REGIONS & CITIES
European Week | Brussels
9-12 October 2017

SCOTTISH DIGITAL HEALTH & CARE WEEK
20 - 24 November 2017

European Innovation Partnership on Active and Healthy Ageing

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"MEETING THE CHALLENGE OF AGEING"

Co-funded by the Health Programme of the European Union

21 November 2017, Glasgow

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WELCOME & INTRODUCTIONS

DONNA HENDERSON

HEAD OF EUROPEAN ENGAGEMENT

NHS 24, SCOTLAND

Co-funded by the Health Programme of the European Union

Agenda

- **09.20 – 10.50 Keynote presentations**
  - "Reflecting on Europe" Initiative
  - Integrated care in Scotland
  - Integrated care – EC's Perspective
  - Self-assessment tool for integrated care
  - Assessment framework for integrated care
- 10.50 – 11.10 Coffee break
- **11.10 – 12.00 Snapshot presentations**
- **12.00 – 12.45 Spotlight Session – Moderated Discussion**
- 12.45 – 13.30 Lunch
- **13.30 – 15.00 Spotlight Sessions – Moderated Discussion**
- 15.00 – 15.20 Coffee break
- **15.20 – 16.05 Spotlight Session – Moderated Discussion**
- 16.05 – 16.30 Next steps: Twinning & Coaching
- 16.30 Close

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"REFLECTING ON EUROPE" INITIATIVE

CLLR CHRIS MCELENY

INVERCLYDE COUNCIL

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INTEGRATED CARE EUROPEAN COMMISSION'S PERSPECTIVE

FILIP DOMANSKI

DG SANTE

Co-funded by the Health Programme of the European Union

European Commission

INTEGRATED CARE – THE EUROPEAN COMMISSION'S PERSPECTIVE

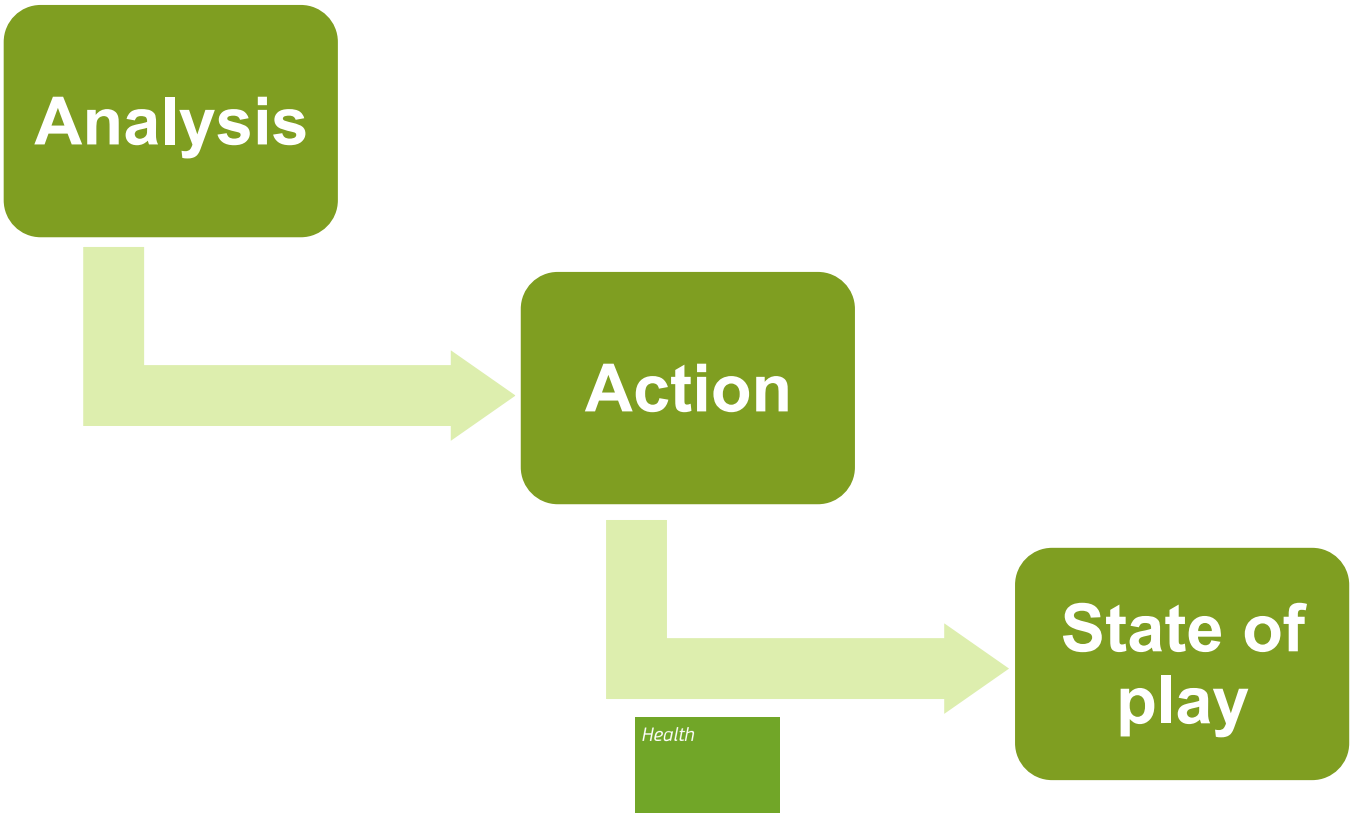
Filip DOMAŃSKI, DG SANTE

Glasgow, November 21st, 2017

Health

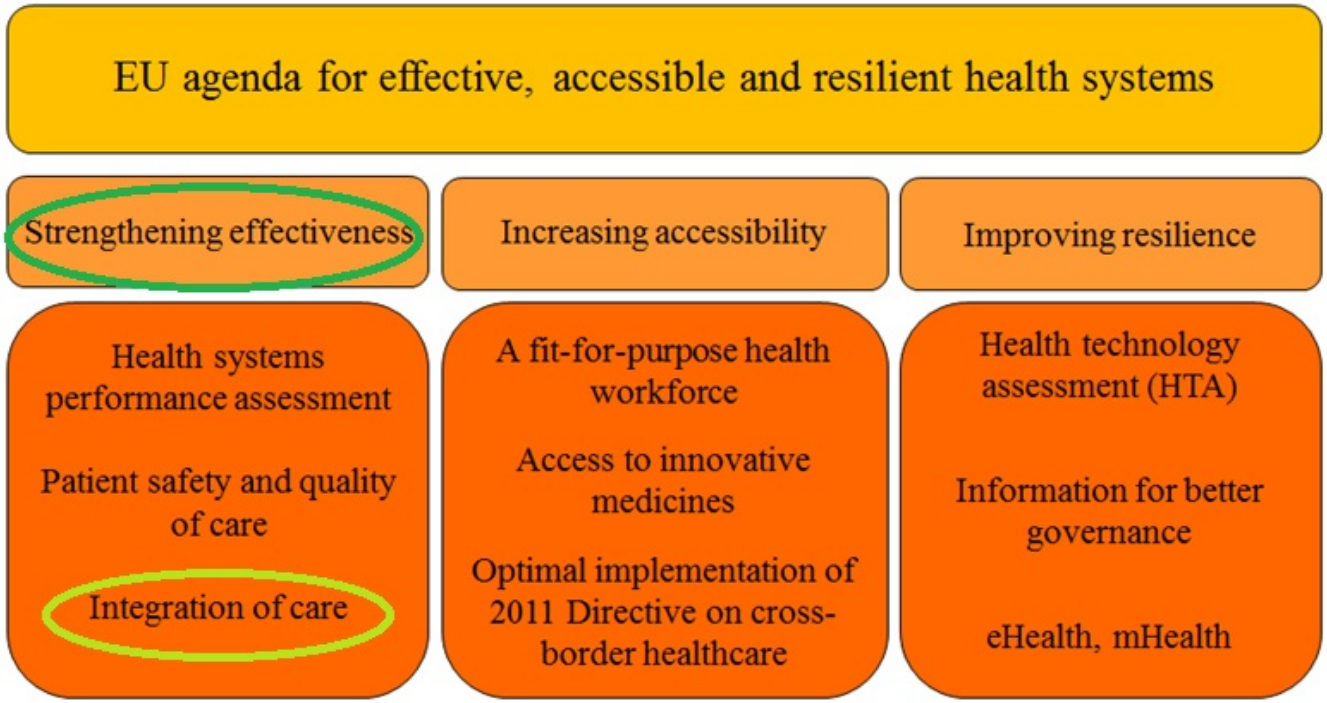
European Commission

INTEGRATED CARE – THE EUROPEAN COMMISSION'S PERSPECTIVE



European Commission

ANALYSIS – EC'S 2014 COMMUNICATION ON EFFECTIVE, ACCESSIBLE AND RESILIENT HEALTH SYSTEMS

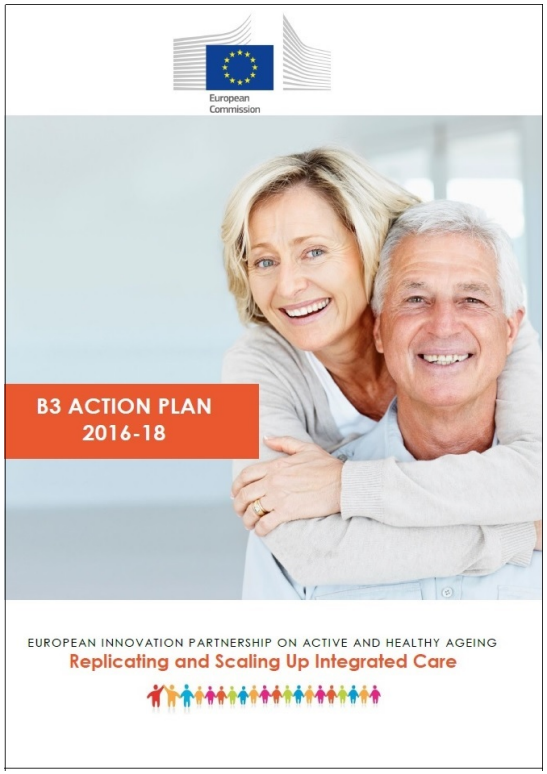


ANALYSIS – EC'S AND ECONOMIC POLICY COMMITTEE'S 2016 JOINT REPORT

Improving integrated care is perceived as an acute policy challenge in 17 EU Member States

European Commission

ACTION – EIP ON AHA AND HSPA EXPERT GROUP



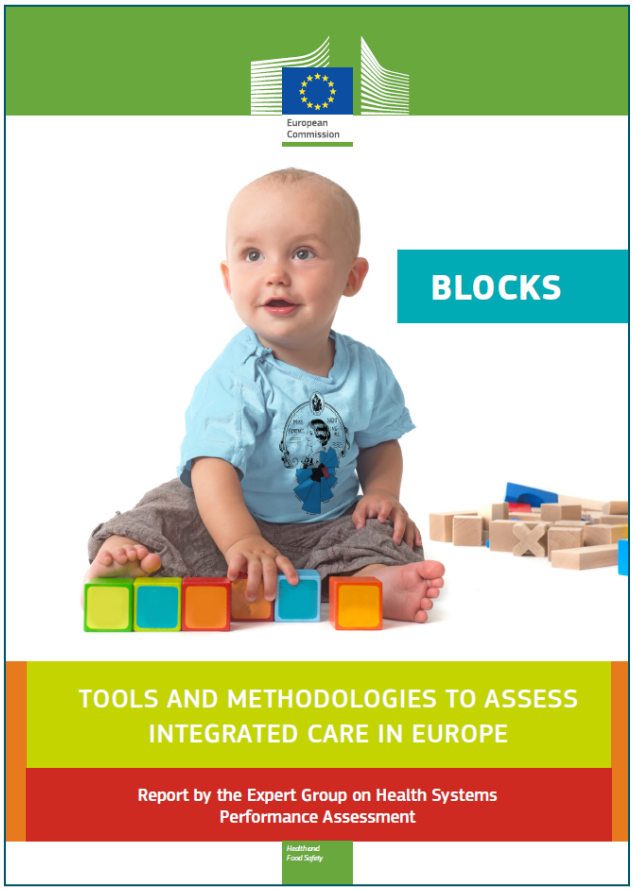
The Expert Group on Health Systems Performance Assessment

OECD WHO

European Observatory

European Observatory on Health Systems and Policies

ACTION – HSPA 2017 INTEGRATED CARE REPORT



1. Introduction
2. What do we mean by integrated care: theory, concepts and definitions
3. Building blocks, design principles and system levers for integrated care
4. Measuring the performance of integrated care
5. Conclusions

