents (48.1%; N=38/79) expressed concerns about teenagers socialising, with primary reasons including bullying and peer pressure (37.8%; N=14/37), the teenager's behaviour or attitude (27.0%; N=10/37), safety concerns related to the environment and peers (21.6%; N=8/37), and anti-social behaviour in the neighbourhood (13.5%; N=5/37). However, a majority (77.5%; N=69/79) were satisfied with their teenager's friends, which aligns with research showing that positive peer

interactions often support adolescent well-being.[99] Regarding behaviour, 22.7% (N=18/79) of respondents reported problematic teenage attitudes or behaviours in the last year, while the majority (77.2%; N=61/79) reported no issues. This aligns with findings that adolescence can present challenges for a minority of families while being relatively stable for others.[100] Among respondents who responded about psychological or emotional conditions (N=64/79; 81.0%), 12.5% (N=8/64) reported a diagnosed condition, while 62.5% (N=40/64) reported none, and 9.4% (N=6/64) were unsure. This suggests that a subset of adolescents face mental health challenges requiring attention. For diagnosed conditions (N=11/11), more than half (54.5%; N=6/11) reported durations exceeding two years, with an equal proportion (54.5%; N=6/11) noting that daily life was affected to some extent. Additionally, 72.3% (N=8/11) of cases were professionally diagnosed, underscoring the importance of medical support for these families.[101] Overall, these findings highlight the nuanced balance between risk and resilience in family dynamics, where the presence of supportive friendships and professional diagnoses may alleviate some concerns while highlighting the need for ongoing attention to mental health and environmental safety. These insights could inform interventions aimed at promoting positive family and peer relationships and addressing specific challenges faced by adolescents and their respondents.

Access to healthcare services and the distribution of health coverage among respondents further reflect health disparities. With 36.1% (N=99/274) of respondents having private health insurance and 35.0% (N=96/274) possessing a medical card, over a quarter (24.5%; N=67/274) reported lacking any form of health cover, placing them in a vulnerable position for healthcare access. This pattern is consistent with studies linking limited insurance coverage to delayed care, financial strain, and poorer health outcomes, particularly among those reliant on public healthcare systems.[102] In comparison to countries with universal healthcare models, the partial coverage in Ireland may disproportionately affect respondents in lower-income urban areas, contributing to the observed gaps in health status and healthcare access.

Dental health poses a significant burden on overall health, as highlighted by the fact that 49.3% (N=135/274) of respondents indicated a need for dental treatment if they were to visit a dentist immediately. This demand reflects the barriers to accessing routine dental care, often linked to financial constraints and inadequate public dental resources.[103] Similar challenges have been observed internationally, where socio-economic disparities in dental care access contribute to unmet dental health needs and subsequent health complications.[104] Additionally, frequent dental pain among 30.6% (N=84/274) of respondents underscores the cumulative impact of inaccessible dental services on daily wellbeing and quality of life, warranting specific attention to improving affordable dental care access in urban settings like Tallaght.

The findings underscore the significant impact of chronic illness on households, revealing notable patterns in prevalence, healthcare utilisation, and associated disabilities. At the household level, 42.9% (N=111/259) of respondents reported at least one household member with a chronic illness, with the most common conditions being neurological illnesses (18.9%; N=21/111), heart disease (15.3%; N=17/111), diabetes (14.4%; N=16/111), and respiratory illnesses (14.4%; N=16/111). This aligns with national data, which estimates that approximately one million people in Ireland are affected by diabetes, asthma, chronic obstructive pulmonary disease (COPD), or cardiovascular disease.[105] When looking at patterns of chronic disease over time we can see some changes in Tallaght. The prevalence of chronic illnesses among respondents decreased from N=284/1313; 21.6% in 2001 and N=234/1082; 21.6% in 2014 to N=111/755; 14.7% in 2024. Notable trends include a significant decrease in heart disease (N=67/284; 23.6% in 2001 to N=17/111; 15.3% in 2024) and respiratory conditions (N=92/284; 32.4% in 2001 to N=16/111; 14.4% in 2024), while neurological conditions increased markedly (N=14/284; 4.9% in 2001 to N=21/111; 18.9% in 2024). These shifts suggest improvements in certain health outcomes, likely due to public health interventions such as Chronic Disease Management hubs or the Integrated Care for Older People community specialist teams but also highlight emerging needs in neurological health management.

Of those citing a chronic illness 10.8% (N=12/111) reported receiving healthcare at home, suggesting a high threshold being met to receive these types of services. Among households with chronic illnesses, GP visits were frequent, with 64.8% (N=72/111) reporting at least one visit in the last three months. Repeat prescriptions (74.9%; N=29/39) and medical check-ups (53.8%; N=21/39) were the most common reasons for these visits, indicating the importance of routine management. However, relatively low participation in chronic disease management programmes (15.0%; N=16/107) suggests under-utilisation of structured support systems, potentially due to accessibility, eligibility or awareness issues. This is notable given the HSE's implementation of the 'Chronic Disease Management Programme', which aims to improve prevention and care for chronic conditions.[105] In terms of disability, 10.5% (N=28/267) of households reported receiving a disability allowance, and nearly one in five households (18.7%; N=50/267) reported a household member with both a chronic illness and a disability. The intersection of these issues presents unique challenges, as chronic illnesses often exacerbate functional limitations, necessitating integrated care approaches. The HSE's "National Framework for the Integrated Prevention and Management of Chronic Disease" emphasises a whole-system approach to integration, including preventive, acute, non-acute, and community-based services.[105] These findings are consistent with global data indicating that chronic illnesses require sustained management and present significant healthcare demands.[106] It highlights the need for tailored interventions to address chronic disease management, improve access to home-based care, and increase participation in structured programmes. Policymakers must strengthen support

systems and fully implement *Sláintecare*, Ireland's health reform programme, to ensure universal access to integrated, person-centred care. *Sláintecare* provides a roadmap for reducing reliance on acute care services, enhancing primary and community care, and addressing chronic illnesses more effectively through a streamlined and equitable healthcare system.[107] Full implementation of *Sláintecare* will be critical in alleviating the burden on households and improving quality of life for those affected by chronic illness and disability.

Critical insights into healthcare service accessibility and utilisation in Tallaght can be gleaned from the results, with findings reflecting the experiences and needs of the surveyed respondents. An important finding is that nearly half of respondents (46.9%; N=125/266) accessed services at Tallaght University Hospital (TUH) in the past 12 months, primarily for diagnostic or clinical investigations. GP referrals were the main pathway to hospital care, which aligns with the broader healthcare trends where primary care serves as a crucial entry point for specialist services. The wide range of issues prompting hospital visits, including musculoskeletal and circulatory concerns, points to a high demand for specialist care, underscoring the need for diversified and accessible local healthcare services.

Satisfaction with services at TUH was largely positive, with two-thirds of respondents (67.2%; N=84/124) expressing satisfaction. Positive feedback often cited the quality of care and compassionate staff interactions as crucial factors, consistent with findings from patient satisfaction studies that emphasise staff empathy as a central component of healthcare quality.[108] However, some respondents were dissatisfied (32.0%; N=40/124) due to long waiting times and inadequate communication. This sentiment reflects broader challenges in health systems, where waiting times and patient-provider communication are ongoing challenges affecting service utilisation and perceived quality of care.[109]

In contrast to TUH's inpatient services, the Emergency Department experienced higher levels of dissatisfaction (66.3%; N=63/95), with almost half of attendees (49.5%; N=47/95) indicating they would not recommend the Emergency Department to others. The main reasons for dissatisfaction included delays, slow care processes, and communication gaps. These challenges are indicative of broader systemic issues often found in emergency departments worldwide, where limited resources for a large number of individuals presenting can impact care quality.[110] The high rate of self-referrals to the Emergency Department also highlights a need for enhanced out-of-hours and primary care services to manage non-urgent cases more effectively outside the emergency context.[110]

Respondents expressed strong demand for expanded GP services, mental health support, and services tailored for children's special needs. These needs align with international calls for a greater focus on community-based services to alleviate

hospital pressures and offer preventive care closer to where people live.[111] The perceived lack of adequate local mental health services signals a pressing gap in service provision that aligns with global trends advocating for integrated mental health support within primary and community health settings.[112] Feedback on future improvements for TUH pointed to a strong interest in reducing waiting times and improving staff availability and patient communication. While only a minority of respondents indicated a desire to be involved in TUH's service decisions, this highlights an opportunity for healthcare providers to engage the community more actively in shaping service offerings. Community involvement in healthcare decision-making has been shown to improve service delivery outcomes and enhance patient satisfaction.[113] Overall, these findings underscore the importance of building a responsive healthcare system that meets the evolving needs of Tallaght's residents and integrates community feedback into its service design and delivery.

Most respondents in Tallaght reported being registered with a GP, with 94.9% (N=260/274) indicating active registration. A small proportion of respondents reported no registration was needed or they were on a waiting list. This high rate of GP registration aligns with trends in other urban areas where GP accessibility remains a cornerstone of health service utilisation.[114] For accessibility, 55.7% (N=146/262) of those registered reported that their GP was within walking distance, suggesting a reasonable spatial distribution of primary care in Tallaght, though 43.5% (N=114/262) reported living further away, highlighting a potential barrier to routine care for nearly half of respondents. Among the small subset not registered (4.4%, N=12/274), barriers included being on a waiting list, lack of immediate need, or accessing GP services outside the Tallaght area. The ability to secure timely GP appointments remains mixed, with 56.4% (N=140/248) able to schedule appointments within three days, while a notable 23.7% (N=65/248) reported waiting over eight days; a delay that may reflect wider issues in GP availability. Satisfaction with GP services was relatively high, with 81.6% (N=214/262) of respondents expressing satisfaction and 79.6% (N=218/274) willing to recommend their GP to family or friends. These satisfaction levels align with studies indicating that GP continuity strongly influence positive patient perceptions.[115]

Out-of-hours services were primarily accessed through the TLC Doc service, utilised by 69.2% (N=101/146) of respondents when household members required after-hours care. A smaller proportion (25.9%, N=71/146) reported visiting the Emergency Department, while 22.6% (N=62/146) made decisions based on situational needs, with some opting for private or telehealth services (12.3%, N=18/146). This pattern mirrors findings from other studies on urban healthcare access, where centralised after-hours services are often utilised to alleviate pressure on emergency facilities and meet population needs outside standard clinic hours.[116] Satisfaction with out-of-hours services was varied; only 40.9% (N=112/274) expressed satisfaction, while 20.4% (N=56/274) were dissatisfied, and 38.7% (N=106/274) were uncertain.

Such ambivalence points to inconsistencies in the perceived reliability or quality of these services, an issue that calls for strategic review to ensure that after-hours care meets the communities' expectations. Overall, these findings underline the need for targeted system level intervention to enhance GP availability and out-of-hours support to better serve Tallaght's growing population. Recommendations include expanding GP clinic hours, potentially through community health initiatives or enhancement of existing partnership models and increasing awareness of and utilisation of alternative care options like telehealth, which could offer accessible solutions for those not requiring an in-person appointment.

Awareness and utilisation of social prescribing services among respondents in Tallaght appears limited, with only 11.7% (N=32/274) of respondents reporting familiarity with these services prior to the survey. This low awareness is consistent with international findings, which indicate that social prescribing remains underutilised due to a lack of public awareness and limited healthcare provider promotion.[117] For those who had heard of social prescribing, sources of information included friends or colleagues (46.9%, N=15/32), GP surgery (18.8%, N=6/32), and other informal sources such as word-of-mouth (15.6%, N=5/32). Notably, conventional channels like voluntary organisations, social media, or leaflets were rarely reported as sources, underscoring a gap in community outreach efforts for these services. Regarding the effectiveness of social prescribing, only 4.7% (N=13/274) of respondents who engaged with these services found them helpful, while 22.3% (N=61/274) did not. Additionally, among the 27.0% (N=74/274) who reported on the perceived link to local services, a substantial 74.3% (N=55/74) stated there was no direct linkage to relevant community activities or services. Satisfaction with social prescribing was also mixed, with only 12.2% (N=9/74) expressing satisfaction and 9.5% (N=7/74) reporting high satisfaction; a considerable 68.9% (N=51/74) were uncertain about their satisfaction levels. These findings align with studies suggesting that a lack of structured, localised service integration and clear referral pathways can undermine the perceived value of social prescribing initiatives.[118-120] Addressing barriers such as awareness, accessibility, and GP referrals could potentially improve uptake and effectiveness of social prescribing services in communities like Tallaght.

4.2 Conclusion

This third round of the Health Assets and Needs Assessment in Tallaght builds on the foundations of previous assessments conducted in 2001 and 2014, offering a comprehensive snapshot of a community undergoing significant demographic, socio-economic, and health-related changes. Despite declining response rates, the 2024 survey has delivered valuable insights into the evolving needs, assets, and challenges of the population, underscoring the importance of ongoing investment in community-based research and public engagement strategies to ensure robust data collection. Key findings reveal a shift towards an ageing population, with increased homeownership and greater utilisation of local amenities, highlighting Tallaght's strengths in community resources and infrastructure. However, challenges such as affordability of healthcare, stress among respondents, and limited awareness of services like social prescribing indicate areas for targeted interventions. These disparities, particularly among economically vulnerable groups, emphasise the need for enhanced access to affordable healthcare and community-based support systems. Improvements in lifestyle behaviours, such as reduced smoking prevalence and increased physical activity, reflect positive trends, yet the low uptake of strenuous and moderate exercise underscores the necessity for sustained investment in public health initiatives. The findings also indicate a need for expanded mental health services, more integrated community healthcare pathways, and enhanced community safety measures to address the social determinants of health affecting Tallaght residents. The study further highlights the mixed satisfaction with healthcare services, particularly out-of-hours care, which suggests the need for service redesign to improve accessibility, reduce waiting times, and foster better patient-provider communication. Increased awareness and integration of initiatives like social prescribing and telehealth could bridge existing gaps in service provision and enhance community engagement.

Overall, this assessment provides a crucial evidence base for informed decision-making and policy development, ensuring that Tallaght's assets and needs are addressed comprehensively. By leveraging these findings, stakeholders can create tailored, sustainable strategies to promote health equity, community resilience, and wellbeing across Tallaght's diverse population.

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Appendices

Appendix A HANA Survey in Tallaght 4-person household questionnaire.

Health Assets and Needs Assessment Tallaght
(HANA in Tallaght – Round 3)

An assessment of health assets, needs and health service satisfaction reported by the population of Tallaght 2024

4 Person Household Questionnaire

Household ID: _____

Interviewer: _____

Date: _____

Instructions

- The primary carer is the person in the household who manages the welfare and health of the family/household. In a house of renters this is the person who pays the bills or whose name is on the rent agreement.
- Unless otherwise specified all questions are to be answered by and in relation to the primary carer.
- Unless otherwise specified tick one answer only for each question.

Part 1: Demographics

Section One: Household Demographic details

Complete the following about the primary carer.