ACTION – INTEGRATED CARE ASSESSMENT STUDY

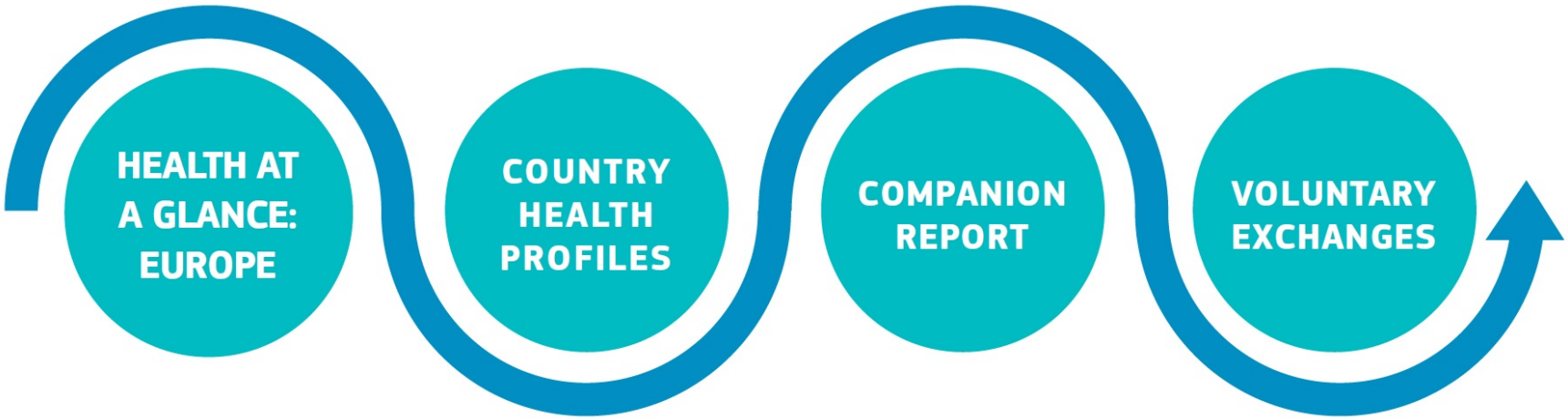
Some deliverables

- D. 3. **Mapping** of strategies and models of IC across the EU health systems (and Norway and Iceland) – **living document**
- D.11. **Assessment framework** model for integrated care – **1Q 2018**

European Commission

STATE OF PLAY – STATE OF HEALTH IN THE EU (SOH)

November 2016 November 2017 November 2017



STATE OF PLAY – SOH 2017 COMPANION REPORT

- To be published on **November 23rd, 2017**
- ec.europa.eu/health/state
- CHAPTER 3. *Integrating care for a sustainable and effective service*

Thank you

filip-michal.domanski@ec.europa.eu

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INTEGRATED CARE IN SCOTLAND

CHARLIE HOGG

SCOTTISH GOVERNMENT

Co-funded by the Health Programme of the European Union

Charlie Hogg

Directorate for Health and Social Care Integration

November 2017

Scottish Government
Riaghaltas na h-Alba
gov.scot

Health and Social Care Integration in Scotland

- Why is it happening?
- When did it start?
- What is it?
- Where is it happening?
- How is it working?

Scottish Government
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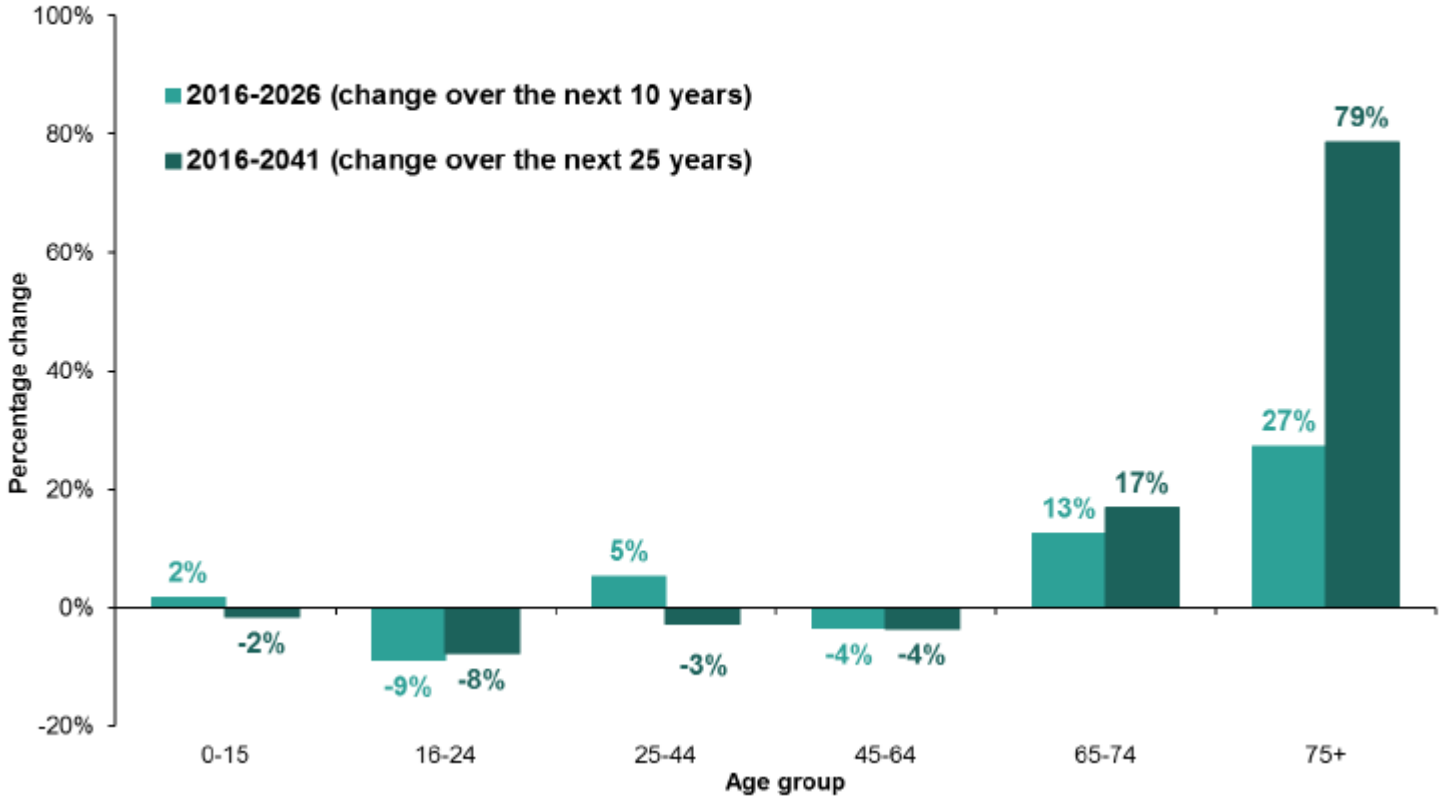
gov.scot

What is the challenge?

- As the population ages, the pressure on our health and social care system increases
  - People live longer, growing population
  - Increased prevalence of illness
  - New medicines and technologies
  - Challenges to family/ carer support
  - Inflation

National registers of Scotland
Projected Population of Scotland (2016-based)

Figure 7: The projected percentage change in Scotland's population by age group, 2016-2026 and 2016-2041



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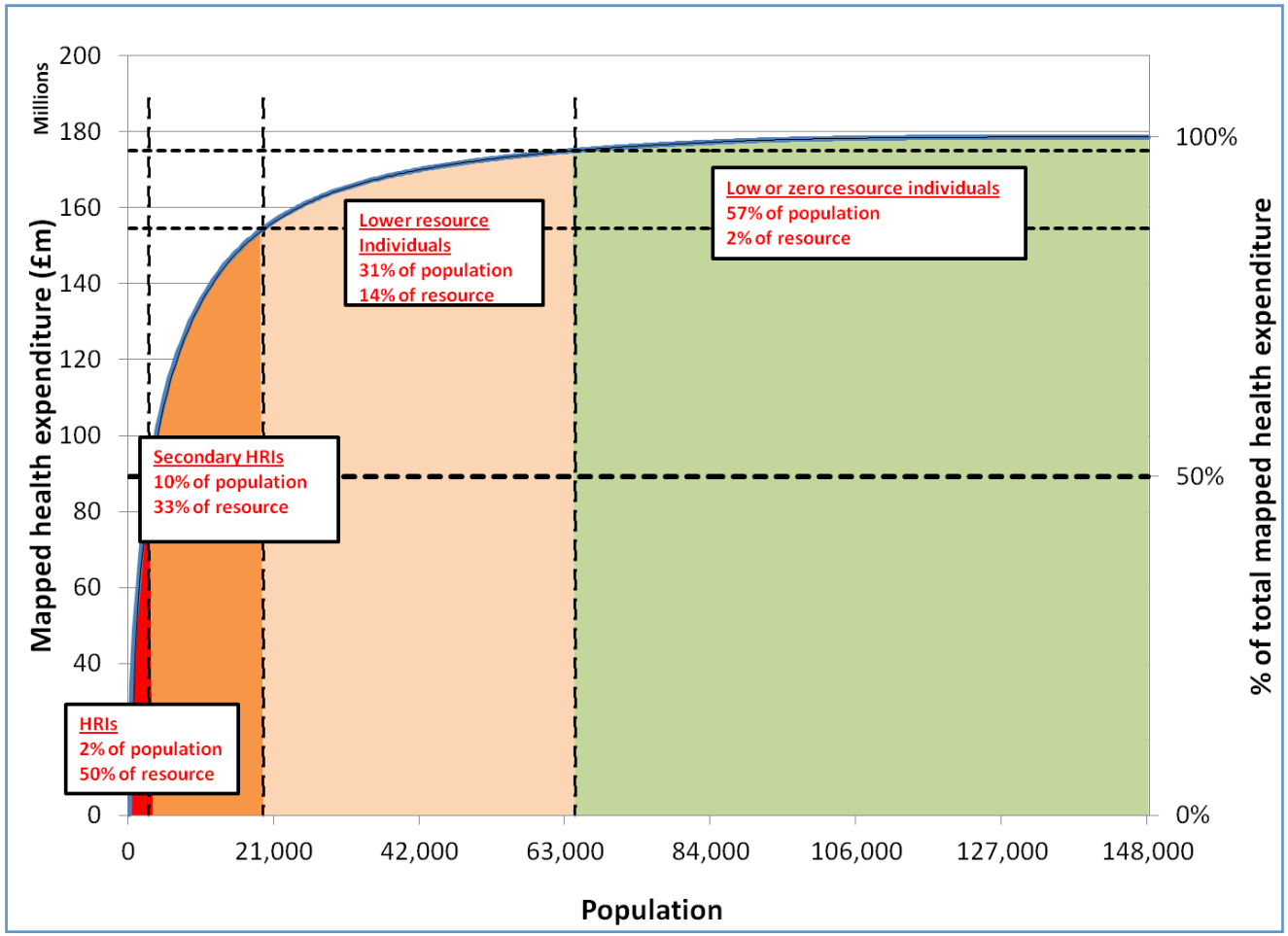
High Resource Individuals



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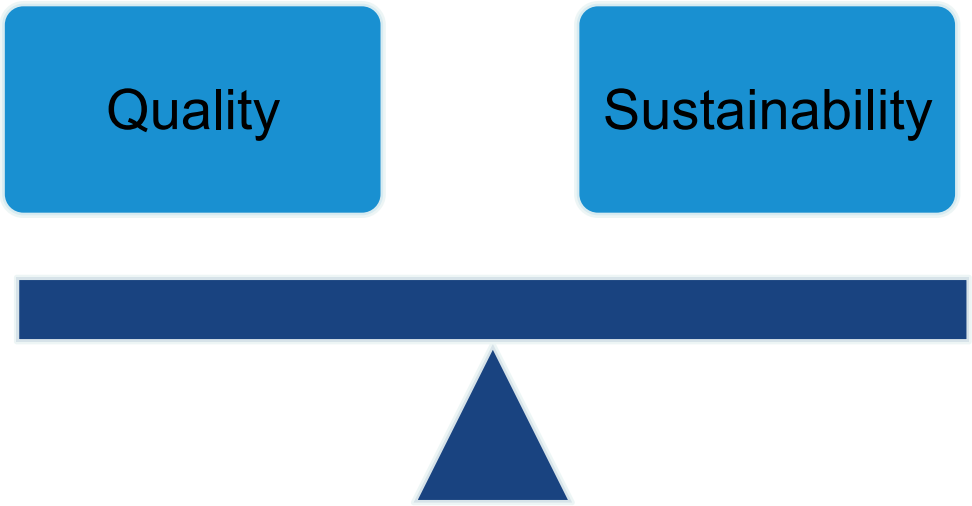
What is the challenge?



“The nature and scale of the challenges facing our NHS - in particular the challenge of an ageing population - mean that additional money alone will not equip it properly for the future.

To be blunt, if all we do is fund our NHS to deliver more of the same, it will not cope with the pressures it faces.

To really protect our NHS, we need to do more than just give it extra money - we need to use that money to deliver fundamental reform and change the way our NHS delivers care.”

John Swinney, DFM
Budget Speech, 12/15

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When did it begin?

- **Joint Futures programme 2000**
- **Community Care and Health (Scotland) Act 2002**
- **NHS Reform (Scotland) Act 2004**
- **Community Health Partnerships 2006**
- **Reshaping Care for Older People 2011**
- **Change Fund 2011-2015**
- **Public Bodies (Joint Working) (Scotland) Act 2014**

By 2020 everyone is able to live longer healthier lives at home, or in a homely setting

What can we do?

- Shift the balance of care from hospital to community
  - Preventing admissions
  - Elective and specialist quality and efficiency
  - Reduce demand across the system

What is integration? Principles of reform

- **Joint budget** – commissioning and service development across health and social care
- **Single point of accountability** for delivery of services – better coordination and responsiveness to local assets and priorities
- Bringing **statutory and non-statutory partners** together to maximise use of resources, skills and assets and plan and deliver services from the bottom up

Health and Social Care Integration

The Scottish Government
Riaghaltas na h-Alba

Supporting people to live well and independently at home or in a homely setting in their community for as long as possible

- www.scotland.gov.uk/HSCI
- follow us on twitter @scotgovIRC

There's no ward like home

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Commitment

"Let me be clear about the objectives of this programme of reform. We want to ensure that adult health and social care services are firmly integrated around the needs of individuals, their carers and other family members; that the providers of those services are held to account jointly and effectively for improved delivery; that services are underpinned by flexible, sustainable financial mechanisms that give priority to the needs of the people they serve rather than the needs of the organisations through which they are delivered; and that those arrangements are characterised by strong and consistent clinical and professional leadership."

Nicola Sturgeon, MSP, Deputy First Minister and Cabinet Secretary for Health and Wellbeing, December 2011

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Public Bodies (Joint Working) (Scotland) Act 2014

2014 asp 9

The Bill for this Act of the Scottish Parliament was passed by the Parliament on 25th February 2014 and received Royal Assent on 1st April 2014

An Act of the Scottish Parliament to make provision in relation to the carrying out of functions of local authorities and Health Boards; to make further provision about certain functions of public bodies; to make further provision in relation to certain functions under the National Health Service (Scotland) Act 1978; and for connected purposes.

PART 1

FUNCTIONS OF LOCAL AUTHORITIES AND HEALTH BOARDS

Integration schemes

1 Integration schemes: same local authority and Health Board area

(1) Subsection (2) applies where the area of a local authority is the same as the area of a Health Board.

(2) The local authority and the Health Board must jointly prepare an integration scheme for the area of the local authority.

(3) An integration scheme is a scheme setting out—

(a) which integration model mentioned in subsection (4) is to apply,

(b) the functions that are to be delegated in accordance with that model,

(c) where functions are to be delegated in accordance with the model mentioned in subsection (4)(b), (c) or (d), the functions of the person to whom functions are to be delegated which are to be carried out in conjunction with the delegated functions,

(d) in relation to any functions to which subsection (14) applies that are to be delegated, a method of determining amounts to be made available by the Health Board for use by the person to whom the functions are delegated in respect of those functions,

The Legislation

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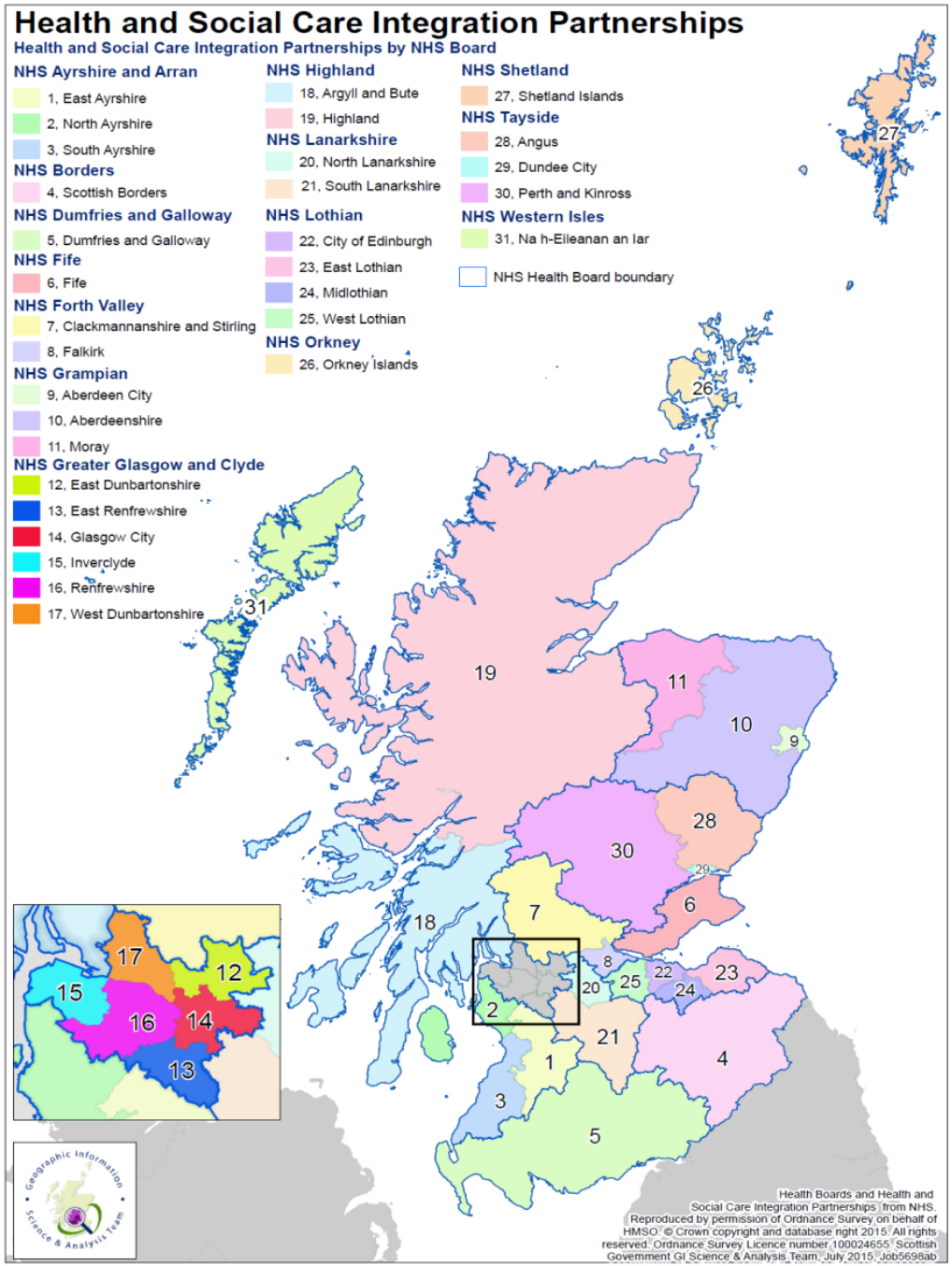
9 National Outcomes

- 9 statutory health and wellbeing outcomes
- Focus on outcomes for people, not performance targets focusing on the system
- Around health gain, maintaining normal life at home, wellbeing and safe.

Where is it happening?



- 31 Partnerships
- 30 Integration Joint Board and 1 Lead Agency Model (Highland)
- Differing levels of delegation to Integration Joint Boards

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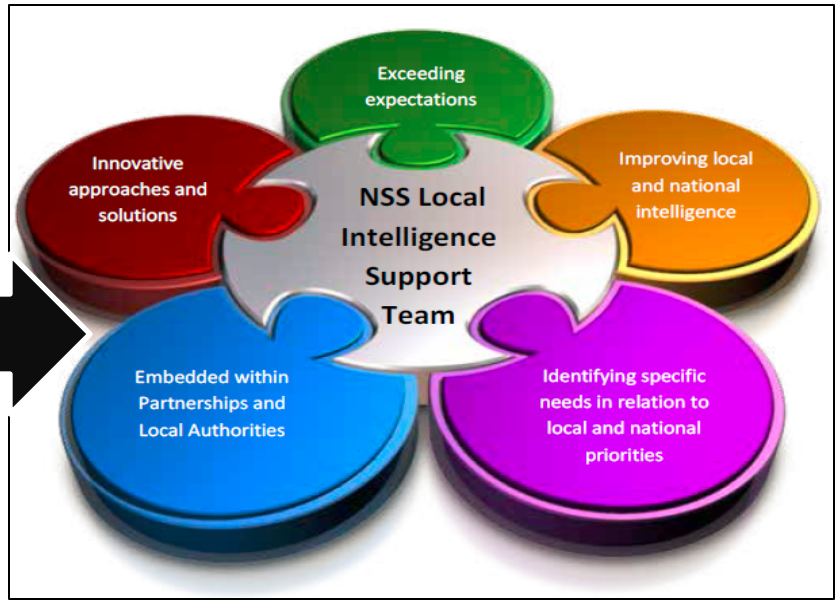
How is it working?

Source

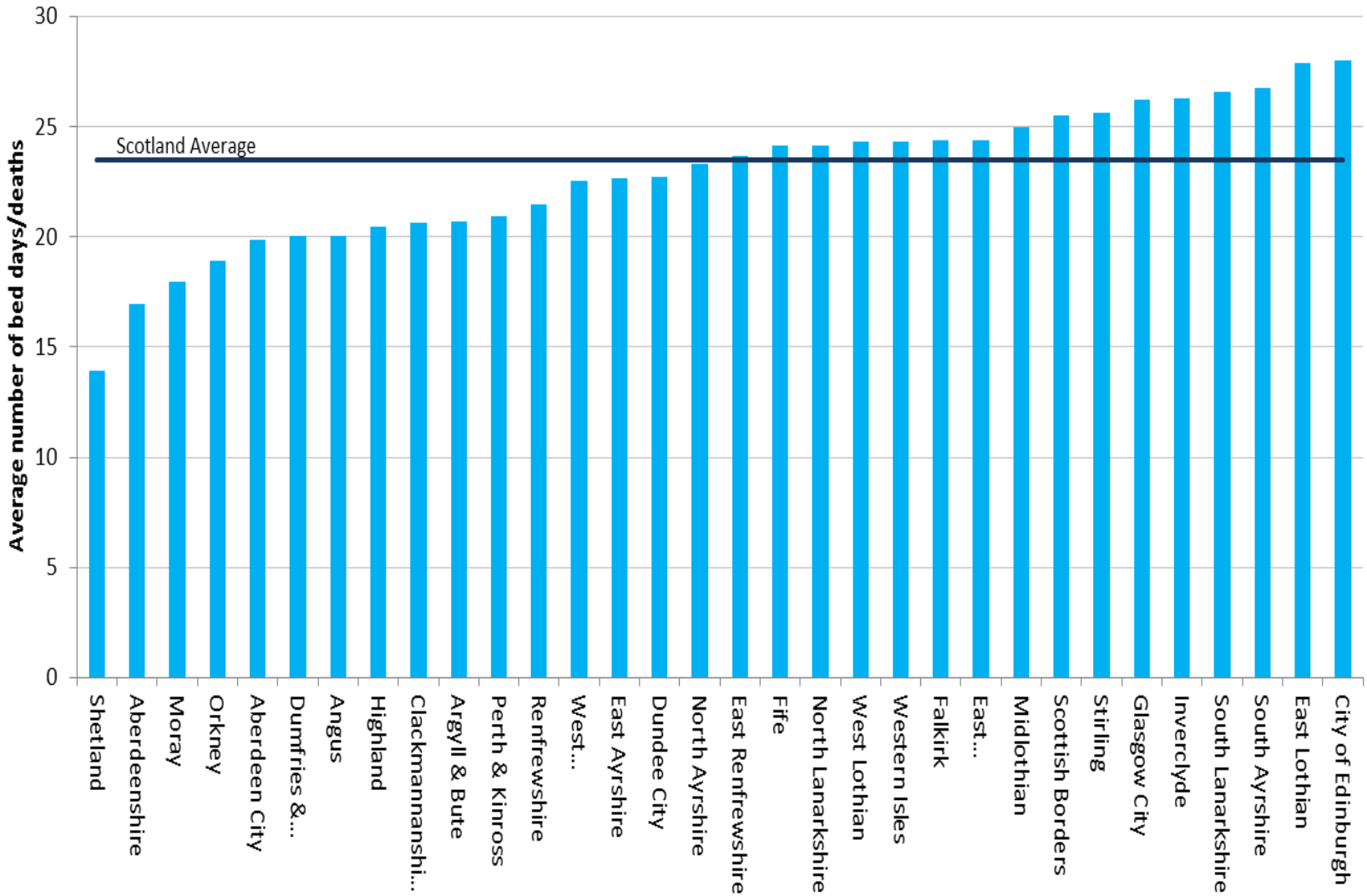
- Linked Health & Social Care File
- Outputs (Dashboards) & Pathways
- Social Care Collection
- IT Infrastructure
- Information Governance

LIST



- Resource Based Locally
- Access to Specialist Skills
- Be-spoke Analytical Support
- Support Local Priorities
- Share Skills, Knowledge & Expertise

Hospitalisation in last six months of life



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Reflections…

- Progress
- Challenges
- Opportunities

Guiding principle…

“. . . effective services must be designed with and for people and communities – not delivered ‘top down’ for administrative convenience”

The Christie Commission Report
Commission on the future delivery of public services, June 2011

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SELF-ASSESSMENT TOOL FOR INTEGRATED CARE

ANDREA PAVLICKOVA

NHS 24, SCOTLAND

Co-funded by the Health Programme of the European Union

Why SCIROCCO?

Challenges of scaling up:

- Systematic use of different types of evidence to maximise the use of existing knowledge and encourage exchange of good practices
- Understanding the context of scaling-up – features of the intervention need to "fit" into the context appropriately;
- Identification of transferable elements of good practice/ intervention for scaling-up;
- Flow of appropriate information between adopting and transferring entities

Lack of tools / frameworks that can help us to understand how to move towards more sustainable health and care systems; how to support implementation, scalability and transferability of integrated care solutions in Europe.