(For multiple-choice questions, please tick one only in each line unless otherwise specified)

1.1 How do you describe your gender?	☐ Male ☐ Female ☐ Transgender ☐ Non-binary ☐ Prefer not to say ☐ Other (please give details)	
1.2 What age are you?		
1.3 What is your ethnic group /background? Choose ONE section from A to D, then mark – the appropriate box	**A White** ☐ Irish ☐ Irish Traveller ☐ Roma ☐ Any other White background **B Black or Black Irish** ☐ African ☐ Any other black background	**C Asian or Asian Irish** ☐ Chinese ☐ Indian/ Pakistan/Bangladeshi ☐ Any other Asian background **D Other, including mixed group/background** ☐ Arabic ☐ Mixed, write in description ☐ Other, write in description
1.4.1 Do you speak a language other than English or Irish at home? *(If no, skip to question 1.5)*	☐ Yes ☐ No	
1.4.2 What is this language? (e.g., Polish, German, Irish sign language)		
1.4.3 How well do you speak English? *(Mark one box only)*	☐ Very well ☐ Well ☐ Not well ☐ Not at all	

1.5	What is your current marital status?	☐ Single (Never married or never in a same-sex civil partnership) ☐ Married (First marriage) ☐ Re-married ☐ In a registered same-sex civil partnership ☐ Separated ☐ Divorced ☐ Widowed ☐ Cohabitating
1.6	What is your highest level of education attained?	☐ Primary education or less ☐ Junior or intermediate certificate, technical/vocational training ☐ Leaving certificate, A level and technical training ☐ Non degree qualification (diploma, certificate) ☐ Degree, professional qualification, or both ☐ Postgraduate qualification
1.7	What is your current employment status? *(Tick all which apply)*	☐ Working full time ☐ Working part time ☐ In education ☐ Work Placement Experience Programme ☐ Working in the home ☐ Ill/unable to work ☐ Unemployed ☐ Retired ☐ Unpaid voluntary work
1.8	How many years have you lived in this house/ apartment?	
1.9	House/apartment occupancy Status	☐ Outright owner ☐ Tenant purchasing plan ☐ Renting privately ☐ Mortgage ☐ Renting from or rent paid by Health Board/ County Council
1.10	How many people live here (including primary carer)?	

Complete the following for each person living in the household (excluding the primary carer).

(For multiple-choice questions, please tick one only in each line unless otherwise specified)

1.10.1.A	Person #	
1.10.1.B	Relationship with primary carer	☐ Spouse/Partner ☐ Child ☐ Grandchild ☐ Parent ☐ Not related ☐ Other _____
1.10.1.C	How would they describe their gender?	☐ Male ☐ Female ☐ Transgender ☐ Non-binary ☐ Prefer not to say ☐ Other (please give details_____)
1.10.1.D	What age are they?	
1.10.1.E	Current employment status *(Tick all which apply)*	☐ Working full time ☐ Working part time ☐ In education ☐ Work Placement Experience Programme ☐ Working in the home ☐ Ill/unable to work ☐ Unemployed ☐ Retired ☐ Unpaid voluntary work

(For multiple-choice questions, please tick one only in each line unless otherwise specified)

1.10.2.A	Person #	
1.10.2.B	Relationship with primary carer	☐ Spouse/Partner ☐ Child ☐ Grandchild ☐ Parent ☐ Not related ☐ Other _____
1.10.2.C	How would they describe their gender?	☐ Male ☐ Female ☐ Transgender ☐ Non-binary ☐ Prefer not to say ☐ Other (please give details_____)
1.10.2.D	What age are they?	
1.10.2.E	Current employment status *(Tick all which apply)*	☐ Working full time ☐ Working part time ☐ In education ☐ Work Placement Experience Programme ☐ Working in the home ☐ Ill/unable to work ☐ Unemployed ☐ Retired ☐ Unpaid voluntary work

(For multiple-choice questions, please tick one only in each line unless otherwise specified)

1.10.3.A	Person #	
1.10.3.B	Relationship with primary carer	☐ Spouse/Partner ☐ Child ☐ Grandchild ☐ Parent ☐ Not related ☐ Other _____
1.10.3.C	How would they describe their gender?	☐ Male ☐ Female ☐ Transgender ☐ Non-binary ☐ Prefer not to say ☐ Other (please give details_____)
1.10.3.D	What age are they?	
1.10.3.E	Current employment status *(Tick all which apply)*	☐ Working full time ☐ Working part time ☐ In education ☐ Work Placement Experience Programme ☐ Working in the home ☐ Ill/unable to work ☐ Unemployed ☐ Retired ☐ Unpaid voluntary work

(For multiple-choice questions, please tick one only in each line unless otherwise specified)

1.10.4.A	Person #	
1.10.4.B	Relationship with primary carer	☐ Spouse/Partner ☐ Child ☐ Grandchild ☐ Parent ☐ Not related ☐ Other _____
1.10.4.C	How would they describe their gender?	☐ Male ☐ Female ☐ Transgender ☐ Non-binary ☐ Prefer not to say ☐ Other (please give details_____)
1.10.4.D	What age are they?	
1.10.4.E	Current employment status *(Tick all which apply)*	☐ Working full time ☐ Working part time ☐ In education ☐ Work Placement Experience Programme ☐ Working in the home ☐ Ill/unable to work ☐ Unemployed ☐ Retired ☐ Unpaid voluntary work

Part 2: Home Resources and Daily Life

Section 2: Daily living

For the primary carer: Complete the following table.

Home resources and quality of life

(For multiple-choice questions, please tick one only in each line unless otherwise specified)

2.1	Do you own a car?	☐ Yes ☐ No
2.2	I can use applications/ programmes (like Zoom) on my mobile phone, computer, or another electronic device on my own (without asking for help from someone else).	☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree
2.3	I can set up a video chat using my mobile phone, computer, or another electronic device on my own (without asking for help from someone else).	☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree
2.4	I can solve or figure out how to solve basic technical issues on my own (without asking for help from someone else).	☐ Strongly Disagree ☐ Disagree ☐ Neutral ☐ Agree ☐ Strongly Agree
2.5	Do you have easy access to a supermarket or shop selling fresh fruit, vegetables, and meat?	☐ Yes ☐ No
2.6	How would you rate the air quality where you live?	☐ Very good ☐ Good ☐ Fair ☐ Poor ☐ Very poor

2.7	Do you worry about debt?	☐ All of the time ☐ Sometimes ☐ Rarely, such as only for certain occasions ☐ Almost never
2.8	For other people in your area, how many do you think worry a lot about debt	☐ Everyone ☐ Most people ☐ Some people ☐ Very few people or none
2.9	If there are people in your area with debt problems, where do they go for advice. *(Tick all which apply) (Please describe any other services under 'Other)*	☐ Citizens Information ☐ MABS the Monetary Advice and Budgeting Service ☐ Insolvency Service Ireland (IS) ☐ Family or friends ☐ Other (please specify)
2.10	How often do you feel cold in your own home because you are trying to save on energy bills?	☐ All the time ☐ At different times during the day ☐ Occasionally during the week ☐ Rarely, only if it's very cold outside ☐ Almost never
2.11	Did you ever put off seeking healthcare because you could not afford it?	☐ Yes ☐ No

Physical Activity

2.12	Consider a seven-day period (1 week). How many times on average do you do the following kinds of exercise for more than 30 minutes during your free time per day (not work related) (please note – these activities can be broken up in bouts of 10 minutes)?	
2.12.1	Strenuous exercise (heart beats rapidly) e.g., running, jogging, hurling, camogie, football, vigorous swimming, vigorous long-distance cycling, advanced aerobics	Times____
2.12.2	Moderate exercise (not exhausting) e.g., fast walking, tennis, badminton, easy swimming, easy cycling, intermediate aerobics, heavy gardening	Times____
2.12.3	Mild exercise (minimal effort) e.g., yoga, golf, easy walking, bowling, beginner's aerobics, light gardening.	Times____
2.12.4	How many days, if any, in an average week do you walk for 30 minutes or more?	Times____

Part 3: Health Needs

Section 3: Health status

Use laminate provided

(For multiple-choice questions, please tick one only in each line unless otherwise specified)

3.1	How would you rate your health in general?	☐ Very bad ☐ Bad ☐ Fair ☐ Good ☐ Very good
3.2	What health cover do you currently have? *(Tick all which apply)*	☐ Medical card/GMS card ☐ Doctor visit card ☐ Private medical insurance ☐ Neither medical card nor private insurance
3.3	How many people in this household are on a waiting list for an assessment or diagnosis?	

Dental health

Complete the following table.

(Tick one only in each line unless otherwise specified)

3.4	How would you rate your dental/oral health?	☐ Very bad ☐ Bad ☐ Fair ☐ Good ☐ Very good
3.5	If you went to the dentist tomorrow, do you think you would need any treatment?	☐ Yes ☐ No ☐ Don't know

3.6	In the last 4 months, has anyone in your household (including you) experienced any pain or aching in your mouth because of problems with teeth, mouth, or dentures?	☐ Never ☐ Hardly ever ☐ Occasionally ☐ Often ☐ Very often
3.7	Regarding your dental care services, which of the following best describes your access and preference in the last two years? (Choose one only)	☐ I primarily accessed public dental care services. ☐ I primarily accessed private dental care services. ☐ I accessed both public and private dental care services equally. ☐ I did not access any dental care services. ☐ I wanted to access dental care services but faced barriers due to costs. ☐ I wanted to access dental care services but faced barriers due to a dentist being unavailable
3.8	In the last two years how many times did you visit the dentist?	Number of times _____
3.9	Have you needed to go to a GP with a dental issue due to difficulty accessing a dentist	☐ Yes ☐ No ☐ Don't know

Stress and loneliness

Complete the following table.

(For multiple-choice questions, please tick one only in each line unless otherwise specified)

3.10	Have you experienced stress within the past 12 months? (If no, skip to question 3.14)	☐ Yes ☐ No
3.11	Thinking about the stress you have experienced, what was the reason for this stress?	
3.12	How would you rate the seriousness of this stress?	☐ 1 (not serious) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (serious)
3.13	Which of the following have you experienced as a result of stress in the last 12 months? (Tick all which apply)	☐ Anxiety ☐ Depression ☐ Eating too much ☐ Eating too little ☐ Annoyed ☐ Illness ☐ Aggressive ☐ Sleeplessness ☐ Taking more alcohol/drugs ☐ Smoking more ☐ None ☐ Other _____
3.14	Which of the following actions have you taken as a result of stress that you have experienced in the last 12 months? (Tick all which apply)	☐ Visited counsellor/psychiatrist/ psychologist ☐ Taken prescription medication ☐ Visited church ☐ Visited GP ☐ Talked to friends/relatives ☐ Online resources ☐ Peer support groups ☐ None ☐ Other _____

3.15 How often do you feel lonely?	☐ Hardly ever or never ☐ Some of the time ☐ Often

Disability/chronic illness

Use laminate provided

3.16 How many people in this household have a *chronic illness?	_____
3.17 How many people in this household are in receipt of disability allowance?	_____
3.18 How many people in this household have both a chronic illness and a disability? (If no one has either a disability or chronic illness, skip to question 3.20)	_____

Complete the following table for each person in the household who has a chronic illness. If none, skip to 3.20.1.A

*A chronic illness is an illness that has been present for some time or recurs frequently requiring medical treatment, see laminate for examples.

Tick one only in each line unless otherwise specified.

3.19.1.A Person # with a chronic illness	_____
3.19.1B What chronic illness(es) does this person have?	
3.19.1.C Does X receive healthcare at home? (If no, skip to question 3.18.1.E)	☐ Yes ☐ No
3.19.1.D What kind of home healthcare does X receive? (Choose all that apply)	☐ Public health service ☐ Private professional services ☐ Informal care (e.g., family members providing care). ☐ NA

3.191.E Degree of care required	☐ No assistance ☐ Medication only ☐ Housekeeping including medication ☐ Housekeeping, medication and help to sit out in a chair ☐ Total nursing care as confined to bed
3.19.1.F In the last three months, how many times was X visited by a public health nurse in relation to their chronic illness?	Number of times_____ ☐ NA
3.19.1.G In the last three months, how many times did X visit the GP in relation to their chronic illness? If NA, skip to 3.19.I	Number of times_____ ☐ NA
3.19.1.H What was the reason for this/ these GP visit (s)? Please select all that apply	☐ Repeat prescription ☐ Medical check up ☐ Sudden illness ☐ Advice ☐ Other _____
3.19.1.I In the last three months, did X visit the GP Practice Nurse in relation to their chronic illness?	Number of times_____ ☐ NA
3.19.1.J What was the reason for this/these GP Practice Nurse visit (s)? Please select all that apply	☐ Repeat prescription ☐ Medical check up ☐ Sudden illness ☐ Advice ☐ Other
3.19.1.K In the last three months, how many times did X use other community health services in relation to their chronic illness? Please record number of visits to each health service, if any:	☐ Community pharmacist ☐ Physiotherapist ☐ Occupational therapist ☐ Speech and language therapist ☐ Dietitian ☐ Podiatrist ☐ Psychologist or counsellor ☐ Other _____

3.19.1.L In the last three months, did X attend Tallaght University Hospital in relation to their chronic illness?	☐ Yes ☐ No
3.19.1.M Is this person on a waiting list for services?	☐ Yes ☐ No
3.19.1.N Does person attend a "chronic disease hub" or "chronic disease treatment programme"?	☐ Yes ☐ No

Complete the following table for each person in the household who are in receipt of disability allowance.

If none, skip to 3.21.

Tick one only in each line unless otherwise specified.

3.20.1.A Person # with a disability	_____
3.20.1B What type of disability does this person have?	
3.20.1.C Does X receive healthcare at home? (If no, skip to question 3.20.1.F)	☐ Yes ☐ No
3.20.1.D What kind of home healthcare does X receive? (Choose all that apply)	☐ Public health service ☐ Private professional services ☐ Informal care (e.g., family members providing care). ☐ NA
3.20.1.E Degree of care required	☐ No assistance ☐ Medication only ☐ Housekeeping including medication v Housekeeping, medication and help to sit out in a chair ☐ Total nursing care as confined to bed

3.20.1.F In the last three months, how many times was X visited by a public health nurse in relation to their disability?	Number of times_____ ☐ NA
3.19.1.G In the last three months how many times did X visit the GP in relation to their disability? If NA, skip to 3.20.1.K	Number of times_____ ☐ NA
3.20.1.H What was the reason for this/ these GP visit (s)? Please select all that apply	☐ Repeat prescription ☐ Medical check up ☐ Sudden illness ☐ Advice ☐ Other _____
3.20.1.I In the last three months did X visit the GP Practice Nurse in relation to their disability?	Number of times_____ ☐ NA
3.20.1.J What was the reason for this/these GP Practice Nurse visit (s)? Please select all that apply	☐ Repeat prescription ☐ Medical check up ☐ Sudden illness ☐ Advice ☐ Other
3.20.1.K In the last three months, how many times did X use other community health services in relation to their disability? Please record number of visits to each health service, if any: If NA, skip to 3.20.1.M	☐ Community pharmacist ☐ Physiotherapist ☐ Occupational therapist ☐ Speech and language therapist ☐ Dietitian ☐ Podiatrist ☐ Psychologist or counsellor ☐ Other _____ ☐ NA
3.20.1.L In the last three months, did X attend Tallaght University Hospital in relation to their disability?	☐ Yes ☐ No
3.20.1.M Is this person on a waiting list for services?	☐ Yes ☐ No

Substance Use

3.21 How many people in your household vape?	_____
3.22.1 How many people in your household smoke? If the primary carer smokes, then please ask the following table items, otherwise skip to question 3.22.	_____
3.22.2 During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking? If the respondent selects 'Yes', proceed to next question. Otherwise, skip next question.	☐ Yes ☐ No ☐ Don't Know ☐ Refused
3.22.3 During your last attempt to give up, did you use any help, such as products, medication, or quit support services?	☐ No help used, attempted to quit "cold-turkey" ☐ Nicotine patches, gum, lozenges, spray ☐ Varenicline/Champix or Bupropion/Zyban (prescribed medication) ☐ Acupuncture ☐ Smoker's telephone Quitline/ Helpline ☐ www.quit.ie ☐ www.facebook.com/HSEquit ☐ E-cigarettes ☐ Other aid, help, support (please specify) ☐ Don't Know ☐ Refused
3.23 Which of the following substances do people in your household use?	☐ Alcohol ☐ Pain medication (e.g., soluble Solpadine or Maxilief) ☐ Sedatives not prescribed by a doctor (e.g., Valium, Xanax) ☐ Cocaine/crack cocaine ☐ Ecstasy

	☐ Ketamine ☐ Heroin ☐ Oxycodone ☐ Illegal/street methadone ☐ Cannabis ☐ Weed ☐ Nitrous oxide ☐ Other _____ ☐ None

Relationships with teenagers

Many parents have difficulties coping with children during their teenage years, we would like to ask your current experience of the teenage children in this household. For each teenager between the age of 13 and 19 years of age complete the following table.