European Innovation Partnership on Active and Healthy Ageing

SCIROCCO Tool for Integrated Care

Development of SCIROCCO Tool

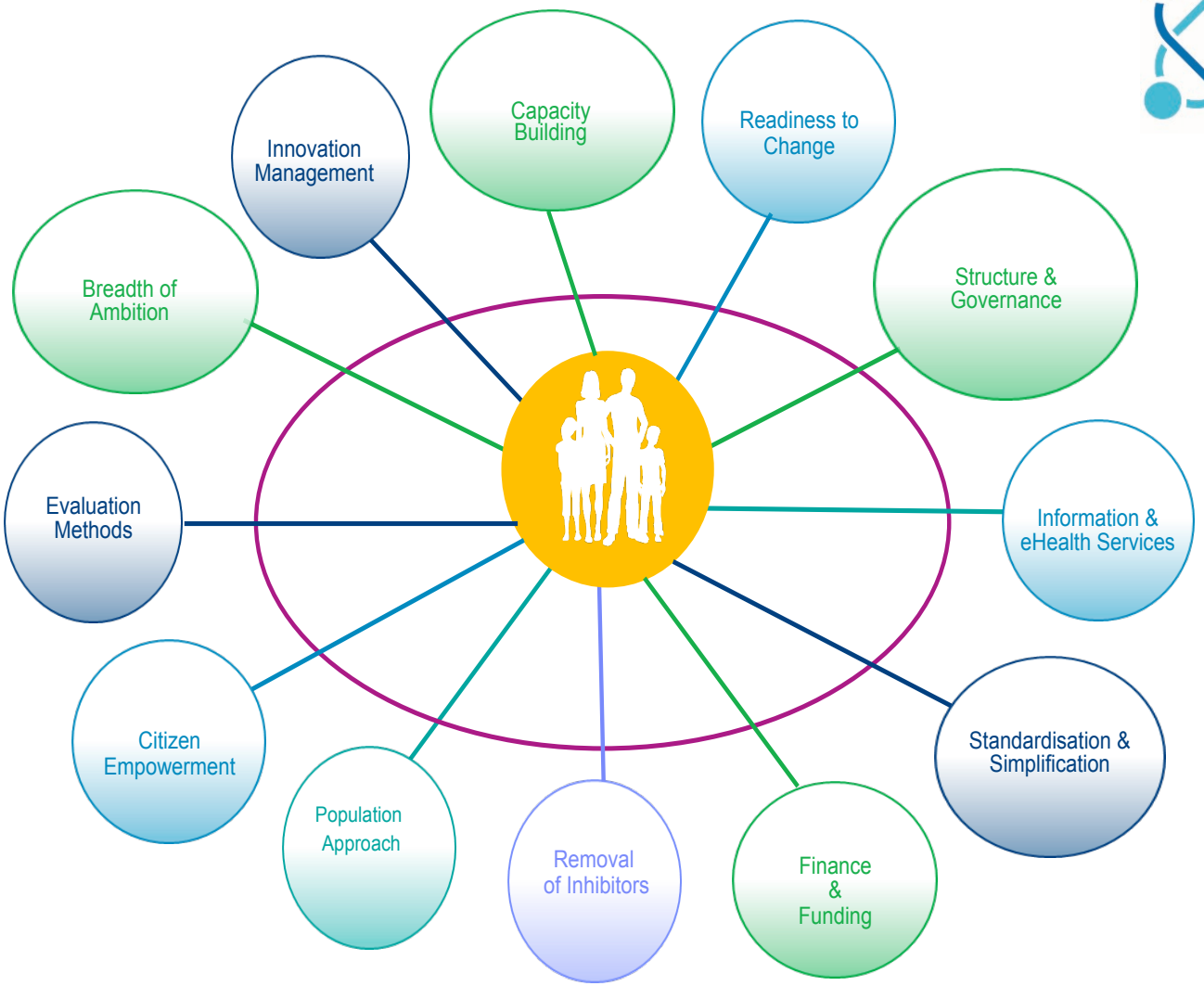
- Based on the **Maturity Model** developed by the Action Group on Integrated Care of EIP on AHA

European Innovation Partnership on Active and Healthy Ageing

- Eases the adoption of Integrated Care by:
  - Defining **Maturity** to adopt Integrated Care
  - Assessing the **Maturity** of Healthcare Systems
  - Assessing **Maturity Requirements** of Good Practices
  - Supporting Twinning and Coaching to transfer good practices

Development of SCIROCCO Tool

European Innovation Partnership on Active and Healthy Ageing



- Based on interviews with 12 European health & care systems
- 12 dimensions with explanatory narrative
- Each dimension is rated on a 0-5 scale;

Narratives

1. Readiness to Change (to enable more integrated care)

If the existing systems of care need to be re-designed to provide a more integrated set of services, this will require change across many levels, the creation of new roles, processes and working practices, and new systems to support information sharing and collaboration across care teams. This will be disruptive and may be viewed negatively by workers, press and public, so a clear case needs to be made for those changes, including a justification, a strategic plan, and a vision of better care.

- Creating a compelling vision, with a real sense of urgency, and enlisting stakeholder support including political leadership, management, care professionals, public and press.
- Accepting the reality that care systems are unsustainable and need to change.
- Publishing a clear description of the issues, the choices that need to be made, and the desired future state of the care systems, stating what will be the future experience of care.
- Creating a sense of urgency to ensure sustained focus, and building a ‘guiding coalition’ for change.

Rating Scale

1. Readiness to Change (to enable more integrated care)

0 – No acknowledgement of compelling need to change

1 – Compelling need is recognised, but no clear vision or strategic plan

2 – Dialogue and consensus-building underway; plan being developed

3 – Vision or plan embedded in policy; leaders and champions emerging

4 – Leadership, vision and plan clear to the general public; pressure for change

5 – Political consensus; public support; visible stakeholder engagement.

From Conceptual Model to an Online Self-Assessment Tool for Integrated Care

Scirocco
Scaling Integrated Care in Context

@ SCIROCCO_EU

Using the SCIROCCO Tool

http://scirocco-project-msa.inf.ed.ac.uk/login/

New Maturity Model Questionnaire

Please reply to all of the questions

Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q10 Q11 Q12

2. Structure & Governance * **Required**

- Fragmented structure and governance in place
- Recognition of the need for structural and gove
- Formation of task forces, alliances and other inf
- Governance established at a regional or nationa
- Roadmap for a change programme defined and
- Full, integrated programme established, with fu

If someone asked you to justify your rating here wh
short sentences):

How confident are you of your rating?

Who do you think could provide a more confident judgement?

Questionnaire name: *
ALEC DEMO

Save questionnaire

Q2. Structure and Governance: Objectives

The broad set of changes needed to deliver integrated care at a regional or national level presents a significant challenge. It needs multi-year programmes with excellent change management, funding and communications, and the power to influence and (sometimes) mandate new working practices. This means alignment of purpose across diverse organisations and professions, and the willingness to collaborate and put the interest of the overall care system above individual incentives. It also means managing the introduction of eHealth services to enable integrated care in a way that makes them easy to use, reliable, secure, and acceptable to care professionals and citizens alike.

- Enabling properly funded programmes, including a strong programme, project management and change management; establishing ICT or eHealth competence centres to support roll-out; distributed leadership, to reduce dependency on a single heroic leader; excellent communication of goals, progress and successes.
- Managing successful eHealth innovation within a properly funded, multi-year transformation programme.
- Establishing organisations with the mandate to select, develop and deliver eHealth services.

Ok

New Maturity Model Questionnaire

Your questionnaire was successfully saved

Q1 Q2 Q3 Q4 Q5 Q6 Q7 Q8 Q9 Q10 Q11 Q12

1. Readiness to Change (to enable more integrated care) *

- ○ No acknowledgement of compelling need to change
- ○ Compelling need is recognised, but no clear vision or strategic plan
- ○ Dialogue and consensus-building underway; plan being developed
- ○ Vision or plan embedded in policy; leaders and champions emerging
- ◉ Leadership, vision and plan clear to the general public; pressure for change
- ○ Political consensus; public support; visible stakeholder engagement

If someone asked you to justify your rating here what would you say (please provide a few short sentences):

There are policy documents in place, the minister is prepared to speak on this matter. However the organisations who will implement have not fully adopted the approach and it is patchily represented in their plans

How confident are you of your rating?

Moderately confident

Who do you think could provide a more confident judgement?

XXX who leads on Change Mar

Questionnaire name: *

ALEC DEMO

Update questionnaire

Planning for Self-assessment Process

1. Identification of regional/local stakeholders

Outcome: XY experts

2. Self-assessment survey

Outcome: Stakeholders' perceptions on current state of art in integrated care

3. Data collection/data analysis

Outcome: Spider diagrams – weakness and strengths in integrated care

4. Stakeholder workshops

Outcome: Consensus on spider diagrams

5. Summary of results and feedback on the process

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Scaling Integrated Care in Context

HOW CAN YOU BENEFIT?

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Tool to Assess Maturity Requirements of Good Practices

"Building Healthier & Happier Communities" – Scotland

"SCIROCCO tool has already proven its worth. It has helped facilitate round table discussions on evaluating our understanding of good practice development and also prompted focussed discussion on our perception of progress toward achieving strategic objectives around health and social care integration."

Ian Mathieson
Coordinator,
Health and Social Care

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Tool to Assess Maturity of the Healthcare System

"The SCIROCCO tool is useful to drive discussions during brainstorming: sometimes in meetings it is easy to miss the focus". It also provides a clear vision of the strengths and weaknesses of the regional context. If used properly, it is an extraordinary participatory policy tool."

Giovanni Gorgoni
CEO, Regional Strategic Agency for Health and Social Affair (AReSS Puglia)

STRENGTHS

WEAKNESSES

"The SCIROCCO tool could also be used in the validation of other regional policies, not just related to chronicity."

Social Welfare Regional Manager

Active Citizenship

"The SCIROCCO tool helps us to understand the level maturity of eHealth in our regions. It is also useful as it provides information on the different views of regional stakeholders and for the provider to better understand patient needs."

Tool to Facilitate Discussions & Negotiations Experience of the Basque Country

Decision Maker of the Basque Health Department

Hospital Nurse

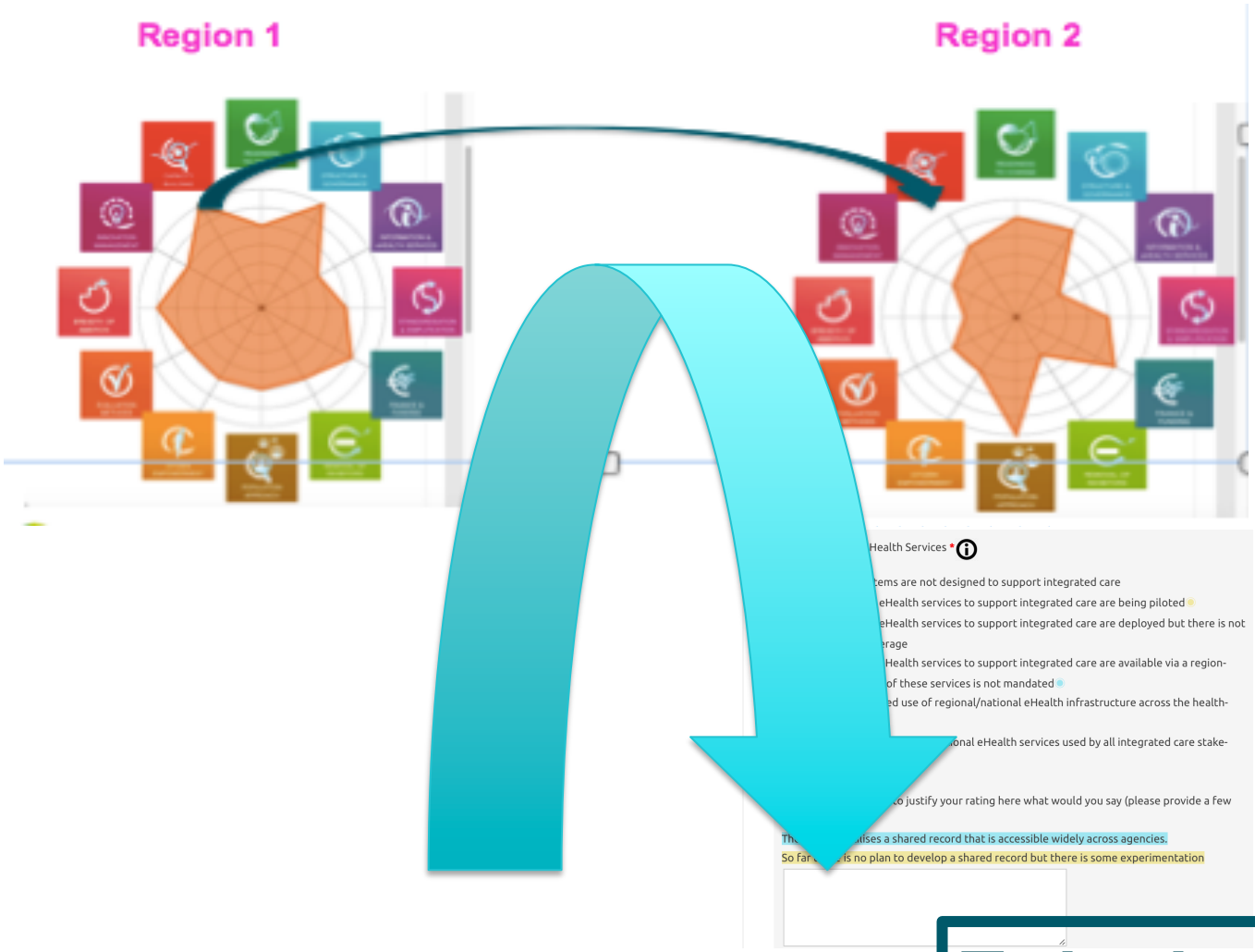
Social and Health Care Coordinator

BASQUE COUNTRY

"Aiming for an integrated care system, Osakidetza has moved towards a new organizational and management model. This has meant a cultural change for Osakidetza's professionals, whom have had to assume new roles and face new challenges. The SCIROCCO self-assessment process has allowed us to contrast opinions within a group of multidisciplinary colleagues, and review progresses in integrating health and care systems, making us better aware of where we are."