If no teenagers in the household, skip to 4.1.1.
(Tick one only in each line unless otherwise specified)

3.24.1.A Teenager #	
3.24.1.B Do you worry about X when they socialise? (If no, skip to 3.24.1.D)	☐ Yes ☐ No
3.24.1.C Why do you worry about X when they socialise?	
3.24.1.D Are you happy with X friends? their friends	☐ Yes ☐ No ☐ Don't know
3.24.1.E Have you found X attitude or behaviour problematic in the last 12 months? (If no, skip to 3.24.1.H)	☐ Yes ☐ No
3.24.1.F What action or behaviour have you found most problematic in the last 12 months?	☐ Challenging behaviour ☐ Takes/sells drugs or alcohol ☐ Dieting ☐ Refuses to go to school/study ☐ Mood swings ☐ Time spent online ☐ Social isolation ☐ Other _____ ☐ None

3.24.1.G Where have you gone for help for yourself about your teenager's behaviour in the last 12 months? (Tick all which apply)	☐ Family ☐ Teacher ☐ GP ☐ Social/youth worker ☐ Friend ☐ Church ☐ Counsellor ☐ Garda ☐ Online resources ☐ Other_____ ☐ None
3.24.1.H Does X have a psychological or emotional condition? (If no or don't know, skip to 4.1.1)	☐ Yes ☐ No ☐ Don't know
3.24.1.I If yes, since when has X had this condition? Please write as MM/YYYY	Date: _____
3.24.1.J Is X hampered in his/her daily activities by this condition or difficulty?	☐ Yes, severely ☐ Yes to some extent ☐ No
3.24.1.K Has this condition been diagnosed by a professional?	☐ Yes ☐ No

Section 4: Tallaght University Hospital

4.1.1 How many people in your household (including you) have had tests or treatment in Tallaght University Hospital (excluding the Emergency Department within the last 12 months?	___

Complete the following questions for you (or anyone else in the household) who attended for tests or received treatment in Tallaght University Hospital (excluding the Emergency Department) within the last 12 months.

Otherwise skip to question 4.2.
(If more than one visit please describe the most recent visit. For multiple-choice questions, tick one only in each line, unless otherwise specified)

4.1.2	Reason for attending Tallaght University Hospital	
4.1.3	Source of referral	☐ Self-Referral ☐ GP ☐ Hospital Doctor
4.1.4	How would you rate your satisfaction with Tallaght University Hospital? (If rated 1-3 please answer 4.1.4 and skip 4.1.5) (If rated 4-6 please skip 4.1.4 and answer 4.1.5)	☐ 1 (Dissatisfied) ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 (Satisfied)
4.1.5	If you rated Tallaght University Hospital 1-3 what were your main reasons for dissatisfaction? (Tick all which apply)	☐ Lack of friendliness/respect/ compassion provided by staff ☐ Poor quality of care ☐ Hospital environment ☐ Long waiting times ☐ Poor communication from staff ☐ Hospital cleanliness ☐ Speed of care too slow ☐ Hospital safety ☐ Speed of care too quick ☐ Other _____
4.1.6	If you rated Tallaght University Hospital 4-6 what were your main reasons for satisfaction? (Tick all which apply)	☐ Friendliness/respect/ compassion provided by staff ☐ Quality of care ☐ Hospital environment ☐ Short waiting times ☐ Good communication from staff ☐ Hospital cleanliness ☐ Speed of care ☐ Hospital safety ☐ Other _____
4.1.7	Would you recommend Tallaght University Hospital to a friend/ family member?	☐ Yes ☐ No ☐ Don't know
4.2	Do you think that Tallaght University Hospital is beneficial to the surrounding community? If no, skip to question 4.4.	☐ Yes ☐ No ☐ Don't know

4.3	If yes, why do you think that Tallaght University Hospital is beneficial to the surrounding community?	_____
4.4	Did you have any unmet healthcare needs in the last 12 months because of Tallaght University Hospital waiting lists?	☐ Yes ☐ No
4.5	Please comment on how you think Tallaght University Hospital could improve the service it provides?	_____
4.6	Would you like to be more involved in the decisions Tallaght University Hospital makes in changing and improving its services?	☐ Yes ☐ Yes, but unsure what difference it would make ☐ No ☐ Don't know

Tallaght University Hospital Emergency Department

4.7.1	Has anyone in your household (including you) used Tallaght Emergency Department over the past 12 months? If no or don't know, skip to Section 5 ☐ Yes	☐ No ☐ Don't know

Thinking of the most recent visit to Tallaght Emergency Department by anyone in your household (including you) in the past 12 months complete the following.
(For multiple-choice questions, tick one only in each line unless otherwise specified)

4.7.2	How were you/they referred?	☐ GP referral ☐ Came in by ambulance ☐ Self-referral ☐ Other _____
4.7.3	If self-referral, why did you/they not go to see another healthcare professional, such as your GP, beforehand?	☐ GP was not available ☐ GP too expensive ☐ GP didn't have access to same tests e.g., x-ray ☐ Not registered with a GP ☐ Other_____

4.7.4 How long were you/they sick before attending Tallaght Emergency Department?	☐ <24 hours ☐ 1-2 days ☐ 3-7 days ☐ 1-2 weeks ☐ 2-4 weeks ☐ 1-2 months ☐ >2 months
4.7.5 What was your/their reason for attendance? (Please state)	
4.7.6 Would you recommend the Tallaght Emergency Department to a friend/ family member?	☐ Yes ☐ No ☐ Don't know
4.7.7 How would you rate Tallaght Emergency Department?	☐ 1 Dissatisfied ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 Satisfied
4.7.8 If you rated Tallaght Emergency Department 1-3, what were your main reasons for dissatisfaction? (Tick all which apply)	☐ Lack of friendliness/respect/ compassion provided by staff ☐ Poor quality of care ☐ Hospital environment ☐ Long waiting times ☐ Poor communication from staff ☐ Hospital cleanliness ☐ Speed of care too slow ☐ Hospital safety ☐ Speed of care too quick ☐ Other _____
4.7.9 If you rated Tallaght Emergency Department 4-6, what were your main reasons for satisfaction? (Tick all which apply)	☐ Friendliness/respect/ compassion provided by staff ☐ Quality of care ☐ Hospital environment ☐ Short waiting times ☐ Good communication from staff ☐ Hospital cleanliness ☐ Speed of care ☐ Hospital safety ☐ Other _____

4.7.10	Would you recommend Tallaght University Hospital Emergency Department to a friend/family member?	☐ Yes ☐ No ☐ Don't know

Section 5: General Practice and Healthcare Services

General Practice Services

(For multiple-choice questions, tick one only in each line unless otherwise specified)

5.1.1	Are you registered with a GP? (If yes, skip to question 5.2)	☐ Yes ☐ No ☐ Don't know
5.1.2	If no, why are you not registered with a GP	_____
5.1.3	If no, how do you access healthcare?	_____
5.2	Is your GP within walking distance of your house?	☐ Yes ☐ No ☐ Don't know ☐ Not registered with a GP
5.3	Would you recommend your GP to a friend/family member?	☐ Yes ☐ No ☐ Don't know ☐ Not registered with a GP
5.4	How would you rate your satisfaction with your GP?	☐ 1 Dissatisfied ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 Satisfied
5.5	When anyone in your household (including you) need 'out-of-hours' doctor services what do you do? (Tick all which apply)	☐ TLC Doc ☐ Go to the Emergency Department ☐ House call ☐ Depends on situation ☐ N/A ☐ Other _____

5.6	Are you satisfied with current 'out-of-hours' doctor service options?	☐ Yes ☐ No ☐ Don't know
5.7	If you need to see your GP, how long does it take for you to get an appointment?	____ (day/s)

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Social Prescribing Services

Social prescribing offers GPs and other health professionals a means of signposting people to a range of non-clinical community supports which can have significant benefits for their overall health and wellbeing. For example, dance classes, walking groups, arts and crafts workshops, supportive peer networks, cooking classes, caregiver supports, volunteering roles, gardening/allotments etc.

(For multiple-choice questions, tick one only in each line unless otherwise specified)

5.8	Have you heard of 'social prescribing services' before completing this survey? (If no, skip to question 5.10)	☐ Yes ☐ No
5.9	How did you hear about social prescribing services?	☐ Through my GP surgery ☐ From a friend/colleague ☐ From a voluntary organisation ☐ Via social media ☐ Web search ☐ Via a leaflet ☐ Other (please specify) _____
5.10	If you as Primary Carer (or for those you are for) have availed of social prescribing, did you find it helpful?	☐ Yes ☐ No
5.11	Did it link you with a local service/ activity?	☐ Yes ☐ No
5.12	Overall, how satisfied are you as Primary Carer (or for those you care for) with your experience of using social prescribing services?	☐ Very dissatisfied ☐ Dissatisfied ☐ Neutral ☐ Satisfied ☐ Very satisfied

5.13 What might stop you using a social prescribing service/activity?	☐ Feeling that I would be judged if I used this service/ joined in this activity ☐ Availability of appointments (long waiting times/time of appointments) ☐ Long travelling distances (if appointments aren't in my local area) ☐ Lack of appropriate transport to the service/activity area ☐ Difficulty making an appointment ☐ Not being able to refer myself/ having to refer through GP ☐ Other (please specify) _____

General Healthcare Services

5.14 What healthcare services are needed in the Tallaght community?	_____ _____ _____ _____

Part 4: Health Assets

Section 6: Personal and Community Characteristics

6.1 What are the top three good things about living in Tallaght?	1. _____ _____ 2. _____ _____ 3. _____ _____
6.2 What are the top three bad things about living in Tallaght?	1. _____ _____ 2. _____ _____ 3. _____ _____

6.3 Generally speaking, would you say that most people can be trusted, or that you can't be too careful in dealing with people?	
Please tell me on a scale of 1 to 10, where 1 means that you can't be too careful and 10 means that most people can be trusted. (Tick one only)	☐ 1 You can't be too careful ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Most people can be trusted
6.4 How safe do you feel in your area/ neighbourhood on a scale of 1-5, where 1 is very unsafe and 5 is very safe?	☐ 1 Very unsafe ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very safe
During the day? After dark?	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
6.5 Do you do any community volunteering in your neighbourhood? (If no, skip to question 6.6.1)	☐ Yes ☐ No
6.5.1 If yes, please specify the primary area of your volunteering (such as tidy town, church, school, arts/music, youth service, older aged, disability, sports club, etc)	_____
6.6.1 South Dublin County Council, as part of the Ireland's climate change strategy, is looking to increase the number of people who walk and cycle in Tallaght (not just pupils going to school). What do you think needs to be put into place to make this happen?	_____
6.6.2 Where do you think this needs to happen?	_____

6.7.1	Would you like to see more Active Travel Infrastructure (e.g., walking paths and cycling lanes) put in within Tallaght? (If no, skip to question 6.8)	☐ Yes ☐ No
6.7.2	If yes, where would you like to see them put?	_____
6.8	Does concern about anti-social behaviour impact your decision to walk or cycle in certain areas of Tallaght?	☐ Yes ☐ No
6.9.1	Do you think that South Dublin County Council is good at providing healthy recreation opportunities for the community in Tallaght? (If yes, skip to question 7.1.1)	☐ Yes ☐ No
6.9.2	If no, why not?	_____

Section 7: Community Facilities Inventory

Use laminates provided

7.1.1	Did anyone in your household (including you) use parks in the last 12 months? (If no or don't know, skip to question 7.2)	☐ Yes ☐ No
7.1.2	If "Yes", where did you use the parks? (If in Tallaght only, answer following questions and skip question 7.1.6) (If outside of Tallaght only, skip to question 7.1.6)	☐ In Tallaght ☐ Outside of Tallaght ☐ Both
7.1.3	How often did your household use parks in Tallaght in the last 12 months?	☐ Daily ☐ Weekly ☐ Monthly ☐ Bimonthly ☐ Once or twice

7.1.4 Are parks in Tallaght an asset to the community? (If no, answer question 7.1.5)	☐ Yes ☐ No ☐ Don't know
7.1.5 If no, please indicate why not?	_____
7.1.6 Why did your household use parks outside of Tallaght?	_____
7.2.1 Did anyone in your household (including you) use playgrounds in the last 12 months? (If no or don't know, skip to question 7.3)	☐ Yes ☐ No ☐ Don't know
7.2.2 If "Yes", where did you use the playgrounds? (If in Tallaght only, answer following questions and skip question 7.2.6) (If outside of Tallaght only, skip to question 7.2.6)	☐ In Tallaght ☐ Outside of Tallaght ☐ Both
7.2.3 How often did your household use playgrounds in Tallaght in the last 12 months?	☐ Daily ☐ Weekly ☐ Monthly ☐ Bimonthly ☐ Once or twice
7.2.4 Are playgrounds in Tallaght an asset to the community? (If no, answer question 7.2.5)	☐ Yes ☐ No ☐ Don't know
7.2.5 If no, please indicate why not?	_____
7.2.6 Why did your household use playgrounds outside of Tallaght?	_____
7.3.1 Did anyone in your household (including you) use community centres in the last 12 months? (If no or don't know, skip to question 7.4)	☐ Yes ☐ No ☐ Don't know

7.3.2	If “Yes”, where did you use the community centres? (If in Tallaght only, answer following questions and skip question 7.3.6) (If outside of Tallaght only, skip to question 7.3.6)	☐ In Tallaght ☐ Both ☐ Outside of Tallaght
7.3.3	How often did your household use community centres in Tallaght in the last 12 months?	☐ Daily ☐ Weekly ☐ Monthly ☐ Bimonthly ☐ Once or twice
7.3.4	Are community centres in Tallaght an asset to the community? (If no, answer question 7.3.5)	☐ Yes ☐ No ☐ Don’t know
7.3.5	If no, please indicate why not?	_____
7.3.6	Why did your household use community centres outside of Tallaght?	
7.4.1	Did anyone in your household (including you) use community services in the last 12 months? (If no or don’t know, skip to question 7.5)	☐ Yes ☐ No ☐ Don’t know
7.4.2	If “Yes”, where did you use the community services? (If in Tallaght only, answer following questions and skip question 7.4.6) (If outside of Tallaght only, skip to question 7.4.6)	☐ In Tallaght ☐ Both ☐ Outside of Tallaght
7.4.3	How often did your household use community services in Tallaght in the last 12 months?	☐ Daily ☐ Weekl ☐ Monthly ☐ Bimonthly ☐ Once or twice
7.4.4	Are community services in Tallaght an asset to the community? (If no, answer question 7.4.5)	☐ Yes ☐ No ☐ Don’t know

7.4.5	If no, please indicate why not?	_____
7.4.6	Why did your household use community services outside of Tallaght?	_____
7.5.1	Did anyone in your household (including you) use churches/places of worship in the last 12 months? (If no or don't know, skip to question 7.6)	☐ Yes ☐ No ☐ Don't know
7.5.2	If "Yes", where did you use the churches/ places of worship? (If in Tallaght only, answer following questions and skip question 7.5.6) (If outside of Tallaght only, skip to question 7.5.6)	☐ In Tallaght ☐ Outside of Tallaght ☐ Both
7.5.3	How often did your household use churches/places of worship in Tallaght in the last 12 months?	☐ Daily ☐ Weekly ☐ Monthly ☐ Bimonthly ☐ Once or twice
7.5.4	Are churches/places of worship in Tallaght an asset to the community? (If no, answer question 7.5.5)	☐ Yes ☐ No ☐ Don't know
7.5.5	If no, please indicate why not?	_____
7.5.6	Why did your household use churches/ places of worship outside of Tallaght?	_____
7.6.1	Did anyone in your household (including you) use youth services in the last 12 months? (If no or don't know, skip to question 7.7)	☐ Yes ☐ No ☐ Don't know
7.6.2	If "Yes", where did you use the youth services? (If in Tallaght only, answer following questions and skip question 7.6.6) (If outside of Tallaght only, skip to question 7.6.6)	☐ In Tallaght ☐ Outside of Tallaght ☐ Both