Rosa González, Integration and chronicity service of the General Directorate of Osakidetza

Next steps:
Comparing the regional context



Twinning & Coaching

Capturing the Experience of Stakeholders

Key Messages

- *"SCIROCCO tool is an effective tool to analyse the state of the art of the context. It enables **easy and quick detection of** areas of improvement, **gaps, and strengths**. It is a great tool to drive and **facilitates multidisciplinary discussions**" – Puglia region, Italy*

- *"This is a very valuable tool, useful for all stakeholders to reveal weaknesses and **orientate efforts to the most effective collaborations**" – Attica region, Greece*

- *" A good way to reflect **"where we are"** and a good basis for structured discussion on "**where we want to be**" – Norrbotten region, Sweden*

Key Messages

- *"This is **an easy to use model** that is understandable **to a broad spectrum of stakeholders** and beneficial for interregional and international comparison of integrated care" – Olomouc region, Czech Republic*

- *"SCIROCCO tool gives a clear list of aspirational goals to aspire to, **has allowed systematic consideration** and could also be considered for assessment at a local level" - Scotland*

SCIROCCO Engagement & Sustainability

European Innovation Partnership on Active and Healthy Ageing

euregha
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ACT @ Scale

smartcare

BeyondSilos

- Flanders, Belgium
- Catalonia, Spain
- Skane, Sweden
- Wales, UK
- Attica, Greece
- Saxony, Germany
- Iceland
- Lombardy, Italy
- Kaunas, Lithuania
- Netherlands
- Stawanger, Norway
- Lodz, Poland
- Region of South Denmark
- Asturias, Spain
- Northern Ireland, UK
- Amadora, Spain
- Gesundes Kinzigtal, Germany
- Murcia, Spain
- Valencia, Spain
- Extremadura, Spain
- Carinthia, Greece
- Badalona, Spain
- Sofia, Bulgaria
- Campania, Italy

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WE ARE INTERESTED TO HEAR FROM YOU!

www.scirocco.eu

Andreapavlickova@nhs.net

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ASSESSMENT FRAMEWORK MODEL FOR INTEGRATED CARE

HUGO SANT ANNA PEREIRA

OPTIMITY ADVISORS

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HEALTH SYSTEM PERFORMANCE ASSESSMENT

–

INTEGRATED CARE ASSESSMENT

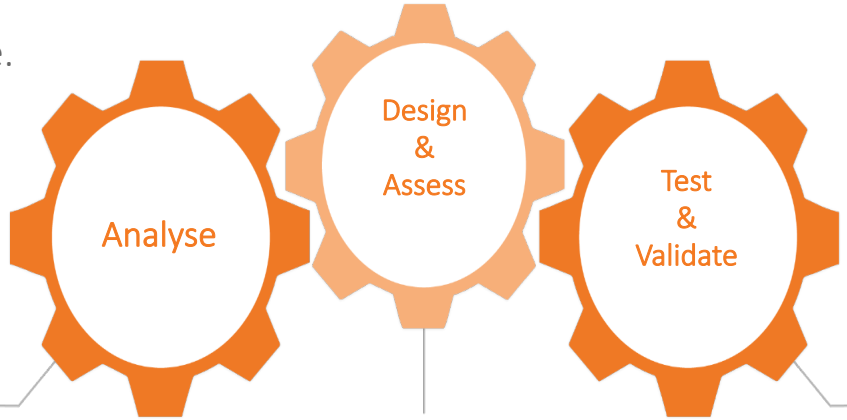
Meeting the challenge of ageing

Glasgow, 21 November 2017

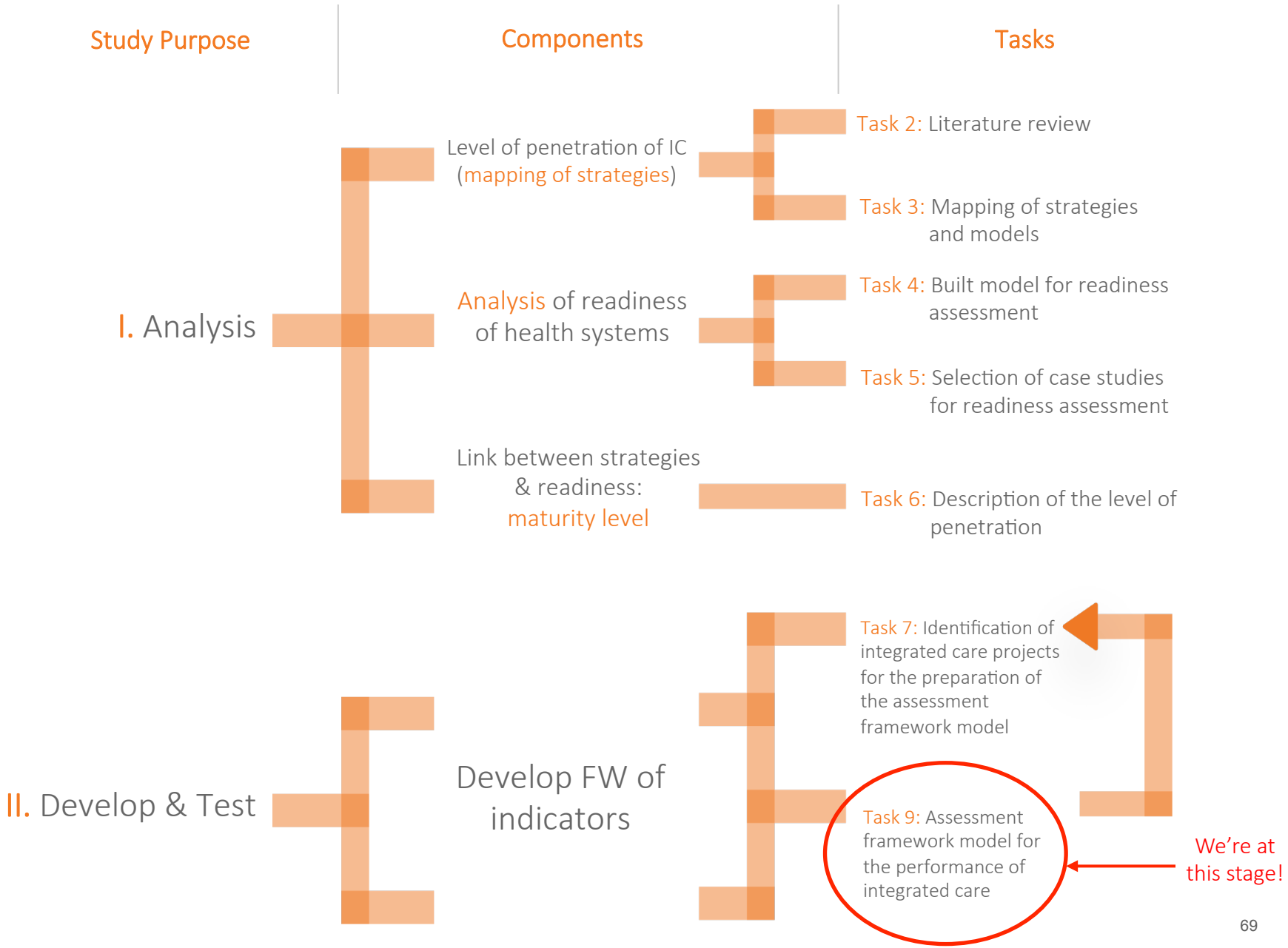
The study

The study, commissioned by Chafea and overseen by DG SANTE, has two main purposes:

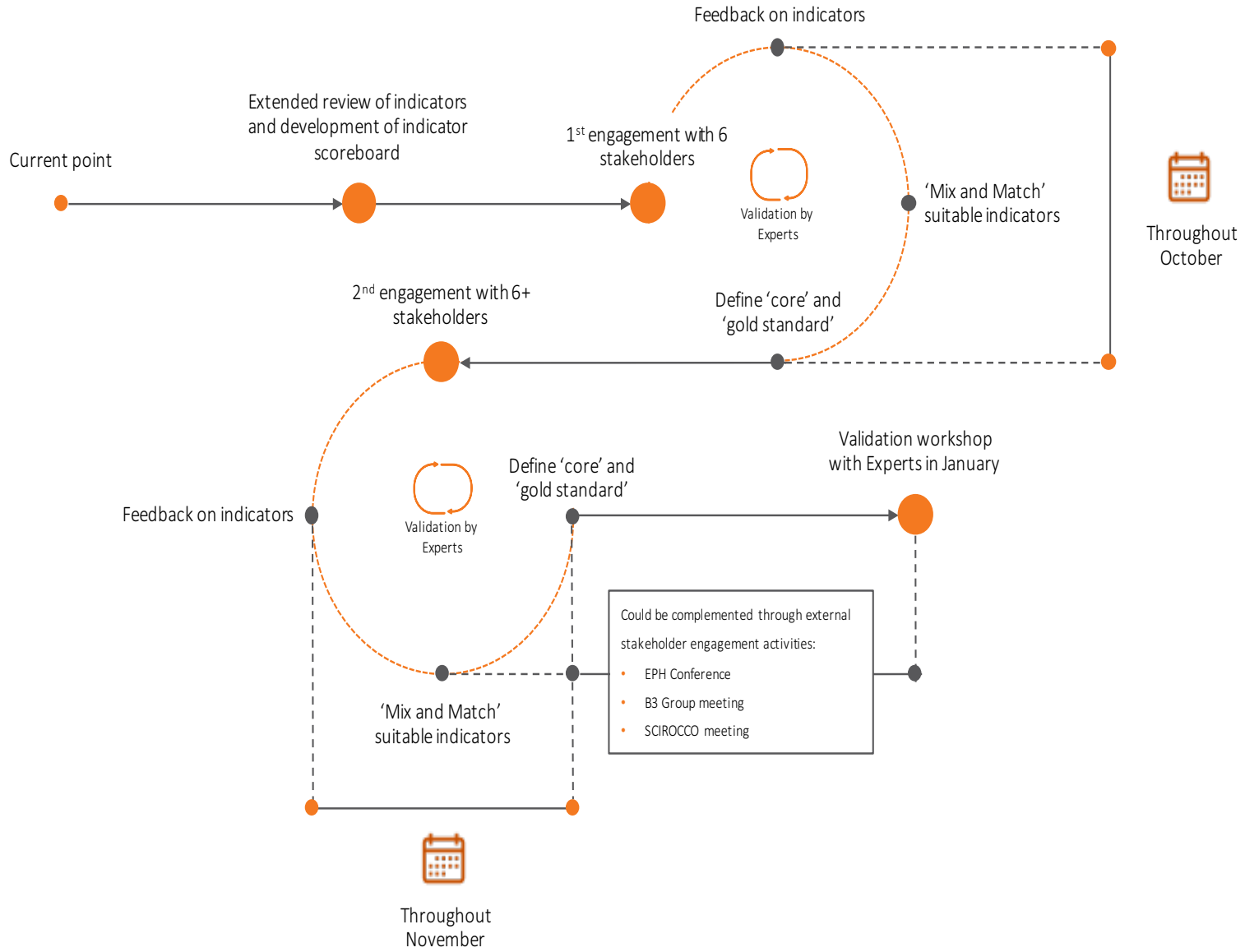
- Purpose 1: to review progress on integration of care at national and regional level, by:
  - Analysing the level of penetration or adoption of integrated care models in health systems; and
  - Analysing the readiness of health systems to successfully implement integrated care.
- Purpose 2: to propose and test a framework of indicators to assess the performance of integrated care.