7.6.3	How often did your household use youth services in Tallaght in the last 12 months?	☐ Daily ☐ Weekly ☐ Monthly ☐ Bimonthly ☐ Once or twice
7.6.4	Are youth services in Tallaght an asset to the community? (If no, answer question 7.6.5)	☐ Yes ☐ No ☐ Don't know
7.6.5	If no, please indicate why not?	_____
7.6.6	Why did your household use youth services outside of Tallaght?	_____
7.7.1	Did anyone in your household (including you) use senior citizen services in the last 12 months? (If no or don't know, skip to question 7.8)	☐ Yes ☐ No ☐ Don't know
7.7.2	If "Yes", where did you use the senior citizen services? (If in Tallaght only, answer following questions and skip question 7.7.6) (If outside of Tallaght only, skip to question 7.7.6)	☐ In Tallaght ☐ Outside of Tallaght ☐ Both
7.7.3	How often did your household use senior citizen services in Tallaght in the last 12 months?	☐ Daily ☐ Weekly ☐ Monthly ☐ Bimonthly ☐ Once or twice
7.7.4	Are senior citizen services in Tallaght an asset to the community? (If no, answer question 7.7.5)	☐ Yes ☐ No ☐ Don't know
7.7.5	If no, please indicate why not?	_____
7.7.6	Why did your household use senior citizen services outside of Tallaght?	_____

7.8.1 Did anyone in your household (including you) use transport services in the last 12 months? (If no or don't know, skip to question 7.9)	☐ Yes ☐ No ☐ Don't know
7.8.2 If "Yes", where did you use the transport services? (If in Tallaght only, answer following questions and skip question 7.8.6) (If outside of Tallaght only, skip to question 7.8.6)	☐ In Tallaght ☐ Outside of Tallaght ☐ Both
7.8.3 How often did your household use transport services in Tallaght in the last 12 months?	☐ Daily ☐ Weekly ☐ Monthly ☐ Bimonthly ☐ Once or twice
7.8.4 Are transport services in Tallaght an asset to the community? (If no, answer question 7.8.5)	☐ Yes ☐ No ☐ Don't know
7.8.5 If no, please indicate why not?	_____
7.8.6 Why did your household use transport services outside of Tallaght?	_____
7.9.1 Did anyone in your household (including you) use support groups in the last 12 months? (If no or don't know, skip to question 7.10)	☐ Yes ☐ No ☐ Don't know
7.9.2 If "Yes", where did you use the support groups? (If in Tallaght only, answer following questions and skip question 7.9.6) (If outside of Tallaght only, skip to question 7.9.6)	☐ In Tallaght ☐ Both ☐ Outside of Tallaght
7.9.3 How often did your household use support groups in Tallaght in the last 12 months?	☐ Daily ☐ Weekly ☐ Monthly ☐ Bimonthly ☐ Once or twice

7.9.4 Are support groups in Tallaght an asset to the community? (If no, answer question 7.9.5)	☐ Yes ☐ No ☐ Don't know
7.9.5 If no, please indicate why not?	_____
7.9.6 Why did your household use support groups outside of Tallaght?	_____
7.10.1 Did anyone in your household (including you) use disability services in the last 12 months? (If no or don't know, skip to question 7.11)	☐ Yes ☐ No ☐ Don't know
7.10.2 If "Yes", where did you use the disability services? (If in Tallaght only, answer following questions and skip question 7.10.6) (If outside of Tallaght only, skip to question 7.10.6)	☐ In Tallaght ☐ Outside of Tallaght ☐ Both
7.10.3 How often did your household use disability services in Tallaght in the last 12 months?	☐ Daily ☐ Weekly ☐ Monthly ☐ Bimonthly ☐ Once or twice
7.10.4 Are disability services in Tallaght an asset to the community? (If no, answer question 7.10.5)	☐ Yes ☐ No ☐ Don't know
7.10.5 If no, please indicate why not?	_____
7.10.6 Why did your household use disability services outside of Tallaght?	_____
7.11.1 Did anyone in your household (including you) use libraries in the last 12 months? (If no or don't know, skip to question 7.12)	☐ Yes ☐ No ☐ Don't know
7.11.2 If "Yes", where did you use the libraries?	☐ In Tallaght ☐ Outside of Tallaght ☐ Both

7.11.3	How often did your household use libraries in Tallaght in the last 12 months? (If in Tallaght only, answer following questions and skip question 7.11.6) (If outside of Tallaght only, skip to question 7.11.6)	☐ Daily ☐ Weekly ☐ Monthly ☐ Bimonthly ☐ Once or twice
7.11.4	Are libraries in Tallaght an asset to the community? (If no, answer question 7.11.5)	☐ Yes ☐ No ☐ Don't know
7.11.5	If no, please indicate why not?	_____
7.11.6	Why did your household use libraries outside of Tallaght?	_____
7.12.1	Did anyone in your household (including you) use services for children under the age of 5 years in the last 12 months? (If no or don't know, skip to question 7.12)	☐ Yes ☐ No ☐ Don't know
7.12.2	If "Yes", where did you use the use these services for children under the age of 5 years? (If in Tallaght only, answer following questions and skip question 7.11.6) (If outside of Tallaght only, skip to question 7.11.6)	☐ In Tallaght ☐ Outside of Tallaght ☐ Both
7.12.3	How often did your household use these services for children under the age of 5 years in Tallaght in the last 12 months?	☐ Daily ☐ Weekly ☐ Monthly ☐ Bimonthly ☐ Once or twice
7.12.4	Are services for children under the age of 5 years in Tallaght an asset to the community? (If no, answer question 7.11.5)	☐ Yes ☐ No ☐ Don't know
7.12.5	If no, please indicate why not?	_____

7.12.6	Why did your household use services for children under the age of 5 years outside of Tallaght?	_____
7.13.1	Did anyone in your household (including you) use other services in the last 12 months? (If no or don't know, skip to section 8.1.1)	☐ Yes ☐ No ☐ Don't know
7.13.2	If "Yes", where did you use the other services? (If in Tallaght only, answer following questions and skip question 7.13.6) (If outside of Tallaght only, skip to question 7.13.6)	☐ In Tallaght ☐ Outside of Tallaght ☐ Both
7.13.3	How often did your household use other services in Tallaght in the last 12 months?	☐ Daily ☐ Weekly ☐ Monthly ☐ Bimonthly ☐ Once or twice
7.13.4	Are other services in Tallaght an asset to the community? (If no, answer question 7.12.5)	☐ Yes ☐ No ☐ Don't know
7.13.5	If no, please indicate why not?	_____
7.13.6	Why did your household use other services outside of Tallaght?	_____

Section 8: Sport and Hobby Facility Inventory

Use laminates provided

8.1.1	Did anyone in your household (including you) use hobby facilities in the last 12 months? (If no or don't know, skip to question 8.2)	☐ Yes ☐ No ☐ Don't know

8.1.2	If “Yes”, where did you use the hobby facilities? (If in Tallaght only, answer following questions and skip question 8.1.6) (If outside of Tallaght only, skip to question 8.1.6)	☐ In Tallaght ☐ Outside of Tallaght ☐ Both
8.1.3	How often did your household use hobby facilities in Tallaght in the last 12 months?	☐ Daily ☐ Weekly ☐ Monthly ☐ Bimonthly ☐ Once or twice
8.1.4	Are hobby facilities in Tallaght an asset to the community? (If no, answer question 8.1.5)	☐ Yes ☐ No ☐ Don’t know
8.1.5	If no, please indicate why not?	_____
8.1.6	Why did your household use hobby facilities outside of Tallaght?	_____
8.2.1	Did anyone in your household (including you) use sports clubs and facilities in the last 12 months? (If no or don’t know, skip to section 9.1)	☐ Yes ☐ No ☐ Don’t know
8.2.2	If “Yes”, where did you use the sports clubs and facilities? (If in Tallaght only, answer following questions and skip question 8.2.6) (If outside of Tallaght only, skip to question 8.2.6)	☐ In Tallaght ☐ Outside of Tallaght ☐ Both
8.2.3	How often did your household use sports clubs and facilities in Tallaght in the last 12 months?	☐ Daily ☐ Weekly ☐ Monthly ☐ Bimonthly ☐ Once or twice
8.2.4	Are sports clubs and facilities in Tallaght an asset to the community? (If no, answer question 8.2.5)	☐ Yes ☐ No ☐ Don’t know

8.2.5	If no, please indicate why not?	_____
8.2.6	Why did your household use sports clubs and facilities outside of Tallaght?	_____

Section 9: Missing Assets

9.1	Is there anything missing from these lists which are an asset to your life in Tallaght?	_____ _____ _____ _____ _____ _____

End of questionnaire
Thank you

Appendix B Impact of HANA Round 2 on Community Development, 2014.

A HANA Implementation Group was established which had all the key members/ stakeholders, and it was the results of this group using the data collected that the changes were made. This included CEO (TUH), Billy Coman (SDCC) and senior members of local HSE Primary Care team.

Specific actions taken associated with the recommendations:

1. **Develop, implement and evaluate interventions to tackle sedentary behaviour and encourage physical activity.**

South Dublin County Council, with funding from Healthy Ireland, is supporting local health initiatives through the Local Sports Partnerships, influenced by insights from the HANA project. Among these initiatives, the ExWell programme, founded by Dr. Noel McCaffrey, has been implemented for a three-year period. ExWell Medical provides supervised exercise classes and home programs tailored for individuals with various chronic conditions. To assess the programme's impact, the Academic Primary Care Centre (APCC) is conducting a research study, with involvement from Trinity College Dublin, local GPs, and Tallaght University Hospital.

2. **Focus on the prevention of chronic diseases such as heart disease, diabetes and respiratory problems, which are the three major chronic diseases, reported in Tallaght.**

The HSE's Enhanced Community Care (ECC) program, with a focus on older adults and chronic conditions like heart disease, diabetes, and respiratory issues, aims to expand community health services and alleviate hospital pressures. Supported by a €240 million investment through the Sláintecare program, ECC has enabled staffing increases across Tallaght University Hospital (TUH) and HSE Dublin South City & West, Dublin South West, Kildare & West Wicklow Integrated Healthcare Areas, HSE Dublin & Midlands (formerly recognised as Community Healthcare Network 7) with over 100 new healthcare professionals. The Integrated Care Programme for Older Persons (ICPOP), launched as a pioneer site in 2016, addresses frailty, falls, and dementia in older adults using case management and in-home assessments. In 2021-2022, a second ICPOP team was established under TUH, with services expanded into Clondalkin.

Additionally, TUH and the HSE Dublin South City & West, Dublin South West, Kildare & West Wicklow Integrated Healthcare Areas, HSE Dublin & Midlands significant Sláintecare funding for cardiology projects that are now part of standard care,

working closely with ECC. Community care expansions include additional inpatient beds at Tymon North Community Unit, a new Acute Frailty Unit, and the refurbished Burkitt ward, which offers enhanced rehabilitation spaces. Innovative programs like GEDI, COPD Outreach, and a Pathfinder initiative aim to reduce Emergency Department visits and support home-based care for older adults. The COPD team has also developed an app for patients to facilitate at-home exercise, reducing hospital visits.

Further community engagement initiatives, such as health talks and partnerships like the Local Integrated Care Committee (LICC), focus on public education and professional collaboration to improve care access and coordination in the Tallaght and Clondalkin regions. Peamount Healthcare has also expanded its rehabilitation and long-term care capacities, adding new beds across multiple specialties to meet growing patient needs.

3. **Develop, implement and evaluate interventions to target the mental and physical effects of chronic stress, which has increased in prevalence and severity over the past 12 years.**

The project's findings were presented to mental health teams in Tallaght, sparking interest from Prof. Brendan Kelly, who expanded the project to address specific local needs. Additionally, Prof. Veronica O'Keane, a Consultant Psychiatrist, used these insights to guide her team in developing a stress management program. The identified health needs also supported the enhancement of the Liaison Psychiatry service at Tallaght University Hospital (TUH), leading to the addition of a new Liaison Psychiatry consultant and two specialist nurses focused on managing self-harm cases.

4. **Focus on decreasing the duration of time that patients have to wait for treatment in Tallaght University Hospital.**

As part of its 2019-2024 strategy, Tallaght University Hospital (TUH) prioritised key developments to improve patient care and reduce wait times. The opening of the Reeves Day Surgery Centre significantly decreased waiting times for day surgeries, and the hospital expanded its endoscopy services. Despite these advancements, challenges remained with access to the Emergency Department, prompting TUH to collaborate with the HSE on a proposal to add 72 beds based on local healthcare needs.

In 2015, TUH expanded its Emergency Department by over 50%, adding more assessment capacity, and further increased capacity in 2022 with the opening of the Acute Frailty Unit and additional Medical and Surgical Assessment Units. TUH also worked with the HSE to establish offsite outpatient services for Neurology and Endocrinology in the SIMMs building.

In 2018, a major investment facilitated the relocation and enhancement of the Cardiac Risk in the Young (CRY) Centre to Tallaght Cross West. This facility, a partnership between CRY Ireland, TUH, and the Department of Health, provided free cardiac screening and support for individuals and families affected by Sudden Cardiac Death and inherited cardiac conditions.

5. **Expand GP services locally by recruiting more GPs, enhance access to GP services by considering longer opening hours of traditional GP practices and further developing the existing TLC 'out-of-hours' service.**

Professor Tom O'Dowd and Dr Darach O'Ciardha utilised the HANA findings to argue the case for an increase in resourcing for TLC (which started in 2001); this included encouraging more local GP practices to participate in the 'out of hours' service and a case to the HSE for additional funding to facilitate the move to Carbury House.

6. **Determine the feasibility and cost effectiveness for the expansion of GP services to include x-rays, blood tests and ultrasound. Consider piloting a programme locally to determine whether this improves access to diagnostics for the community or whether the existing diagnostics within Tallaght University Hospital should be further developed.**

In early 2020 the community radiology facility in Tallaght Cross opened. This provides improved access for x-ray, ultrasound and now provides access for DEXA scans. The facility was developed by the HSE, the radiology dept. at TUH run the service. In early 2024 the facility will be expanded to include CT and MRI.

7. **Increase the availability of mental health services including psychiatric, psychological and community support services.**

The local consultant psychiatrists (as above) utilised the data to inform service design.

8. Increase the availability of addiction services.

Professor Bobby Smyth (Youth Drug and Alcohol Services; YODA) in Tallaght included HANA data as a part of the case to move the service to the Airton Square. It is my understanding that this has subsequently helped to expand the range of services that the team can offer and integrate it more into other community services.

9. Encourage and enable greater community involvement in decision making for developing and improving Tallaght University Hospital.

Patient Community Advisory Council (PCAC) forum is being used to inform and develop links with the community. In addition, the LICC committee focus on developing services in collaboration with GP's, HSE and TUH.

Community Health talks series outlined above provide an opportunity for clinicians to meet patients/ carers and member of the public in the delivery of specific services.

10. Encourage a greater focus on the positive aspects of Tallaght.

There was a collective agreement from all stakeholders that a concerted effort would be made to highlight the positives in Tallaght. I know that SDCC very much embraced this and Billy Coman and Danny McLoughlin (CEO) were undergoing a significant rebranding of the work of the Council, this also coincided with the introduction of Healthy Ireland (which I was a part of too, nationally and locally) and the messaging that came out from the Council (again coinciding with other factors so I do not think that HANA can take all of the credit), but was to discuss the assets and the deficits of the community in a more rounded way.