Study design

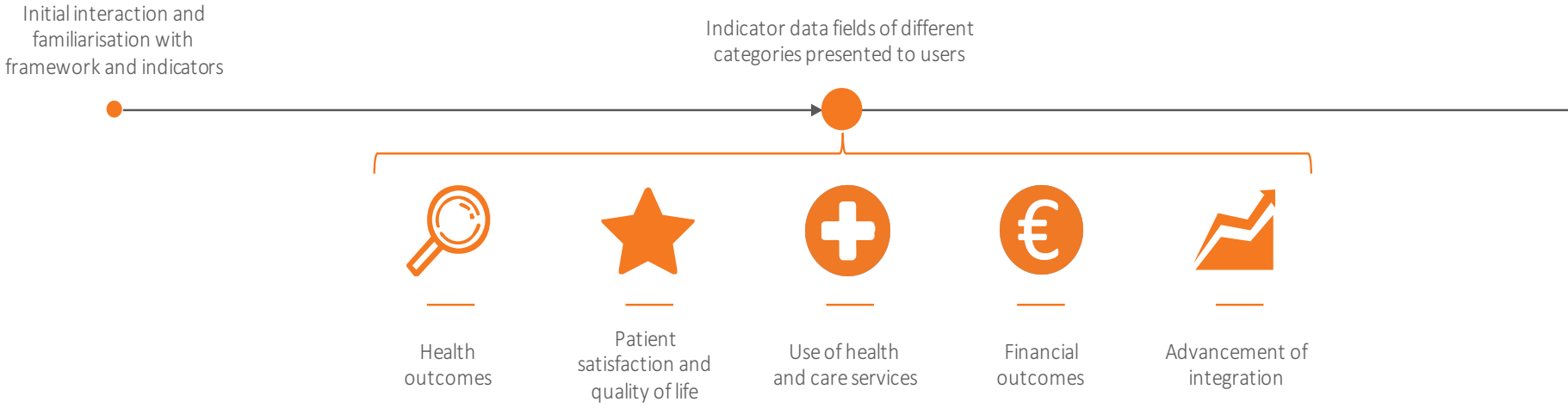


Approach to design of assessment framework model

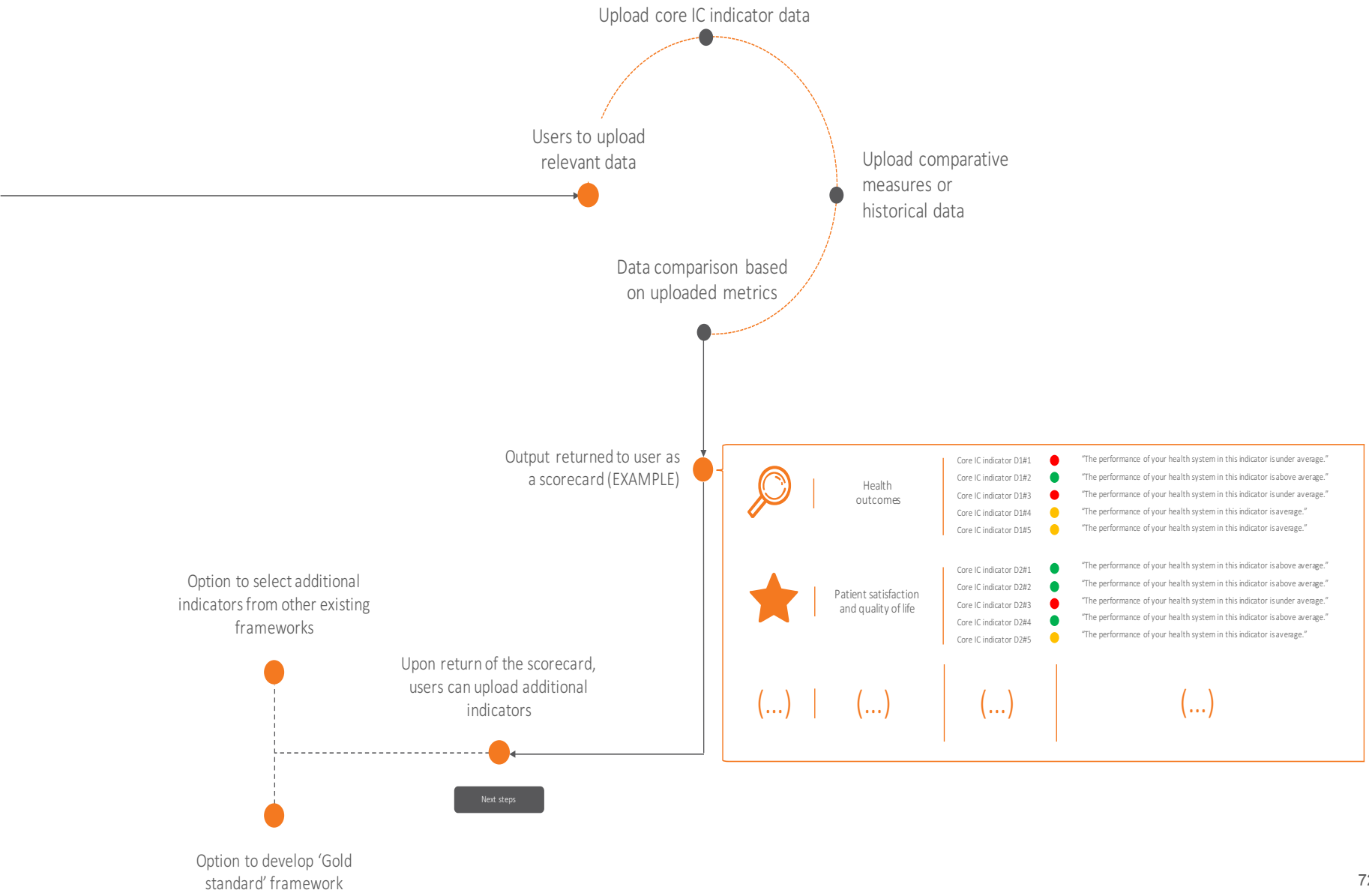


Assessment framework model – User Journey

- The design of the framework model is currently being carried out through engagements with several integrated care projects in Europe that have demonstrated excellence in implementing integrated care at local, regional or national level.
- Members of these projects are co-designing the assessment framework model together with our team and panel of experts. In this way, we envision that the model will reflect real performance assessment and data availability needs, sourced directly from health system managers and users.



Assessment framework model – User Journey



Collaborating with our study and Next steps

- Firstly, we would like to acknowledge the great support of several members of the European IC community, such as the B3 AG and the SCIROCCO project throughout the development of the study.
- We would also highly value any additional contributions from the wider integrated care community for the co-design of the IC performance assessment model.
- This would involve short virtual engagement(s) (e.g. phone or Skype or Yammer) with our team to jointly review and prioritise a series of data indicators around your performance assessment needs in the context of integrated care

Task 9 – Assessment framework model for integrated care	Design of a framework to assess the performance of integrated care models across Europe.	1st July – 30th November	Interact with the Study Team to assess if the integrated care indicators selected to date fulfil a set of Key Testing Criteria for inclusion in the final version of the framework.
Task 11 – Presentation of the findings at a workshop (January 2018)			
Task 13 – Submission of final report (March 2018)			

THANK YOU FOR YOUR VALUABLE TIME

Thank you for your valuable time.
For further information, please contact:

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COFFEE BREAK

10.50 – 11.10

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SNAPSHOT PRESENTATIONS ON EXPERIENCE OF EUROPEAN REGIONS WITH INTEGRATED CARE

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SELF-ASSESSMENT PROCESS IN FLANDERS REGION

SOLVEJG WALLYN
FLANDERS AGENCY FOR CARE AND HEALTH

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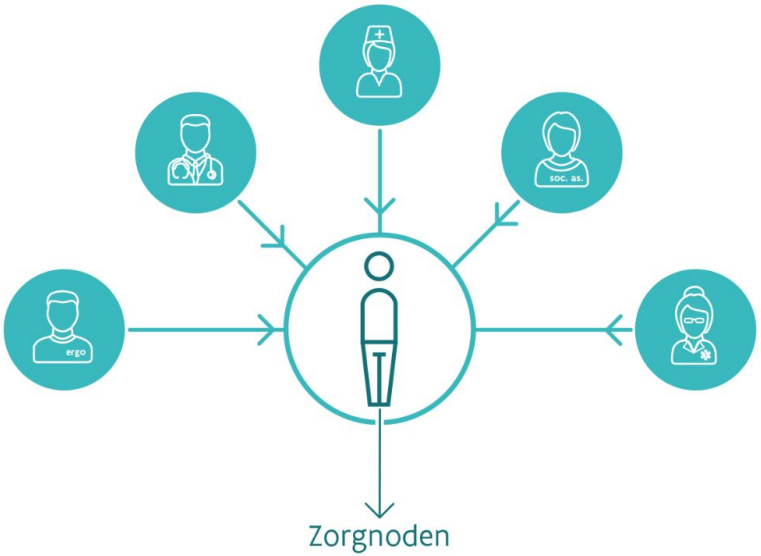
Healthcare System in Flanders - Belgium

- Reform of the Primary Care – 6th State Reform
- Complex situation: Belgium has 7 authorities responsible for health matters
- A Compulsory health care insurance
- Freedom of choice for patients (no gatekeeping)
- Therapeutic freedom and independency for physicians
- State controlled, executed by private not-for-profit
  - Majority of physicians are independent and self-employed
  - Majority of hospital are private and not-for-profit

Integrated Care in Flanders = Person with a care need at the centre



- Integrated approach
- Promote self-management and skills
- Carer as fully-fledged partner in the care
- Care aims via care plan
- More care in the neighbourhood
- Broad reception with information points
- Integration of prevention, mental health care, family care, residential care, social policy


READINESS TO CHANGE
STRUCTURE & GOVERNANCE
INFORMATION & eHEALTH SERVICES
STANDARDISATION & SIMPLIFICATION
FINANCE & FUNDING
REMOVAL OF INHIBITORS
POPULATION APPROACH
CITIZEN EMPOWERMENT
EVALUATION METHODS
BREADTH OF AMBITION
INNOVATION MANAGEMENT
CAPACITY BUILDING

Self-Assesment in Flanders “Outcomes”

Strengths

- Breadth of Ambition
- Readiness to Change

Weaknesses

- Population Approach
- Standardisation & Simplification

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SELF-ASSESSMENT PROCESS IN HUNGARY

ISABELLA NOTARANGELO
HOPE – EUROPEAN HOSPITAL AND HEALTHCARE FEDERATION
ICT4LIFE PROJECT

Co-funded by the Health Programme of the European Union

Healthcare System in Hungary

- Tax-funded universal healthcare system, organised by the state-owned National Health Insurance Fund
- Central Government responsible for social welfare and health care provision
- "Functional privatisation"

Health Expenditure	Hungary	EU28
THE as % of GDP	7.4%	9.4%
% of PHE on THE	65.9%	76.2%
THE per capita in PPP$	1,826.7	3,508.8

WHO - European Health For All Database, July 2017

Integrated Care in Hungary

Integration of care emerged as a response to the need **to bring care closer to patients' homes.**

It has several dimensions: **hospital and community**, **hospital care** and **primary care**, **health care** and **social care**.

The premise for integrated care is **to implement an effective ICT system** allowing providers **to share information** and **to work together**.

Institutions should collaborate closely and resources need to be co-ordinated by **multi-disciplinary teams***.

**HOPE Exchange Participants, 2016.*

Self - Assessment in Hungary – "Outcomes"

STRENGHTS

Structure & Governance (Rate 3)

Strategic Document released by the Central Government for 2013-2020, addressing resources for chronic patients and promoting more integrated system of care.

Standardisation & Simplification (Rate 2)

- IT infrastructure allowing the information exchange among HC providers;
- Integration of registries;
- eReferral, eReceipt
- HER repositories.

WEAKNESSES

Citizen Empowerment (Rate 0)

Citizens are not usually involved (directly or indirectly) in health policy issues.

Evaluation Method (Rate 0)

No data available on the level of integrated care services in place or in development but local differences may occur.

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AReSS
Agenzia Regionale per la Salute ed il Sociale Puglia

SELF-ASSESSMENT PROCESS IN PUGLIA REGION

Francesca Avolio
Raffaele Lagravinese

Co-funded by the Health Programme of the European Union

Puglia Region

- 4,1 millions population
- 40% Chronic patients
- 21% over 65yrs

Southern Italy

Healthcare System in Puglia

- In Puglia the healthcare system is mainly public. There are also private structures that contributes to the delivery of care cooperating formally with the public System so that citizens can access the service undergoing the same rules of the public services. In the recent two years the system is undergoing a complete reorganization. At the moment the service is organized as follow:

- 49 Districts gathered in 6 Local Health Authorities which includes 31 Integrated Health Community centers
- 5 second level hospitals (average 825 beds)16 first level hospitals (average 299 beds)12 basic hospitals (average 127 beds).
- The above listed hospitals includes 2 Hospital Trusts and 2 Research Hospitals.

1. COMPREHENSIVE HOSPITAL NETWORK

5

Second Level Hospitals

average

825 beds

1. COMPREHENSIVE HOSPITAL NETWORK

16

First Level Hospitals

average

299 beds

1. COMPREHENSIVE HOSPITAL NETWORK

12

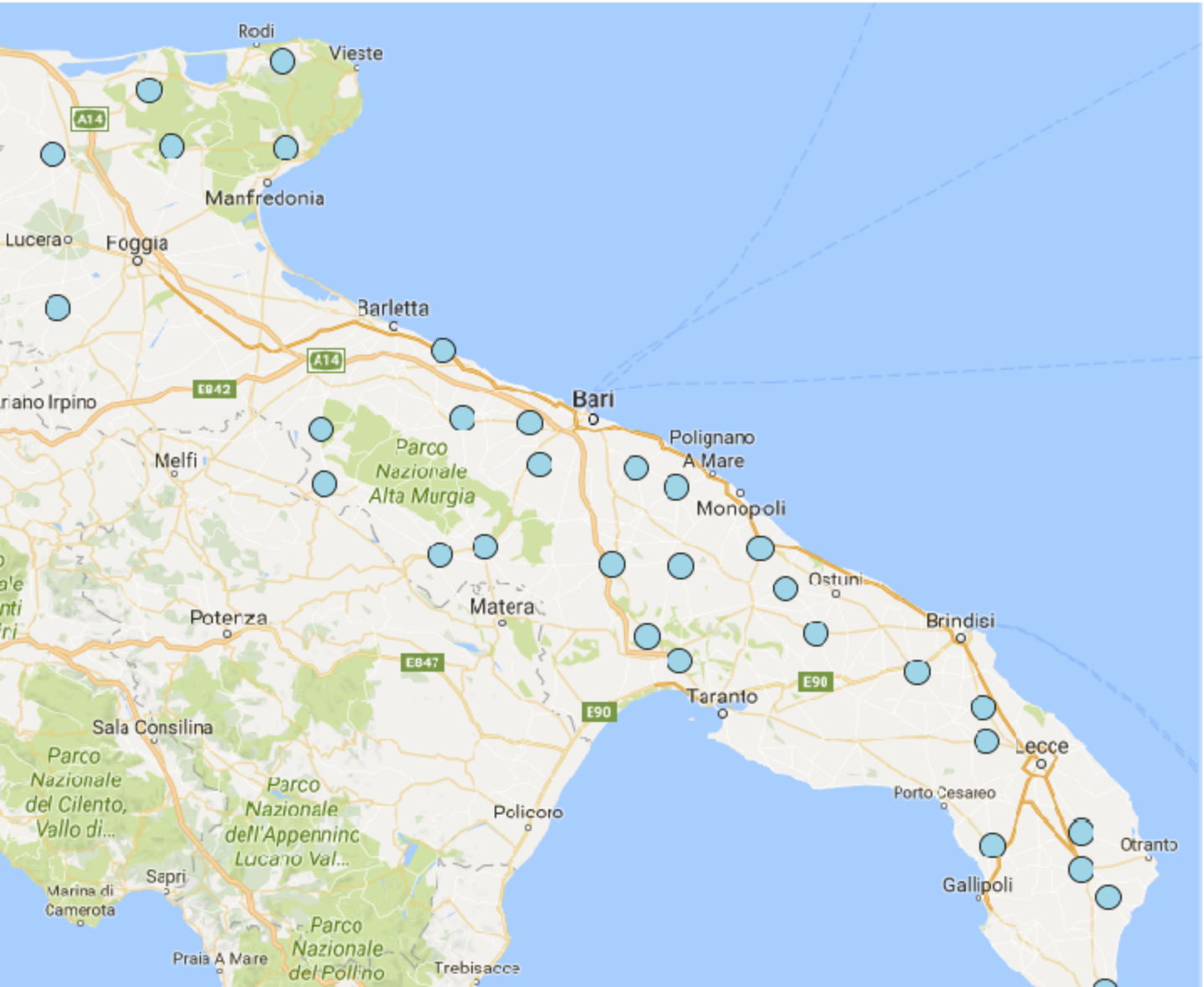
Basic

Hospitals

average

127 beds

2. INTEGRATED HEALTH COMMUNITY CENTERS (PTA)



- *31 PTA (Presidi Territoriali di Assistenza)*
- *Most of them once (2010 e 2016) were hospitals*
- *PTA is not a "box full of things"*
- *…but a center of integrated healthcare service*

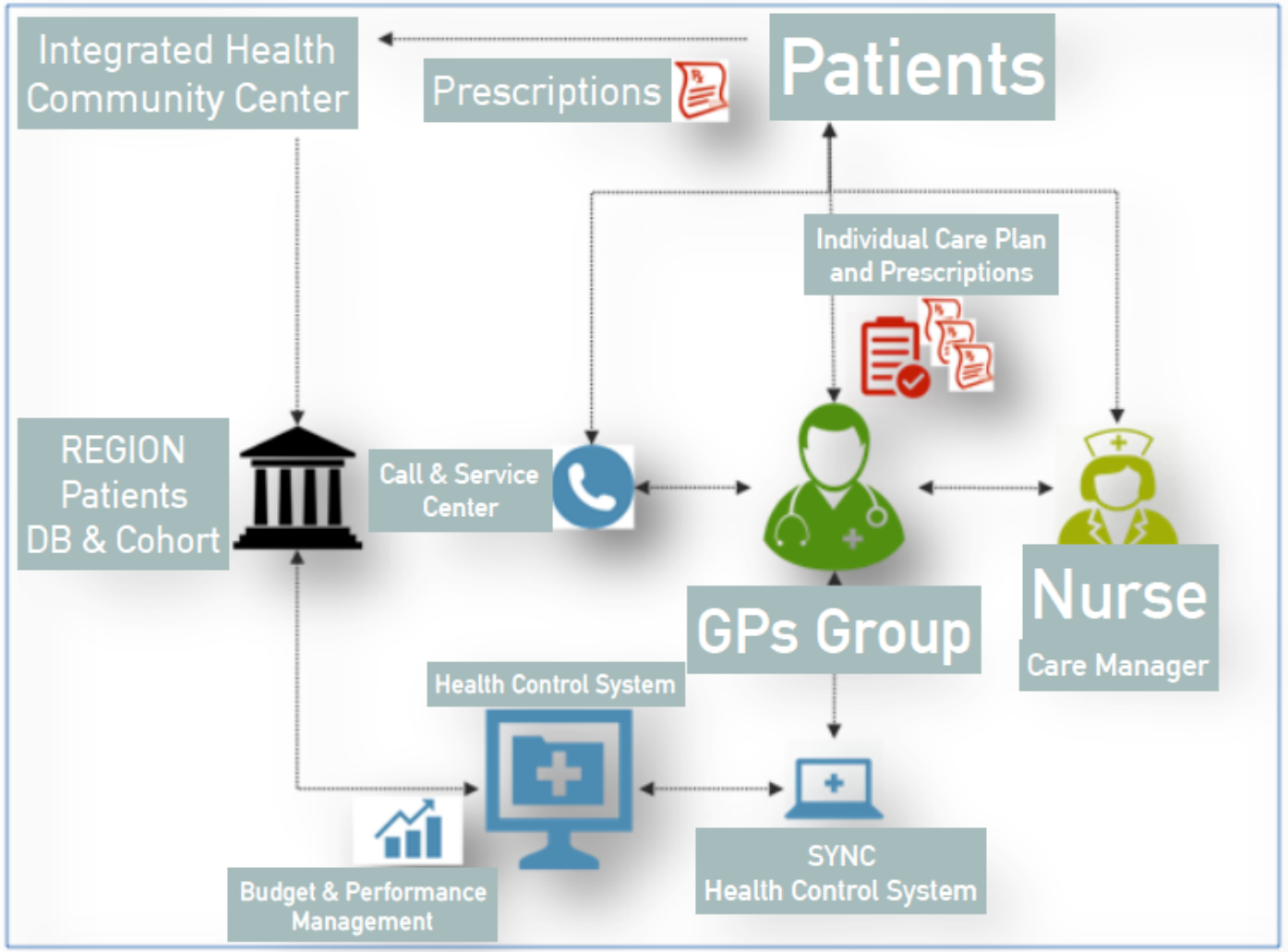
2. INTEGRATED HEALTH COMMUNITY CENTERS (PTA)

- *Patient Information and Orientation*
- *Primary Care and GPs associated*
- *Ambulatory Care and Outpatient Surgery*
- *Bioimaging and Diagnostics*
- *Dyalisis Center*
- *Prevention and Vaccination Services*
- *Rehabilitation Services and Accommodation*
- *Health Community Housing (hospice, disability, senior)*
- *Family Counselling and Maternal Services*
- *Psychiatric services and housing*

Integrated Care in Puglia

- Since 2004 Puglia started experimenting the introduction of Integrated Care Model to improve the disease and Care Management of chronic patients.
- The experimented model, which is now at its 3.0 revision, is based on the vertical integration among professionals , among different care settings(Hospital and Territory). I Implies the definition of specific Healthcare Pathways per pathology, promotion of Patients Empowerment, co-creation of Digital systems to support the delivery of care to citizens, facilitate communications among professionals for more effective disease and care management of Chronic Patients (see above picture), better control of resources, more appropriate care setting delivery.
- In Puglia Integrated Care concept the patient is not at the center of the care plan. The patient is actor of the decision about the personal care plan. The plan is tailored on patient needs as a result of a team work between Specialist, GP, Specialized nurse and care giver.

3. CARE PUGLIA FOR CHRONIC PATIENTS: THE MODEL



Self - Assessment in Puglia Region – "Outcomes"

Major strengths include building capacity, structure and governance, finance and funding, whereas citizen empowerment seemed to be a week point.

Puglia Context came out to be coherent with the **2 stars level of maturity stated by the EC when awarding Puglia Reference Site in the ElPonAHA**: Governance infrastructure in place, rightly oriented in priorities and funding

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ARESS Agenzia Regionale per la Salute ed il Sociale Puglia

Thank you!

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SELF-ASSESSMENT PROCESS IN ÎLE-DE-FRANCE

ISABELLA NOTARANGELO

HOPE – EUROPEAN HOSPITAL AND HEALTHCARE FEDERATION

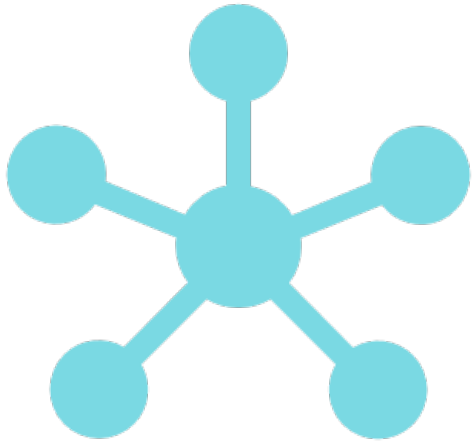
ICT4LIFE PROJECT

Co-funded by the Health Programme of the European Union

Healthcare System in France

- Universal healthcare system, based on SHI (Statutory Health Insurance)
- Jurisdiction of health policy and regulation of the health system divided among Central Government, SHI and ARS (planning & provision)
- Mixed provision of care: private for-profit/not-for profit & public hospitals; private/ independent providers
- "Third sector".

Health Expenditure	France	EU28
THE as % of GDP	11.5%	9.4%
% of PHE on THE	78.2%	76.2%
THE per capita in PPP$	4,508.1	3,508.8



WHO - European Health For All Database, July 2017

Integrated Care in Île-de-France

Integration of care emerged as a response to the need **to bring care closer to patients' homes.**

It has several dimensions: **hospital and community**, **hospital care** and **primary care**, **health care** and **social care**.

The premise for integrated care is **to implement an effective ICT system** allowing providers **to share information** and **to work together**.

Institutions should collaborate closely and resources need to be co-ordinated by **multi-disciplinary teams***.

**HOPE Exchange Participants, 2016.*

Self - Assessment in Île-de-France – "Outcomes"

STRENGHTS

Breadth of Ambition (Rate 3)

"*Territory of Digital Care*", funding programme of 80 Million Euro for 2014-2017 aimed at implementing tech solutions to support the patients and to strengthen coordination among professionals.

Innovation Management (Rate 3)

- National Strategy for Health: ICT as a lever to reach objectives;
- E-Health Strategy: development of tele-medicine solutions to ensure access to care for patients;
- National Strategic Committee of ICT in Health.

WEAKNESSES

Readiness to Change (Rate 2)

Two competing linkage models that failed to integrate social and health care services. The integration of health service provision requires changes across many levels. In Île-de-France such a shift can be triggered by national political engagement.

Population Approach (Rate 2)

Some initiatives have been introduced for prevention of myocardial infarction and pneumonia.

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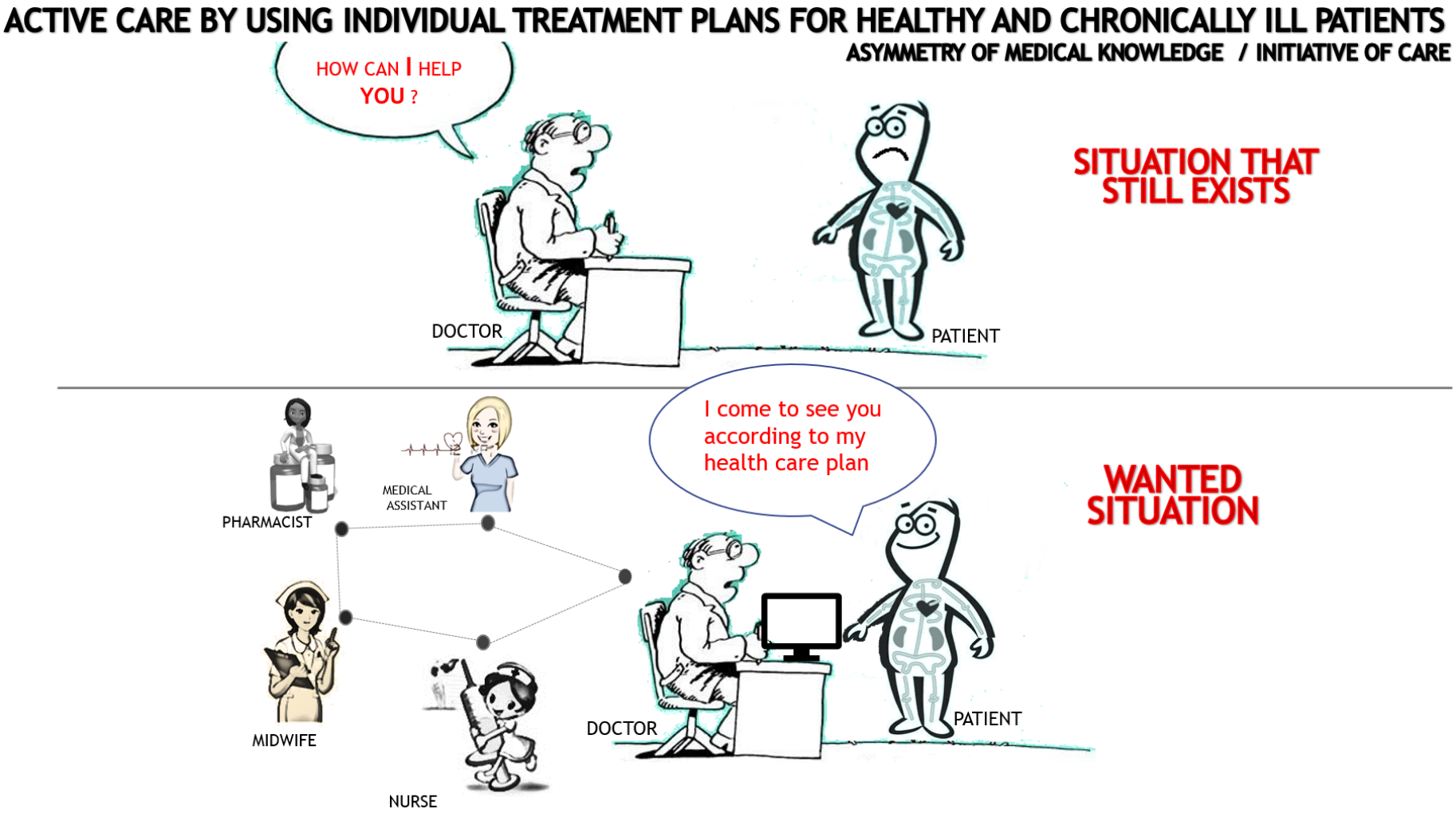
SELF-ASSESSMENT PROCESS IN EAST MAZOVIA REGION IN POLAND