11. Develop greater awareness of the available facilities and services and promote their use within Tallaght.

Patient Community Advisory Council (PCAC) forum is being used to inform and develop links with the community. In addition, the LinCC committee focus on developing services in collaboration with GP's, HSE and TUH.

With the support of funding from AHF the Hospital has continue this community engagement through a series of podcasts

12. Develop an evidence-based approach to community led initiatives to tackle crime, particularly petty crimes, such as joyriding, theft and burglaries.

Catherine Darker had worked closely with Inspector Jerry Keohane from Tallaght Garda Station when Catherine was designing the safety protocols necessary for the data collectors. He invited Catherine to meet with the JLO (Juvenile Liaison Officers) in advance of the project starting. That meeting went very well and the JLO's present were genuinely keen to know the results of the project when available. A follow-up meeting happened the following year and gave them an overview. Efforts were made to make sure that they were aware of our work and to try to look at some of the data around anti-social behaviour etc.

The Meath Foundation provided some subsequent HANA funding (Brendan Kelly project).

It was led by Brendan Kelly with significant inputs from Catherine Darker and others on the original team (e.g., Joe Barry, Lucy Whiston). Brendan took the methodology from HANA and focused on mental health in the community. I have attached the main report findings from this work and two subsequent papers.

The HANA report has been used to validate and support numerous funding submissions by TUH to the HSE over the past 9 years and is widely used by TUH Staff.

Appendix C Sampling details of 2001 and 2014 study - classification of electoral divisions by level of deprivation.

Study area:
The study area covered thirteen electoral divisions of Tallaght including Belgard, Glenview, Kilnamanagh, Kingswood, Millbrook, Oldbawn, Springfield, Avonbeg, Fettercairn, Jobstown, Killinarden, Kiltipper, and Tymon (North and South).

Deprivation has a role to play in terms of health status[43,44] and service uptake45 and therefore it was necessary to take account of this factor when selecting the sample.

However, there have been changes in the Small Area Health Research Unit (SAHRU) deprivation score.[47] The SAHRU deprivation score has been updated based on 2011 census data and the revised deprivation score ranges from one to ten, where one is *least deprived and ten is most deprived*. In keeping with the original research, a deprivation score of 1-6 and 7-10 would roughly equate to the classification of high/low deprivation on the 1-5 scale, however, it must be noted that using 1-6 and 7-10 as cut-off points for high/low deprivation may cause dilution of contrasts (as indicated by A. Kelly, head of SAHRU).

The research team made the decision to choose 1-6 and 7-10 as cut-off points for low/high deprivation (thus keeping in line with previous research) – classification of EDs based on this decision can be seen in table 2, however, examining these results indicates a substantial deviation in classification from the original research. A total of 2,157 households were listed in the low deprivation EDs and 24,009 were listed in the higher deprivation EDs.

Appendix D HANA household invitation letter.

The Resident
Tallaght
Dublin 24
May 2024

Dear Resident,

Trinity College Dublin Institute of Population Health along with the HSE, Tallaght University Hospital, and the Adelaide Health Foundation are looking at the health and wellbeing of people living in Tallaght. The hospital wants to make sure it is giving good quality services and meeting the health needs of everyone in Tallaght. To do this, we have teamed up with Ipsos B&A, a research company, to talk with people in Tallaght and hear their thoughts.

We would like to talk with the person in your house who takes care of everyone's health. We will ask about how everyone is feeling and what you think about the health and community services here. We are also curious about what other services you think would be helpful in Tallaght.

Sometime soon, someone from Ipsos B&A will come by to talk with you about this survey. They will have an ID card with them, so you will know it's them and we have attached an example. This will take around 30 to 45 minutes. We can do it during the day or in the evening, between 6 pm and 9 pm. If that does not work for you, just let the researcher know and we will find another time.

This is your chance to make sure your thoughts are heard in a report that healthcare and community planners will read. But, of course, it is up to you if you want to join in or not. If you decide not to, that is okay, and we will respect your choice. If you do join in, you will need to sign a form, but you can change your mind anytime.

If you decide to take part, we will keep your information private. We won't share it with anyone outside the research team. Your participation is voluntary, and you can back out whenever you want. Once we anonymize your information, it won't be connected to you anymore.

Thanks for reading this and considering sharing your thoughts with us. If you have questions or don't want to take part, just reach out to Kaye Stapleton, our Project Coordinator, at kstaplet@tcd.ie or via 01-8961087. She'll be happy to help.

Yours sincerely,

_____

Catherine Darker
Associate Professor in Health Services Research
Institute of Population Health
School of Medicine
Trinity College Dublin

Appendix E Participant information leaflet and consent form

Participant Information Leaflet

Health Assets and Needs Assessment of the Tallaght Community

Study Title	**Health Assets and Needs Assessment of the Tallaght Community (HANA)**
Research Site	Tallaght Community
Principal Investigator (PI) and Co-Investigators (Study Team)	Prof Catherine Darker (Project PI), Prof Noel McCarthy, Dr David Loughrey, Kaye Stapleton (project coordinator). Study team are all from the Institute of Population Health, School of Medicine, Trinity College Dublin.
Study Funders	HSE and Adelaide Health Foundation
Data Controller	Trinity College Dublin
Data Protection Officer (Research Data)	Data Protection Officer Secretary's Office Trinity College Dublin Dublin 2

We would like to invite you to take part in a research study that is being carried out by the Institute of Population Health, School of Medicine, Trinity College Dublin. The study involves completing an interview in your home. Before you decide whether or not you wish to take part, please take time to read this information leaflet carefully and discuss it with your family, friends or GP if you wish. If there is anything which is not clear, or if you would like more information, please ask the researchers. Don't feel rushed or under pressure to participate or to make a quick decision. You should understand the risks and benefits of taking part in this study so that you can make a decision that is right for you.

Do I have to take part?

No, you don't have to take part in this study. It is entirely voluntary and up to you. If you decide not to take part, it won't affect your current or future medical care. You can change your mind and opt out at any time even if the study has started.

This leaflet has 5 parts:

Part 1 - The Study
Part 2 - Data Protection
Part 3 - Approval, and Funding
Part 4 - Further Information
Part 5 – Next steps

Part 1 – The Study

Why have I been invited to take part in this study?

You are being invited to take part in this study because you are living in the Tallaght area. We want to understand your health needs and your satisfaction with the health services provided in the Tallaght area. We are hoping that 420 households will take part in the study.

Why is this study being done?

We are doing this study to assess health needs in Tallaght. This will be compared with previous assessments which were carried out in 2001 and 2014.

What does taking part in the study involve?

Taking part in the study involves an interview with a researcher. We will be using a market research company, Ipsos B&A, to complete these interviews. Each researcher will carry an identity card. The researcher will come to your home. They will discuss the study with you and answer any questions that you have. They will ask you to sign a consent form which you will be given a copy of.

They will go through a series of interview questions with you. The interview will take between 45 minutes to one hour. We plan to conduct the interviews during the daytime and also between 6 pm and 9 pm each evening. If this time does not suit you, the researcher will arrange an alternative time to call.

We will ask you about the health of your household members and your satisfaction with the health services provided in the area. We also want to find out what other services you think are needed.

Please note that you do not have to answer any questions that you do not want to. If you become distressed or upset during the interview, you have the right to stop the interview without giving an explanation.

If you require support after the interview, we have also arranged for a Drop-in Counselling Services within Russell Building, Tallaght which can be contacted at 01-7957601. We would also recommend that you contact your GP. You can also contact the PI of the Project, Professor Catherine Darker, to discuss this. Email: catherine.darker@tcd.ie

What are the potential benefits of taking part in this study?
We hope that by taking part, you will have a say in creating better health care services for people in your local community. The main benefit is to help improve community health services for the Tallaght community. For example, since the last HANA survey in 2014, Tallaght University Hospital have new services looking after your memory, heart care, older persons' care, and they have more staff.

Are there any possible disadvantages or risks from taking part?
There are no known risks involved in this study. At all times, the well-being of participants takes priority over research activities.

Great care will be taken to ensure the confidentiality of all data and the risk to participants of a breach of confidentiality is considered very low.

What will happen to the results of the study?
The study results will be used to help plan health service in the Tallaght area. The results of the study will be reported in medical/scientific/educational journals and presented at medical/scientific conferences.

Part 2 – Data Protection

What information about me (personal data) will be used for this study?
We will need the following information about you: your household address to arrange an interview, demographics (age, gender, racial/ethnic background), other background questions (employment status, educational level, debt), health related factors and information relating to your family and your lifestyle and social circumstances.

Ipsos B&A will collect your name and mobile number so that they can complete a quality check with you. However, please note that your name and contact number will not be shared to the TCD research team.

Who will access my personal data?
We will be using a market research company to conduct the interview. The market research company is called Ipsos B&A. They will replace your household address with a code before uploading to a separate secure research database accessible to Trinity College Dublin.

How is the information kept confidential and secure?
Your privacy is important to us. We take many steps to make sure that we protect your confidentiality. We have a contract in place with Ipsos B&A to ensure the confidentiality of your personal information. Ipsos B&A use servers to keep your data secure. These servers are located in Bulgaria (within the EU) and a back-up server is located in the UK.

Limitations on Confidentiality: Confidentiality may be breached in circumstances in which: The research team has a strong belief or evidence exists that there is a serious risk of harm or danger to either the participant or another individual.

How long will my personal information used for this study be retained for?
Your personal information will be retained for until the study is completed on 30th September 2024. After that period of time, we will break the link between your household and your interview. Two years after the completion of the study, we will delete any data that could be used to link the information back to you, thereby making the data anonymous.

We will archive the information after a period of seven years, in anonymous format. It is considered 'good scientific practice' that research data is archived and made available for other researchers to use it at a later stage. We intend on archiving the data collected as a part of this research in a data archive so as that other researchers (both in Ireland and outside of Ireland) may use it in the future.

There is no way at this point that your data can be traced back to you in any way.

Your consent form will be retained for a period of 7 years and then deleted to protect privacy.

What is the lawful (legal) basis to use my personal data?

We will only use your personal information for this research project, which we hope will improve health services and assets and inform health policy in line with (Article 6(1)(e) and 9(2)(j) of the GDPR. We will also ask for your consent as a requirement of the Irish Health Research Regulations.

What are my rights under Data Protection law?

You are entitled to:

- object to our use of your personal data or any further use;
- request access to your personal data and to receive a copy of it;
- request inaccurate personal data be corrected or deleted;
- request restriction of our use of your personal data (if it is inaccurate);
- request deletion of your data.

By law you can exercise the above rights in relation to your personal data, unless the request would make it impossible or very difficult to conduct the research. For example, if the study results / information is about to be published then we may not be able to delete it. You can exercise these rights by contacting your study researcher Prof. Catherine Darker or the Trinity College Data Protection Officer, Secretary's Office, Trinity College Dublin, Dublin 2, Ireland. Email: dataprotection@tcd.ie. Website: www.dataprotection.ie

Part 3 Approval, Organising and Funding

Has this study been approved by a research ethics committee?

Yes, this study has been approved by Trinity College Dublin Faculty of Health Sciences Research Ethics Committee (REC). Approval was granted on February 21, 2024. An annual report will be provided to the REC and on completion of the study.

Who is organising and funding this study?

This study is being conducted by the research team in the Institute of Population Health, School of Medicine, Trinity College Dublin. Ipsos B&A have been contracted to collect the data on behalf of the research team. This study is being funded by Adelaide Health Foundation, and the Health Service Executive (HSE).

The Steering Committee for this research includes representatives from multiple external organisations - Adelaide Health Foundation, Health Service Executive (HSE) Dublin South City & West, Dublin South West, Kildare & West Wicklow Integrated Healthcare Areas, HSE Dublin & Midlands, the HSE National Health Intelligence Unit, South Dublin County Council, Tallaght University Hospital, General Practitioners and the Childhood Development Initiative. They will be provided with an anonymous report. They will not have access to your personal data.

Is there any payment for taking part?

No, we are not paying participants to take part in the study.

Part 4 – Further Information

What happens if I change my mind?

Your participation in this study is voluntary and you can change your mind even if the study has started up to the point when your information is anonymised as after this point, we will no longer be able to identify you. You do not have to give a reason for changing your mind. If you would like to withdraw from the study, please contact the Project Coordinator, Kaye Stapleton (kstaplet@tcd.ie) who can take you through the process outlined below and organise this for you.

Please note that we will not be able to remove personal data which has been shared or pooled for use in publication before your request for deletion.

Who should I contact for information or concerns?

If you have any concerns or questions, you can contact:
Principal Investigator: Prof Catherine Darker. Email: catherine.darker@tcd.ie

If you have any questions in relation to your rights under data protection law, you can contact the Data Protection Officer, Secretary's Office, Trinity College Dublin, Dublin 2, Ireland. Email: dataprotection@tcd.ie. Website: www.dataprotection.ie

Under GDPR, if you are not satisfied with how your data is being processed, you have the right to raise a concern with the Office of the Data Protection Commission, 21 Fitzwilliam Square South, Dublin 2, Ireland. Website: www.dataprotection.ie

Part 5 - Next Steps

If you would like to take part in this study, please contact [Ipsos B&A interviewer details] who will arrange a mutually suitable date and time for the interview with you.

Will I be contacted again?

Ipsos B&A will contact you in seven (7) days' time, to give you time to consider your participation in the study, by calling to your door. If you are not in they will leave note to arrange a suitable date and time for the interview with you. If they do not hear back from you, they will contact you on one further occasion and if they do not hear from you after that, they will not contact you again.

Thank you for taking the time to read this Participant Information Leaflet. You will be given a copy of this Leaflet and the signed Consent Form to keep. Please retain these in case they are needed for future reference.

Health Assets and Needs Assessment Participant Consent Form

Health Assets and Needs Assessment of the Tallaght Community

There are **two sections** in this form.

Section 1 contains statements of understanding and asks you to tick each if you understand. Please ask any questions you may have when reading each of the statements.
Section 2 asks for your informed consent. Please select either 'yes' or 'no' to indicate your choice.

Thank you for participating.
The end of this form is for the researchers to complete.

1. General Understanding	Tick
I confirm that I have read and understood the Information Leaflet for the above study. The information has been fully explained to me and I have been able to ask questions, all of which have been answered to my satisfaction.	☐
I understand that taking part in this study is entirely voluntary.	☐
I understand that not taking part will have no negative impact on me.	☐
I understand that I can leave this study at any time without giving a reason. I understand that leaving this study will have no negative impact on me now or in the future.	☐
I understand that I will not be paid for taking part in this study.	☐
I know how to contact the research team if I need to.	☐
By ticking each box above and choosing my options below and signing this document I agree to participate in this' study as described in the Participant Information Leaflet.	☐

2. Consent

	Yes	No
I agree to take part in this research study, having been fully informed of the risks and benefits in the participant information leaflet provided to me.	☐	☐
I agree to the use of information about me (personal data collected during the interview) being used by the research team for this research study as described in the participant information leaflet.	☐	☐

Participant Name (Block Capitals) Participant Signature

Date

To be completed by the Principal Investigator or nominee.
I, the undersigned, have taken the time to fully explain to the above participant the nature and purpose of this study in a way that they could understand.
I have explained the risks and possible benefits involved. I have invited them to ask questions on any aspect of the study that concerned them.
I have given a copy of the participant information leaflet and consent form to the participant with contact details of the study team.

Researcher name

Title and qualifications

Signature

Date

Household ID

Copy to be retained for PI. A copy to be left with Participant.

Appendix F Standard questions used in the quality control process conducted by Ipsos B&A.

An Ipsos B&A Interviewer may have called to you recently. After each survey, which Ipsos B&A completes, it is very important that we check to ensure that the interviews were properly completed. Our Interviewers are fully aware of this and they like people to confirm that the interview did, in fact, take place.

We would be very grateful if you would take 1/2 minutes to answer these questions, please.

1. Has a Survey Research Interviewer called to you recently? ☐ Yes ☐ No

2. What was the subject of this survey? _____

3. How long did the survey take? _____

4. (If applicable) Throughout the survey did the interviewer show you show materials to guide you through the survey? ☐ Yes ☐ No

5. In your opinion would you say the Interviewer was:
   ☐ Excellent
   ☐ Very
   ☐ Good
   ☐ Poor

6. Did the Interviewer show you their identity card? ☐ Yes ☐ No

Appendix G Letter to General Practitioners

Head GP
Tallaght
Dublin 24
May 2024

Dear GP,

Trinity College Dublin in collaboration with the Health Service Executive, Tallaght University Hospital, Adelaide Health Foundation, Childhood Development Initiative, South Dublin County Council and South Dublin County Partnership are looking at the health of people living in Tallaght. We will ask residents about the health of the household and satisfaction with the health services provided in the area through a household survey. We will ask about resident's demographics, health status, chronic illness, physical activity, use of healthcare and community facilities in Tallaght. We also want to find out what other services are needs.

We would like you to be aware of this study should any of your patients approach you about it. The survey will take place from May to July 2024 and researchers from Ipsos will carry an identity card. The survey will take about 30 to 45 minutes. We plan to conduct the interviews during the day or in the evening between 6 pm and 9 pm. If this time does not suit, the researcher will arrange an alternative time to call.

This is a good opportunity for the people of Tallaght to ensure that they have a say in the planning of the healthcare services in the area.

Thank you for reading this letter. If you have any questions or would like more information, please contact the project research assistant, Kaye Stapleton (kstaplet@tcd.ie) who will be happy to answer any questions or visit our website at:

https://www.tcd.ie/medicine/public-health-and-primary-care/research/hana/

Yours sincerely,

Catherine Darker

_____

Catherine Darker
Professor in Health Services Research
Institute of Population Health
School of Medicine

Appendix H HANA physical posters and social media communications.

Appendix I HANA physical posters and social media communications.

Appendix J HANA Survey Launch in Tallaght article in Tallaght News.

Shaping the future of Tallaght's Health and Wellbeing: next phase of ground-breaking project begins

Sarah Brooks | May 22, 2024 | CATEGORY - Community News, Health, Tallaght News

Round 3 of the HANA Project will begin over the coming weeks to assess and enhance the overall health landscape of Tallaght.

To prioritise the health and wellbeing of the Tallaght community, Professor Catherine Darker of Trinity College Dublinis leading the third round of the Health Assets and Needs Assessment (HANA) Project. In collaboration with the Health Service Executive, Tallaght University Hospital, Adelaide Health Foundation, Childhood Development Initiative, South Dublin County Partnership and South Dublin County Council, the project aims to assess and enhance the overall health landscape of Tallaght.

The foundation for this ground-breaking project was launched in 2001 and 2013 during Rounds 1 and 2. The HANA Project reviewed health and wellbeing through mapping health and community services in 13 electoral divisions of Tallaght. Household letters were sent inviting the main carers in randomly selected households to have their say, resulting in the response of over 1,000 people. Their opinions have since played an important role in shaping the development of Tallaght, ensuring that the services provided meet the needs of the community.

In Round 3, Prof Catherine Darker and her team are focusing on the positive developments that have occurred since the beginning of the project. This round will emphasise healthcare, sport and hobby facilities, and community amenities, to better understand the current health landscape in Tallaght.

How will Round 3 of the HANA project work and how you can get involved: Between May and July, main carers in households across Tallaght will be invited to interview, providing an opportunity for community members to voice their opinions on necessary services. The information gathered will contribute to a report that will be made available to healthcare planners, allowing the community's needs to be accurately represented. It is important to note that participation in this study is entirely voluntary. Prof Catherine Darker emphasizes that individuals have the option to decide whether to take part or not, with full respect for their decision.

Highlighting the positive outcomes from previous rounds, including the establishment of a community radiology unit in Tallaght Cross and the launch of 'out of hours' doctors' services, Prof Catherine Darker is optimistic about the impact of Round 3.

She said: *"We have seen real improvements in the community's health services based on the valuable input from previous rounds. This is a testament to the power of community engagement and the importance of each voice in shaping the future of healthcare in Tallaght. We look forward to further enhancing the health and wellbeing of our community in Round 3."*

The HANA Project stands as a community effort to create a healthier, happier, and more vibrant Tallaght. Together, the residents of Tallaght are invited to be a part of this transformative journey, ensuring that their voices shape the future of healthcare in their community.

Further information www.tcd.ie/medicine/public-health-and-primary-care/research/hana/

Appendix K HANA Healthcare Asset Inventory 2024

GP Surgery	Pharmacy	Dental Care	Other Primary Care Services	Mental Health Services	Support Groups	Addiction Services	Disability Support
Aylesbury Clinic, Aylesbury Shopping Centre	Boots Pharmacy, The Square Shopping Centre	Priory Dentists, 5 Main Street	Old Bawn Podiatry, 86 Old Bawn Road	CAMHS Lucena Clinic, Exchange Hall, Belgard Square North	Anam Cara (support bereaved parents and siblings), HCL House, Cookstown Industrial Estate	C.A.R.P (Community Addiction Response Programme), Killinarden Heights	Regional Autism Services (Beechpark Services), Main Road
Park House Family Practice, HSE Brookfield Health Centre	Brookfield Pharmacy, Jobstown	Glenview Dental Surgery, 189 Glenview Park	Insight Opticians, Kilnamanagh Shopping Centre	Jigsaw Dublin Southwest, St. John's House, High Street	Bethany Old Bawn Bereavement Group, C/O 86 Killinarden Heights	Community Alcohol Services, Kilnamanagh Tymon Primary Care	A Helping Hand, Whitestown Business Park
Tallaght Medical Centre, Castletymon Shopping Centre	Meagher's Pharmacy Glenview Park	Mayberry Dental Care, 20 Birchview Drive	Specsavers, The Square Shopping Centre	Killinarden Family Resource Centre	Foróige Office Tallaght, Tallaght Youth Centre	Fettercairn Drugs Rehab Programme, Fettercairn Youth and Community Centre	HSE EVE New Horizon Training Centre, 44 Broomhill Close
Tallaght Medical Centre Kingswood	Bates Pharmacy, Aylesbury Shopping Centre	Old Bawn Dental Practice, 72 Old Bawn Road	Vision Express, The Square Shopping Centre	St. Catherines' Counselling Service, Saint Marys' Priory	South Dublin Migrant Integration Forum, Mountain Park Centre for Creative Learning	HSE Community Drug Team, Kilnamanagh Tymon Primary Care	National Learning Network, 77 Broomhill Road
Tallaght Medical Centre Killinarden, HSE Killinarden Primary Care Health Centre	Hickey's Pharmacy, 13 Fortunestown Lane	Mountain Park Dental Practice, 51 Mountain Park	TLC Doc (out-of-hours), Carbury House	Tabor Counselling and Therapy Centre, Belgard Heights	Irish County Women's Association, Rúa Red South Dublin Arts Centre	Jobstown Assisting Drug Dependency (JADD)	SJOG, Liffey Services, Cookstown Way
Glenview Medical Centre, Centric Health Old Bawn Shopping Centre	Hickeys' Pharmacy, The Square Shopping Centre	Old Bawn Smile Clinic, 1 Old Bawn Terrace	Primary Care Radiology Unit, Russell Centre, Tallaght Cross West	Tallaght Mental Health Services, Sheaf House, Belgard Road	Pastoral Care, Tallaght University Hospital	RU Recovery Programme, Lifegate Bible Baptist Church	Tallaght Parents of Children with Autism Support Group, Killinarden Community Centre

GP Surgery	Pharmacy	Dental Care	Other Primary Care Services	Mental Health Services	Support Groups	Addiction Services	Disability Support
John Simon Family Practice, Kilnamanagh	Jobstown/ Grogan Pharmacy, Kiltalawn Shopping Centre	Smiles Dental Clinic, Unit 3B Belgard Square West The Square	Affidea ExpressCare, Tallaght Cross East	Crosscare Teen Counselling, Shalom, Raheen Park	Saoirse Women's Refuge, Fettercairn Community Health Project, Fettercairn Community Centre	Reformers Unanimous Ireland, Lifegate Baptist Church	CHIME (Dublin South), Exchange Hall, Belgard Square North
Jobstown Family Practice, Mary Mercer Health Centre	Killinarden Pharmacy, Killinarden Shopping Centre	Dental Surgery Medical Centre, The Square Shopping Centre	Ultrasound Ireland: Medical & Pregnancy Scan Centre, Unit 8 Belgard Square West	The Village Counselling Service, Killinarden Enterprise Park	SWAN Family Support Project, St. Annes National School	Tallaght Community Stop Smoking Service, Mary Mercer Health Centre	Trustus Home Help Service, 1-2 Main Street
Millbrook Lawns Health Centre	Meagher's Pharmacy, Castletymon Park Shopping Centre	Springfield Dental Practice, 23 Maplewood Road	HSE Community Audiology Services, Tallaght Cross West	Grow, St. Mary's Priory	Tallaght Cancer Support Group, 3 Main Rd	St. Aengus Community Action Group, St Aengus Centre	EVE Forás, Kilnamanagh Tymon Primary Care Centre
Patrick O'Connor Family Practice, 12a Glenview Park	New Bawn Pharmacy, St. Dominics Road Shopping Centre	Lion Medical Dental and Health Clinic, Unit 8 High St	Allied Chiropody & Podiatry, 2 Main Street	Pieta House South Dublin, Greenhills Retail Park	Tallaght Travellers Youth Service/ Catholic Youthcare, Brookfield Enterprise Centre	St. Dominics Community Response Project, St. Dominics Contact Centre	SSID – Southside Intellectual disabilities, Kilnamanagh Tymon Primary Care Centre
Dr Torun's Surgery, 59a Old Bawn Way	O.D.C Pharmacy, Kilnamanagh Shopping Centre	Aylesbury Dental Clinic, 42 Heatherview Close	Aylesbury Foot Clinic, Aylesbury Shopping Centre,	HOPE - Suicide Prevention Drop-in Centre Tallaght, Old Bawn Road	Millbrook Child and Family Centre and Acorn Parent Coaching Programme, Millbrook Lawn Health Centre	SWAN-Fao (Family Support Organisation), St. Annes National School	Enable Ireland Disability Services, Tymon North Road
Springfield Medical Centre	Pharmacy O'Regan, Old Bawn Shopping Centre	Crystal Smiles Clinic, 14 Belgard Square West	Tallaght Cross Physiotherapy, Russell Centre, Tallaght Cross West	EVE - New Horizons, Airton Road	West Dublin YMCA, Brookfield Enterprise Centre	Tallaght Drug & Alcohol Task Force South Dublin County Partnership	NCBI, Talbot House, Tallaght Cross East
Tallaght Medical Practice	Rossfield Pharmacy, Brookfield Enterprise Centre	H.S.E Orthodontic Service, Simms Building Tallaght Cross West	MyPhysio & Rehab Tallaght, Block 6 High Street	TUD Tallaght Counselling, Blessington Road	Parent and Toddler Group, Killinarden Family Resource Centre	Tallaght Rehabilitation Project, Kiltalown House	Autism Initiatives Ireland, Unit 1 Village Square

GP Surgery	Pharmacy	Dental Care	Other Primary Care Services	Mental Health Services	Support Groups	Addiction Services	Disability Support
The Coady Practice, 1 Old Bawn Way	Springfield Pharmacy	Mary Mercer Centre Primary Care Dental	Somerton Physio Old Bawn / Tallaght, 68 Old Bawn Road	Threshold Training Network, Unit 17-19, Tallaght Enterprise Centre	Tallaght COPD Support Group - Siel Blue, Rúa Red, South Dublin Arts Centre	YODA- Youth drug and alcohol services, Kilnamanagh Tymon Primary Care	Suzanne House, 6 Main Road
Birchview Surgery, Kilnamanagh Tymon Primary Care Centre	Tallaght Cross Pharmacy, The Russell Centre, Tallaght Cross West		Tallaght Sports Injury and Massage Clinic, Saint Dominic's Shopping Centre	HEADSUP, South Dublin County Partnership	Slim & save, Killinarden Community Centre	We Can Quit, Killinarden Community Centre	Sensory Fun with Friends, Brookfield Youth & Community Centre
GPs at Tallaght Cross, Russell Centre, Tallaght Cross West	Village Green Pharmacy		KF Athletic Therapy, One Life Fitness Gym, Belgard Square West	CIPC Counselling in Primary Care, Kilnamanagh-Tymon Primary Care Centre	Parent & Toddler, Killinarden Community Centre	Tallaght Daily Reprieve, St Aengus Community Centre	Special Needs Service, c/o HSE, Chamber House
Dr Gordon Cantwell and Eamonn Spillane, 23 Old Bawn Way	Lloyds Pharmacy, The Square Shopping Centre		Hidden Hearing, Cookstown Way	Centric Mental Health - Tallaght Cross GP, Russell Centre, Tallaght Cross West	Tallaght Traveller Community Development Project, 12 Brookfield Court	Tallaght The Common Solution Group, Kingswood Community Centre	Balrothery Arch Club, St. Joseph's Special School
Airton Medical, 192B Glenview Park	McCabes Pharmacy Tallaght, Lidl Complex, Main St		Roma Clinic, GPs at Tallaght Cross, Russell Centre, Tallaght Cross West	MHID – Mental health in Dublin, Kilnamanagh Tymon Primary Care Centre	The CRY Centre, Tallaght Cross West	HSE QUIT (Smoking Cessation Service), 52 Broomhill Road	
Dr Pilar, My Family Doctor in Tallaght, 14 Belgard Square W	McCabes Pharmacy Springfield, Springfield Shopping Centre		Kiltipper Woods Care Centre, 24 Kiltipper Rd	Daughters of Charity Child and Family Services, Mary Mercer Health Centre		Kilnamanagh/ Tymon Stop Smoking Clinic, Junction House	
Medical Centre, The Square Shopping Centre	Pharmacy Hub Belgard, Belgard Rd		TUSLA– Child and Family Agency, Mary Mercer Centre	Susi Lodola Counselling, 68 Old Bawn Rd		Fettercairn Stop Smoking Service, Fettercairn Community Health Project, Fettercairn Community Centre	

GP Surgery	Pharmacy	Dental Care	Other Primary Care Services	Mental Health Services	Support Groups	Addiction Services	Disability Support
Tallaght Medical Centre Kilnamanagh	Lloyds Pharmacy, Aylesbury Shopping Centre		Physiotherapy, HSE Brookfield Health Centre			Tallaght Addiction and Support (TASP), South Dublin County Partnership	
HSE Primary Care Centre, Russell Centre, Tallaght Cross West	Superdrug, The Square Shopping Centre		Speech and Language Therapist, Tallaght Cross Primary Care Centre, Russell Centre, Tallaght Cross West			New Hope Residential Centre, Kiltalown Cottage	
Centric Health Old Bawn, Old Bawn Shopping Centre Swiftbrook Medical Centre, TLC Centre, Citywest	Pharmacy Hub Mace Killinarden Bests Kingswood Pharmacy, Kingswood Shopping Centre						

Appendix L HANA Community Asset Inventory 2024.

Parks & Allotments	Playgrounds & Teen Spaces	Community Centres	Community Services	Churches / Places of Worship	Youth Services	Senior Citizen Services	Transport Services	Support Groups	Libraries	Services for Children Under 5	Other
Aylesbury Park	Fettercairn Community and Youth Centre Playground	Belgard Community Centre	Adelaide Health Foundation, Tallaght University Hospital	Church of Saint Thomas the Apostle	Foróige Office Tallaght	Tymon North Senior Citizens, St. Aengus Community Centre	Bus	Killinarden Garda Clinic, Killinarden Community Centre	County Library, Tallaght	An Turas, Jobstown Village Square	Tallaght MABS, The Square
Bancroft Park	Jobstown Community Centre Playground	Brookfield Youth & Community Centre	Environmental Health, HSE Dublin Mid Leinster, Environmental Health Officers Department	Church of St Martin de Porres	Boost Garda Youth Diversion Project, Brookfield Youth & Community Centre	St Marks Silver Surfers, St. Mark's Church	Luas	Tallaght Garda Station, Hibernian Industrial Estate	Castletymon Public Library	Tallaght Childcare Centre, Fettercairn Community & Youth Centre	Tallaght West Credit Union, Fortunestown Shopping Centre
Butler McGee Park	Killinarden Community Centre Playground	Dominic's Community Centre	Fettercairn Community Enterprise Company, Fettercairn Youth and Community Centre	Church of the Sacred Heart, Killinarden	DDLETB Community Kids Group, Brookfield Youth & Community Centre	Trustus Senior Care, Trustus House		County Library, Tallaght	Mobile library, The Square Shopping Centre	Early Years Education and Care Centre, An Cosán, Kiltalown Village Centre	The Square Post Office, The Square Shopping Centre
Dodder Valley Park	Kiltalown Park	Fettercairn Youth and Community Centre	Fettercairn Community Health Project, Fettercairn Youth and Community Centre	Holy Family Oratory, The Square Shopping Centre	Electra Junior Variety Group, Kilnamanagh Family Recreation Centre	Women's Group, Brookfield Community Centre		The Swan Centre, Tallaght Addiction Support Programme (TASP), St. Aengus Community Centre	Mobile library, Fettercairn Youth and Community Centre	Killinarden Resource Centre (Child-minding service), Killinarden Heights	Aylesbury Post Office
Jobstown Park	Sean Walsh Park Playground	Jobstown Community Centre	Fettercairn Estate Management Office, Fettercairn Youth and Community Centre	Lifegate Bible Baptist Church	Jobstown Community Centre	South Dublin Senior Citizen Club, Dublin Postal Sports and Social Club		Irish Red Cross, The Square Industrial Complex Tallaght		Family Resource Centre, 16 Main Road	Movies@ The Square, The Square Shopping Centre
Killinarden Park	Tallaght Square Playground	Killinarden Community Centre	Killinarden Estate Management Committee, Killinarden Community Centre	Saint Aengus' Church	JAY Garda Youth Diversion Project	Kingswood/ Kilnamanagh Active Age Club (Men)		Men's Shed, Glenview Lodge		Play School, St. Marks Youth and Family Centre	Glenview Post Office
Kilnamanagh Park	Tymon Park Junior Playground	Kilnama-nagh Family Recreation Centre	Killinarden Local Committee, Killinarden Community School	Saint Aidans' Parish Church	Killinarden Community Council Youth Project, Killinarden Community Centre	Golden Circle, Killinarden Community Centre		The Tallaght Men's Shed, Tallaght Enterprise Centre		Sensory Mornings, County Library	Springfield Post Office

Parks & Allotments	Playgrounds & Teen Spaces	Community Centres	Community Services	Churches / Places of Worship	Youth Services	Senior Citizen Services	Transport Services	Support Groups	Libraries	Services for Children Under 5	Other
Kiltalown Park	Kingswood Heights Playground	Kingswood Community Centre	Childhood Development Initiative, St Mark's Youth and Family Centre	Saint Annes Church	St. Marks Youth and Family Centre	Rose Cottage Dementia Resource Centre		Mojo Men's Shed, St Thomas Church		Daisy Chain Play Group, Tymon Bawn Community Centre	Tallaght and District Credit Union
Old Bawn Park	Avonbeg Multi-Use Games Area (MUGA)	St. Aengus Community Centre	South Dublin Community Response Forum, County Hall	Saint Dominics Church	The Boys' Brigade and Girls' Association, Saint Maelruains' Church of Ireland	Senior Swim, Tallaght Leisure Centre, Tallaght Leisure Centre		Brookview/ Fettercairn Men's Shed, Fettercairn Community Centre		St Kevin's Family Resource Centre, St. Kevin's Girls School	Tallaght Credit Union
Sean Walsh Park	Teen Space, Bancroft Park	St. Marks Youth and Family Centre	South Dublin County Council, County Hall	Saint Kevins' Church	Tallaght Travellers Youth Service	Dominic's Crochet Group for the Active Retired, Dominic's Community Centre		Men's Shed, Kilnamanagh Family Recreation Centre		Ard Mór Community Childcare, 37 Ard Mor Court	Kilnamanagh Post Office, Kilnamanagh Shopping Centre
Tamarisk Park	Teen Space, Kingswood, Tynan Hall Park	Tymon Bawn Community Centre	South Dublin County Partnership	Saint Killians' Church	Tallaght Travellers Youth Services, St. Aidan's Community School	Older People Online, An Cosán		Tallaght Cancer Support Group, 3 Main Road		JADD Project Childcare Service, Jobstown	Intreo Centre Tallaght
Tymon Park	Teen Space, Tymon Park - Limekiln	St. Kevins Family Resource Centre	South Dublin County Volunteer Centre	Saint Maelruains' Church of Ireland Saint Marks' Church	Tallaght Travellers Youth Service, St Aengus Community Centre	Day Centre, Kilnamanagh Family Recreation Centre		Women's Collective Ireland, Brookfield Enterprise Park		Young Explorers' Preschool and Afterschool, Dominic's Community Centre	Legal Aid Board, Village Green
Tymonville Park	Tymon Park Woodlawn Playground	West Tallaght Resource Centre	Tallaght Citizens Information Centre		Tallaght Travellers Youth Service	Kiltipper Woods Care Centre		Threshold Training Network, Tallaght Enterprise Centre		Millbrook Child and Family Centre, Acorn Parent Coaching Programme and Early Years, Millbrook Lawns Health Centre	Food Bank, Killinarden Community Centre

Parks & Allotments	Playgrounds & Teen Spaces	Community Centres	Community Services	Churches / Places of Worship	Youth Services	Senior Citizen Services	Transport Services	Support Groups	Libraries	Services for Children Under 5	Other
Tynan Hall Park	Brookfield Community Centre Playground	Mountain Park Centre for Creative Learning	Partas, Tallaght Enterprise Centre	Saint Marys' Priory	Tallaght Travellers Youth Service, Fettercairn Community & Youth Centre	South Dublin Senior Citizens Club, Killinarden Enterprise Park		An Cosán, Kiltalown Village Centre		Dolly Parton Imagination Library, County Library	Tallaght Garda Station
Kiltipper Park	Mac Uilliam Estate Playground	Kiltalown Neigh-bourhood Centre	Tallaght Traveller Community Development Project	Shalom	Tallaght Travellers Youth Service, Brookfield Youth & Community Centre	Ladies Groups, Dominic's Community Centre		Belgard S ister Shed, Belgard Community Centre			DDLETB Tallaght Training Centre, Cookstown Industrial Estate
Tymon Park Allotment	Kiltalown Park Playground	West Dublin YMCA Ard Mor Neigh-bourhood Centre	Victim Support Dublin South	Tallaght Methodist Church and Community Centre	Jobstown Action For Youth Project, Tallaght Travellers Youth Service	DAMS, Dominic's Community Centre		Fettercairn Sister Shed, Fettercairn Community Centre			
Oldcourt Hill Farm Allotment	Avonbeg Playspace	MacUilliam Neigh-bourhood Centre	Daughters of Charity Child and Family Service, Mary Mercer Health Centre	The Church of Incarnation of Fettercairn	Foróige Big Picture	St Mark's Senior Citizens, Shalom, St. Mark's Church Hall		Jobstown Sister Shed, An Cosán, Kiltalown Village Centre			
Kiltalown Neigh-bourhood Park	Aylesbury Park Playground		Tusla, Meitheal	RCCG Joseph's Palace Dublin	Foróige Tallaght	Fettercairn Senior Citizens Group, Fettercairn Community		Women Together Network, Brookfield Enterprise Centre			
			Tusla- Child and Family Agency	Tallaght Mosque	CHI at Tallaght Children's Outpatient and Emergency Care Unit	Centre Senior Games, Sacred Heart Parish		Stroke Support Group, The Rúa Red Arts Centre			
			Fáilte Isteach via Third Age Ireland	Dominican Retreat Centre Tallaght	APT Garda Youth Diversion Project, c/o St Aengus Community Centre	Jobstown Senior Citizens, Jobstown Community Centre		Alzheimer's Support Group, Kilna-managh Family Recreation Centre			
			Saint John of God Community Services Liffey Services	Ireland Vinayaka Temple, Kingswood Community Centre	APT Garda Youth Diversion Project, Dominic's Community Centre	Belgard Seniors, Belgard Community Centre		Women's Group, Brookfield Youth & Community Centre			

Parks & Allotments	Playgrounds & Teen Spaces	Community Centres	Community Services	Churches / Places of Worship	Youth Services	Senior Citizen Services	Transport Services	Support Groups	Libraries	Services for Children Under 5	Other
			The Local Area Employment Services (LAES)	Church of Scientology & Community Centre of Dublin	Garda Youth Diversion Project, Fettercairn Community Centre	Active Age Pilates, Tymon Bawn Community Centre		Brookview Cooperative Childcare Parent Group, Brookfield Youth & Community Centre			
			Dublin and Dun Laoghaire Education and Training Board	D24 Church, Movies@The Square	Barnardos Lorien Project Child and Family Service			HUGG, Maldron Hotel Tallaght			
			The Meath Foundation, Tallaght University Hospital	Tallaght Christian Church, Shalom Christian Fellowship	Foróige APT, Dominic's Community Centre			Box Smart, Tallaght Reha-bilitation Project, Kiltalown House			
			Mountain Park Centre for Creative Learning	The Sanctuary, Kilnamanagh Family Recreation Centre	Foróige Jokers Club, St. Marks Youth and Family Centre						
			Accord, Marriage and Relationship Counselling	Sunday Worship, Tymon Bawn Community Centre	Barnardos Child & Family Centre						
					Foróige, Ard Mor Neigh-bourhood Centre						
					Connect4 Project, MacUilliam Neigh-bourhood Centre						

Appendix M HANA Sport and Hobby Inventory 2024.

Sports Clubs	Football Clubs	Sports Centre	Pitches	Gym	Swimming Pool	Sports Facilities	Hobby Facilities	Hobbies	Youth Hobbies
Croi Ro Naofa GAA Club, Killinarden Park	Ballycragh United Football Club	Belgard Community Centre	Aylesbury Park Pitch	West Park Fitness, Greenhills Road	Tallaght Community School Sports Complex	Fettercairn Youth Horse Project	Alternative Entertainment Artists' Studios, Cookstown Industrial Estate	Bingo, Dominic's Community Centre	KidsComp, Dominic's Community Centre
Dublin Postal Sports and Social Club, Kiltipper Road	St. Aidan's Football Club	St. Aengus Community Centre	Jobstown Park GAA Pitches	Functional Fitness Area, Tymon Park	Tallaght Leisure Centre	Parks Tennis Ireland, Saint Marks Community School	Tallaght Historical Society, County Library	Line Dancing, Dominic's Community Centre	Play Therapy, Dominic's Community Centre
Glennane Hockey Club Glennane park, St. Marks Community School	Fettercairn Football Club, Butler McGee Park	Brookfield Youth & Community Centre	Astro Park Greenhills	Club Vitae, Maldron Hotel	West Park Fitness, Greenhills Road	Sparta Club (spartan MMA), Old Belgard Road	Civic Theatre, Belgard Square East	Creative Writers Group, Dominic's Community Centre	Football Association of Ireland Group, Kilnamanagh Community Centre
Glenville Pitch and Putt Club, Kiltipper Road	Jobstown Celtic Football Club, Jobstown Park	Fettercairn Youth and Community Centre	Ballymount Park Soccer and GAA Pitch	GFT Gym at The Postal Club	Club Vitae, Maldron Hotel	St Mary's Boxing Club, St. Dominic's Road	Des Carty Music School, Rúa Red	TACT Book Club, Dominic's Community Centre	Southside Jiu Jitsu Academy, Kilnamanagh Community Centre
Golden Cobra boxing club, Belgard Square West	Kilnamanagh Association Football Club, Kilnamanagh Park	Jobstown Community Centre,	Bancroft Park Pitch	Broomhill Fitness, 66 Broomhill Road		Tallaght Adventure World, 1 Whitestown Business Park	Electra Junior Variety Group, Kilnamanagh Family Resource Centre	Art Clubs, Dominic's Community Centre	Button Halpin Academy of Irish Dance, Kilnamanagh Community Centre
Greenhills Archers Club, Tallaght Sports Complex	Kingswood Football Club, Ballymount Park	Jobstown Killinarden Community Centre	Butler McGee Park Pitches	Back2Basics, Broomhill Business Complex		Tallaght Leisureplex	Rúa Red, South Dublin Arts Centre	Pilates, Kilnamanagh Community Centre	Ballet, Kilnamanagh Community Centre
Old Bawn Taekwon- Do School, Saint Maelruains National School	Marks Celtic Football Club, Butler McGee Park	Killinarden Community School Sports Complex	Dodder Park Pitches	DMPT, Tallaght Enterprise Centre		Tallaght Community School Sports Complex	Tallaght Choral Society, St. Marys' Priory Tallaght	Line Dancing, Kilnamanagh Community Centre	St Kevin's Knights Basketball Academy for Boys and Girls, Kilnamanagh Community Centre
Roadstone Group Sports Club, Kingswood	Sacred Heart Football Club, Killinarden Park	Kilnamanagh Community Centre	Jobstown Celtics All Weather Pitch	One Life, Belgard Square West		SBG Tallaght, Glen Abbey Complex	Community Arts Centre, Mountain Park	Badminton, Kilnamanagh Community Centre	Twirlers Group, Kilnamanagh Community Centre
Sacred Heart Boxing Club, 108 Donomore Park	Shamrock Rovers F.C, Tallaght Stadium	St Marks Youth and Family Resource Centre	Killinarden Park Pitches	FLYEfit Tallaght, Crosswest		Tallaght Martial Arts and Fitness Centre, 13 Whitestown Drive	Tallaght Theatre, Greenhills Road	History Club, Kilnamanagh Community Centre	Tallaght Marching Band, St. Mary's National School
St. Marys' Boxing Club, St Dominics Road	St Maelruans Football Club, Bancroft Park	Tallaght Sports Complex	Sacred Heart All Weather Facility, Killinarden Heights	Strength and Conditioning HQ SBG Tallaght, Glen Abbey Complex		South Dublin Martial Arts and Fitness, Unit 1 The Arena	Tallaght Theatre, Greenhills Road Tallaght Marching Band, St. Mary's National School	SDCSP Adult Exercise, Brookfield Youth & Community Centre	125th Dublin Old Bawn Scout Group, Tymon Bawn Community Centre

Sports Clubs	Football Clubs	Sports Centre	Pitches	Gym	Swimming Pool	Sports Facilities	Hobby Facilities	Hobbies	Youth Hobbies
St. Marks GAA Club, Butler McGee Park	Tymon Celtic Football Club, Tymonville Estate	Tallaght Leisure Centre	Sean Walsh Park Pitches	ExWell Medical, Thomas Davis GAA Club		Roadstone Sports Group, Kingswood Cross	Carousel Theatre, Rúa Red	Zumba Gold, Brookfield Youth & Community Centre	24th Tallaght Scouts, Old Blessington Road
Tallaght Athletics Club, Bancroft Park	Shamrock Rovers F.C. Academy, Roadstone Sports & Social Club	Tymon Bawn Community Centre	Tallaght Stadium Pitches	ExWell Medical, Tallaght Leisure Centre		TU Dublin, Tallaght Campus Sports Facilities	Tallaght Litter Muggs, Sean Walsh Park	Community Snooker and Pool, Brookfield Youth & Community Centre	Drama Beans Club, St. Marks Youth and Family Centre
Tallaght Basketball Club, National Basketball Arena		St. Kevins Family Resource Centre	Tymon Park Pitches	ExWell Medical, TU Dublin, Tallaght Campus		Skate Park, Dodder Valley Park	Irish Mountaineering Club (IMC), Dublin Climbing Centre	Bingo, Brookfield Youth & Community Centre	Karate Class, St. Marks Youth and Family Centre
Tallaght Swim Team, Balrothery Sports Complex		West Dublin YMCA	TU Dublin (Tallaght) Football Ground			Zen Movement, Unit 14, Oldbawn Shopping Centre	Foróige Tallaght	Greenhill's Archers Club, Tallaght Community School Sports Complex	Fettercairn Jokers, St. Marks Youth and Family Centre
Thomas Davis GAA Club, Kiltipper Road			Tallaght United FC Pitch			Pilates, Tymon Bawn Community Centre	D24 Dance Group, Killinarden Community Centre	Senior Swim, Tallaght Leisure Centre	Fettercairn Juniors, St. Marks Youth and Family Centre
Westside Boxing Club, Brookview Avenue			Old Bawn Football Pitch				The Well, 519 Main Street	Glenview Park Tallaght Walkers, Glenview Park	UCANDANCE, St. Marks Youth and Family Centre
Tallaght Rovers Basketball Club, St Aidan's Community College							Jobstown Chess Club, 1 Sundale Road	Killinarden Community Walking Group, Killinarden Community Centre	Studio 24 Dance Classes, St. Marks Youth and Family Centre
Kick Tallaght, Brookfield Youth and Community Centre							The Dublin Climbing Centre, The Square Industrial Complex	Kiltipper Ramblers, Kiltipper Bar and Lounge	Boom Variety Stage School, Brookfield Youth & Community Centre
Phoenix Gymnastics Club, Unit 1 Broomhill Road							Dublin School of Music, Old Bawn Shopping Centre	Tymon ParkRun, Tymon Park	Kid's Boxercise, Brookfield Youth & Community Centre
South Dublin Panthers, American Football Club, Tymon Park							Old Bawn Community School	Learn2Cycle, Tallaght Leisure Centre	Irish Dancing, Brookfield Youth & Community Centre

Sports Clubs	Football Clubs	Sports Centre	Pitches	Gym	Swimming Pool	Sports Facilities	Hobby Facilities	Hobbies	Youth Hobbies
St Marks Taekwon-Do School, St. Mark's Community School Sports Hall							County Library YMCA, Ard Mor Neighbourhood Centre	ezBADMINTON, Belgard Community Centre	Scoil Aonghusa And Tallaght Community School Walking Group
St. Kevin's Knights Basketball Academy							Music Generation South Dublin, c/o County Library	Tuesday Bowl Ladies Club, Tymon Bawn Community Centre	Build It Brick Club, Tymon Bawn Community Centre
Springfield Ladies Basketball Club, St Mark's Community School								Women's Badminton Club, Tymon Bawn Community Centre	St. Martin's Twirlers, Tymon Bawn Community Centre
Friendly Basketball Club, Killinarden Community School (KCS)									JKS Tallaght Karate Club, St Marks Youth & Family Centre
iSwim Academy, Club Vitae, Tallaght Maldron									Bliss Gymnastics, Kingswood Community Centre
Tallaght Rugby Football Club, Tallaght Rugby Club Pitch									
Tallaght Town AFC, Carolan Park, Kiltipper									
Spartan Club, Old Belgard Road									
Kingswood Castle Football Club, Ballymount Park Kingswood									
St. Kevin's Killian's GAA, Kingswood Heights									
Kingswood Football Club, Tynan Hall Park									
Dublin Tomiki Aikido, Belgard Youth & Community Centre									

Sports Clubs	Football Clubs	Sports Centre	Pitches	Gym	Swimming Pool	Sports Facilities	Hobby Facilities	Hobbies	Youth Hobbies
St. Mary's Boxing Club, 24 St. Dominic's Avenue									
Limekiln Rounders GAA, Tymon Park Jobstown Boxing Club, 79 Kiltalown Road, Jobstown									
Old Bawn Gymnastics, Cookstown Industrial Estate									
Gardians Volleyball Club, Coláiste De Híde, Tymon Road									
Greenhills Taekwon-Do, Greenhills Road									
Tallaght Wheelers, Airton Road									
Learn2Cycle, Tallaght Leisure Centre									
Box Smart, Tallaght Rehabilitation Project, Kiltalown House									

Appendix N Chronic illness examples response card.

Response Card: Q3.16 Chronic Illness Examples

How many people in this household have a chronic illness?

A chronic illness is an illness that has been present for some time or recurs frequently requiring medical treatment such as:

- Heart disease (e.g. angina, coronary artery disease, cerebrovascular disease, ischemic cardiopathy, dysrhythmia- irregular heartbeat)
- Neurodegenerative diseases (e.g. dementia, Alzheimer's, Parkinson's)
- Chronic osteoarticular diseases (e.g. arthritis, osteoporosis)
- Diabetes
- Kidney disease
- Drug or alcohol dependency
- High blood pressure
- Cancer
- Chronic bowel disease
- Epilepsy
- Chronic respiratory illnesses (e.g. asthma, chronic obstructive pulmonary disease (COPD), pulmonary hypertension, recurrent chest infections, cystic fibrosis)
- Chronic pain syndrome (e.g. back injuries, reflex sympathetic dystrophy (RSD) syndrome)
- Anaemia
- Eating disorders (e.g. bulimia, anorexia, obesity)
- Limb deformities
- Mental illnesses (e.g. anxiety, depression, schizophrenia)
- Stroke
- Blindness (e.g. glaucoma)
- Haemophilia
- HIV
- Inactive or overactive thyroid gland
- Multiple sclerosis
- Autoimmune disease (e.g. ulcerative colitis, lupus, Crohn's disease, coeliac disease)
- Addison's disease, Cushing's disease

Appendix O Binary logistic regression model to identify factors associated with having a chronic illness in the Tallaght population in 2024.

Factors	Total number	Reported number	Adjusted Odds Ratio (95% CI)	p-value
On a waiting list				
Yes	268	83	1.81 (0.99-3.32)	0.05
No		126	1	
Experienced stress in the past 12 months				
Yes	272	189	2.84 (1.42-5.67)	0.003
No		83	1	
Self-rated health				
Bad or very bad	274	27	5.26 (1.766-15.64)	0.003
Fair, good or very good		246	1	

Whole model $X^2(3) = 27.78$; $p<0.001$.

A binary logistic regression examined the likelihood of respondents reporting to have a chronic illness based on whether they are on a waiting list or are awaiting a diagnosis, if they have experienced stress in the past 12 months and their perceived self-rated health. This model was highly statistically significant [Whole model $X^2(3) = 27.78$; $p<0.001$.].

Factors linked with individuals having a chronic illness were if they were on a waiting list, have experienced stress in the past 12 months and had reported a 'bad' or 'very bad' score for self-rated health. Specifically, individuals on a waiting list or awaiting a diagnosis were 1.81 times more likely to report having a chronic illness compared to those who were not. Similarly, those who experienced stress in the past 12 months were 2.84 times more likely to report a chronic illness to those who did not.

Likewise, those who rated their health as ‘bad’ or ‘very bad’ were 5.26 times more likely to report a chronic illness compared to those who rated their health as ‘fair’, ‘good’ or ‘very good’.

Demographic factors such as age, gender, employment and education as well as factors like being worried about debt or car ownership were also analysed in a separate model. However, none of these factors showed a significant link to being more likely to report having a chronic illness.

Appendix P Binary logistic regression model to identify factors associated with those reported to be on a waiting list for healthcare services in the Tallaght population 2024.

Factors	Total number	Reported number	Adjusted Odds Ratio (95% CI)	p-value
Being on a TUH waiting list in the last 12 months				
Yes	274	36	5.64 (2.04-15.58)	<0.001
No		233	1	
Chronic illness				
Yes	259	111	1.91 (1.01-3.62)	0.04
No		162	1	
Medical card				
Yes	274	96	1.95 (1.02-3.73)	0.04
No		178	1	
Put off healthcare due to cost				
Yes	269	85	3.85 (1.95-7.61)	<0.001
No		184	1	

Whole model X^2 (4) = 42.88; p<0.001

A binary logistic regression examined the factors associated with those reported to be on a waiting list for healthcare in Tallaght University Hospital. These factors were presented to be if an individual reported they had unmet healthcare needs in the past 12 months due to TUH waiting lists, if they had a chronic illness, used a medical card, and have put off healthcare due to cost. The model was highly significant [X^2 (4) = 42.88; p<0.001].

Factors that were linked with being on a waiting list for healthcare services were individuals with unmet healthcare needs due to TUH waiting lists, as individuals who reported such unmet needs were 5.64 times more likely to be on a waiting list for healthcare services, for those who did not report these needs. Those with chronic illnesses were 1.91 times more likely to be on a waiting list compared to those without a chronic illness, likely reflecting the higher demand for ongoing or specialised care. Similarly, individuals with a medical card were 1.91 times more likely to be on a waiting list compared to those without a medical card, possibly due to a greater accessibility for services with long wait times. Additionally, individuals who delayed healthcare due to cost were 3.85 times more likely to be on a waiting list compared to those who did not postpone care, highlighting how deferring treatment may ultimately increase the need for care and lead to longer wait times.[118] Other factors like self-rated health, smoking and age did not show a significant link to being on a waiting list.

Appendix Q Binary logistic regression model to identify factors associated with the reported use of Tallaght University Hospital Emergency Department in the past 12 months.

Factors	Total number	Reported number	Adjusted Odds Ratio (95% CI)	p-value
Highest level of education				**0.001**
Primary education or less	274	23	2.22 (0.61-8.16)	0.23
Junior or immediate certificate, technical or vocational training		46	4.65 (1.33-16.29)	0.02
Leaving certification,		56	6.26 (1.76-22.29)	0.005
A level and technical training				
Non diploma degree		54	1.96 (0.56-6.86)	0.29
Degree, professional qualification or both		70	0.85 (0.16-4.57)	0.85
Postgraduate qualification		25	1	
Experienced stress in the past 12 months				
Yes	272	189	2.38 (1.25-4.53)	0.009
No		83	1	
Chronic illness				
Yes	259	111	2.37 (1.36-4.14)	0.002
No		162	1	

Whole model X^2 (7) = 41.40; p<0.001.

A binary logistic regression examined the factors associated with the reported use of Tallaght University Hospital Emergency Department in the past 12 months. Factors associated were determined to be if they reported having unmet healthcare needs in the past 12 months due to TUH waiting lists, have experienced stress in the past 12 months and if they had a chronic illness. The model was highly statistically significant [Whole model X^2 (7) = 41.40; $p<0.001$.].

Factors linked to individuals using TUH Emergency Department in the past 12 months included those with reported lower levels of education. Specifically, individuals with junior or intermediate certificates, technical or vocational training were 4.65 times more likely to use TUH Emergency Department compared to those with a postgraduate qualification (the reference category). Those with a leaving certificate, A-level or technical training were 6.26 times more likely to use TUH Emergency Department than those with a postgraduate qualification.

Additionally, individuals who experienced stress in the past 12 months were 2.38 times more likely to report using TUH Emergency Department compared to those who did not experience stress. Similarly, those with a chronic illness were 2.37 times more likely to use the Emergency Department compared to individuals without a chronic illness.

Other education levels, such as primary education or less, non-diploma degrees, and degrees with professional qualifications did not show a statistically significant association with TUH Emergency Department use. Similarly, other factors such as gender, age, smoking habits, dental health or being cold in the home did not show a significant link to TUH Emergency Department use.

Appendix R Binary logistic regression model to identify factors associated with reported satisfaction on General Practice services.

Factors	Total number	Reported number	Adjusted Odds Ratio (95% CI)	p-value
Medical card				
Yes	274	96	2.27 (0.93-5.50)	0.07
No		178 1		
Highest level of education attained				**0.008**
Primary education or less	274	23	13.76 (2.45-77.38)	0.003
Junior or immediate certificate, technical or vocational training		46	4.11 (1.13-14.98)	0.03
Leaving certification,		56	9.59 (2.35-39.22)	0.002
A level and technical training				
Non degree qualification		54	2.67 (0.78-9.16)	0.12
Degree, professional qualification		70	4.27 (0.89-20.39)	0.06
Postgraduate qualification		25	1	
Put off healthcare due to cost				
Yes	269	85	2.90 (1.91-7.08)	0.01
No		184	1	

Whole model X^2 (7) = 28.22; p<0.001

A binary logistic regression examined the factors associated with reported satisfaction with General Practice services. The factors considered were whether the individual had a medical card, their highest level of education attained, and whether they had put off healthcare due to cost. The model was highly significant [Whole model X^2 (7) = 28.22; $p<0.001$].

Factors linked with reported satisfaction with General Practice services included having a medical card, education level and putting healthcare off due to cost. Individuals with a medical card were 2.27 times more likely to report satisfaction with GP services compared to those without a medical card, though this was not statistically significant. Education level was a strong predictor, with those having primary education or less being 13.76 times more likely to report satisfaction compared to those with a postgraduate qualification. Similarly, those with a junior or intermediate certificate, or technical/vocational training were 4.11 times more likely to report satisfaction, and individuals with a leaving certificate, A-level or equivalent technical training were 9.59 times more likely to report satisfaction.

Interestingly, those who put off healthcare due to cost were 2.90 times more to report satisfaction compared to those who did not delay healthcare due to cost. This could be because despite financial barriers, those who eventually sought healthcare found it necessary and led to a higher rating of satisfaction with the perceived level of care they received.[119]

Other education levels, such as non-degree qualifications or degrees with professional qualifications, showed increased likelihoods of satisfaction but were not statistically significant. Similarly, other factors such as age, gender, self-rated health, having unmet healthcare needs due to TUH waiting lists or being on a waiting list did not show a significant link to satisfaction with GP services.

Appendix S Binary logistic regression model to identify factors associated with the reported digital competency.

Factors	Total number	Reported number	Adjusted Odds Ratio (95% CI)	p-value
Age category of the respondent				**<0.001**
20-34	273	38	2.09 (0.41-10.56)	0.37
35-49		107	5.48 (1.12-26.84)	0.04
50-64		67	16.69 (3.09-69.92)	<0.001
65+		61	1	
Car ownership				
Yes	273	206	3.35 (1.63-6.86)	<0.001
No		68	1	
How many people live in the household?				
1 person	272	55	0.39 (0.19-0.84)	0.01
More than 1 persons		217	1	

Whole model X^2 (5) = 60.30; p<0.001

A binary logistic regression examined the factors associated with reported digital competency, including the age category of the respondent, car ownership, and the number of people living in the household. The model was highly significant [X^2 (5) = 60.30; $p < 0.001$].

Key findings include that older respondents (50-64 years old) were 5.5 times more likely to not be digitally literate compared to younger respondents. Respondents who were 65+ years were 14.7 times more likely to be digitally illiterate, highlighting a strong association between older respondents and digital illiteracy. Car ownership was another significant factor, with car owners being 3.35 times more likely to report a higher digital competency than non-car owners, suggesting a greater access or familiarity with technology. Additionally, individuals living alone were 0.39 times as likely to report digital competency compared to those living with others. Other factors such as age, marital status, self-rated health, years living in a household and occupational status did not show significant links to digital competency.