MEDICAL & DIAGNOSTIC CENTRE SIEDLCE, POLAND

Co-funded by the Health Programme of the European Union

Healthcare System in East Mazovia, Poland



Integrated Care in East Mazovia, Poland

MDC approach:

Fullfill (80%) healthcare needs at PHC level in collaboration with core medical specialists:

-cardiologist,

-diabetologist,

-neurologist,

-pulmonologist,

-endocrinologist,

as well as psychologists, dieteticians, educators and physioterapists by

- Emphasizing preventive medicine and changing lifestyle
- Chronic disease managing, including enhancing self- control and self-management

Self - Assessment in East Mazovia Region – "Outcomes"

AREAS OF STRENGTHS

- Readiness to change
- Removal of inhibitors

AREAS OF WEAKNESSES

- ICT & eHealth Services
- Evaluation methods

Self - Assessment in East Mazovia Region vs Medical & Diagnostic Centre

East Mazovia Region

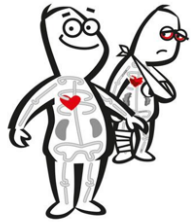
Medical & Diagnostic Centre

Medical & Diagnostic Centre – two models of care at PHC level

ACTIVE CARE IN MDC IS DIRECTED TO:

HEALTHY PATIENT

- CHECKUPS FOR ADULTS
- PREVENTIVE MEDICINE

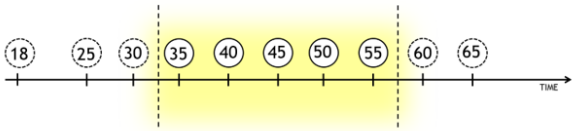


CHRONICALLY ILL PATIENT

- DYSPANSERY GROUPS
- TREATMENT PLANS

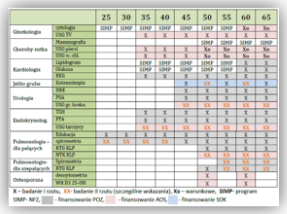
2 MODELS OF CARE IN MDC

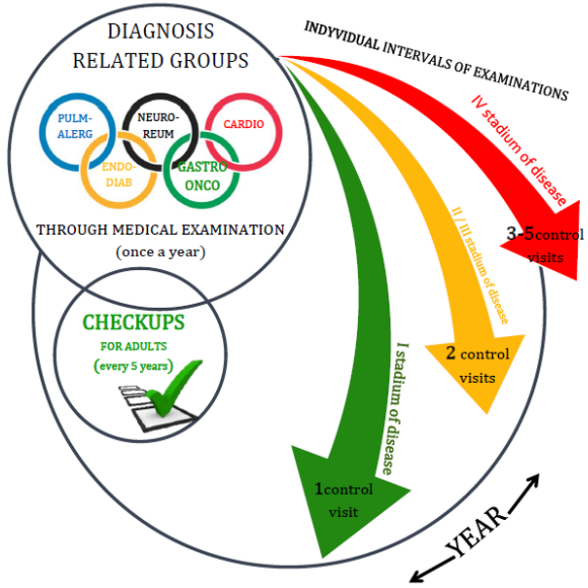
- **TARGET GROUP OF PATIENTS**



- **QUESTIONNAIRE QUALIFING TO CERTAIN DIAGNOSTICS**

- **DIAGNOSTIC PACKEGES**





Medical & Diagnostic Centre – stratification at PHC level

Status as a helpful element for creating the ITPC

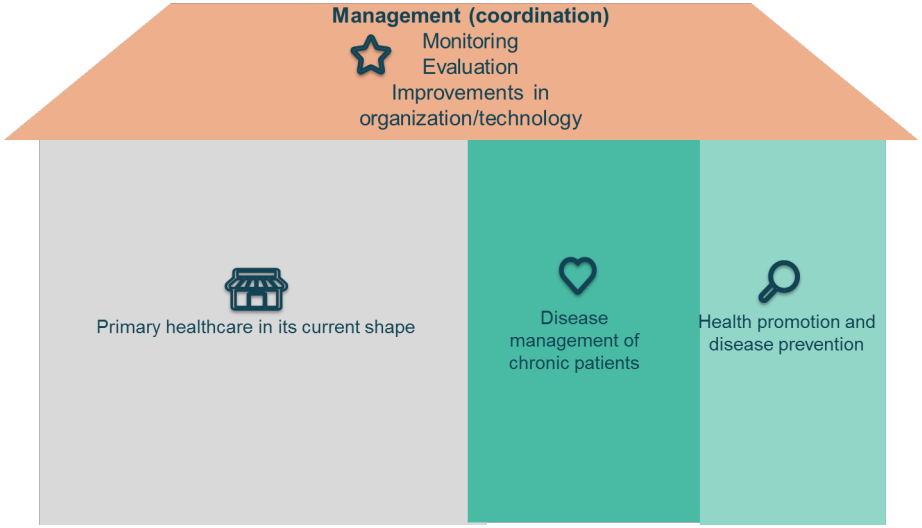
	**GROUP 0**	-	Initial state, before assessing the final stratification group	
	**GROUP I**	HEALTHY PATIENT	Patient with no diagnosis of chronic disease	Every 5 years- **HEALTH CHECKUPS**
	**GROUP II**	CHRONIC PATIENT	Patient with stable condition	**2 visits/year** – 1 general/ main + 1 control every 6 months
	**GROUP III**		Patient with stable condition but needs periodic control visits	**3 visits/year** – 1 general/main + 2 controls every 4 months
	**GROUP IV**		Patient unstable, needs frequent and intense care	**4-5 visits/year** – 1 general/main + 3-4 controls every 3 months
	**GROUP V**		Patient unstable, staying in bed, under home treatment	

MDC MODELS OF CARE CONCEPTS WERE USED IN COORDINATED CARE MODEL FOR POLAND PHC+

Project co- financed by European Union from the European social fund elaborated together with **the Ministry of Health, NHF and the World Bank**

CORE OBJECTIVES:

- Coordination the healthcare over patient
- Health Checkups for adults
- Chronic disease management
- Population stratification



IMPLEMENTATION:

- START in January 2018
- 45 providers
- over 300 thous. PHC patients

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MEDICAL & DIAGNOSTIC CENTRE

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SELF-ASSESSMENT PROCESS IN REGION OF SOUTH DENMARK

CLAUS DUEDAL PEDERSEN
ODENSE UNIVERSITY HOSPITAL, SOUTH DENMARK

Co-funded by
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Healthcare System in Region of Southern Denmark

- The basis for the assessment in RSD was the eHealth ecosystem covering all hospitals in the Region.
- All hospital have a the same fully implemented EMR with integration of all relevant clinical specialised systems like lab, RIS, PACS and workflow management.

Integrated Care in RSD

- The integrated care in RSD builds on two components:
  - A complex of political agreements between the region and the municipalities about division of work and responsibilities between the sectors. This is supported by clinical pathways and electronical communication.
  - A shard care platform for chronic patients that gives hospitals, GP´s, Homecare and patients access to the most relevant common data

Self - Assessment in Region of South Denmark - “Outcomes”

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SELF-ASSESSMENT PROCESS IN THE BASQUE COUNTRY

IGOR ZABALA
OSAKIDETZA

Co-funded by the Health Programme of the European Union

Healthcare System in the Basque Country

- Population: 2,17M
- Financed by taxes: 3.422M€ in 2016
- Universal Healthcare coverage
- Healthcare providers
  - Basque Public Health Service-Osakidetza
    - 13 Integrated Care Organisations
    - 2 Sub-acute Hospitals
    - 3 Mental Health Nets
    - +30.000 Healthcare professionals

Integrated Care in the Basque Country

- **Integrated Care Organisation (ICO)**
  - To achieve less fragmented, more coordinated, more efficient and higher quality care

- **Integrated care is based on three pillars:**
  - Integrative governance
    - Create synergies between different levels of care
  - Population approach
    - Coordination with social and public health actors
  - Culture and values
    - Change from the culture of fragmentation to a culture of integration

Self - Assessment in The Basque Country "Outcomes"

Areas of strengths

Areas of weaknesses

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SPOTLIGHT ON MATURITY
DIMENSIONS OF INTEGRATED CARE

12.00 – 12.45

Co-funded by the Health Programme of the European Union

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POPULATION APPROACH CITIZEN EMPOWERMENT EVALUATION METHODS

ESTEBAN DE MANUEL KEENOY
KRONIKGUNE

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of the European Union

Integrated care can be developed to benefit those citizens who are not thriving under existing systems of care, in order to help them manage their health and care needs in a better way, and to avoid emergency calls and hospital admissions and reduce hospital stays. This is a practical response to meeting today's demands. Population health goes beyond this, and uses methods to understand where future health risk (and so, demand) will come from. It offers ways to act ahead of time, to predict and anticipate, so that citizens can maintain their health for longer and be less dependent on care services as they age.

Assessment scale

0 – Population health approach is not applied to the provision of integrated care services

1 – A population risk approach is applied to integrated care services but not yet systematically or to the full population

2 – Risk stratification is used systematically for certain parts of the population (e.g. high-use categories)

3 – Group risk stratification for those who are at risk of becoming frequent service users

4 –Population-wide risk stratification started but not fully acted on

5 – Whole population stratification deployed and fully implemented.

Health and social care systems are under increasing pressure to respond to demands that could otherwise be handled by citizens and carers themselves. The evidence suggests that many individuals would be willing to do more to participate in their own care if easy-to-use services, such as appointment booking, self-monitoring of health status, and alternatives to medical appointments, were available to them. This means providing services and tools that enable convenience, offer choice, and encourage self-service and engagement in health management.

Assessment scale

0 – Citizen empowerment is not considered as part of integrated care provision

1 – Citizen empowerment is recognised as important part of integrated care provision but effective policies to support citizen empowerment are still in development

2 - Citizen empowerment is recognised as important part of integrated care provision, effective policies to support citizen empowerment are in place but citizens do not have access to health information and health data

3 - Citizens are consulted on integrated care services and have access to health information and health data

4 – Incentives and tools exist to motivate and support citizens to co-create healthcare services and use these services to participate in decision-making process about their own health

5 – Citizens are fully enaged in decision-making processes about their health, and are included in decsion-making on service delivery and policy-making.

As new care pathways and services are introduced to support integrated care, there is a clear need to ensure that the changes are having the desired effect on quality of care, cost of care, access and citizen experience. This supports the concept of evidence-based investment, where the impact of each change is evaluated, ideally by health economists working in universities or in special agencies. Health technology assessment (HTA) is an important method here, and can be used to justify the cost of scaling up good practices to regional or national level.

Assessment scale

0 – No evaluation of integrated care services is in place or in development

1 – Evaluation of integrated care services exists, but not as a part of a systematic approach

2 – Evaluation of integrated care services is planned to take place and be established as part of a systematic approach

3 – Some integrated care initiatives and services are evaluated as part of a systematic approach

4 – Most integrated care initiatives are subject to a systematic approach to evaluation; published results

5 – A systematic approach to evaluation, responsiveness to the evaluation outcomes, and evaluation of the desired impact on service redesign (i.e., a closed loop process).

Readiness for integrated care

Basque Country, Spain

Region of South Denmark

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LUNCH

12.45 – 13.30

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SPOTLIGHT ON MATURITY DIMENSIONS OF INTEGRATED CARE

13.30 – 14.15

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BREADTH OF AMBITION
STRUCTURE & GOVERNANCE
FUNDING

LEO LEWIS

INTEGRATED CARE FOUNDATION

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Integrated care includes many levels of integration, such as integration between primary and secondary care, of all stakeholders involved in the care process, or across many organisations. It may be developed simply for healthcare needs (i.e., vertical integration) or it may include social workers, the voluntary sector, and informal care (i.e., horizontal integration). The broader the ambition, the more numerous and diverse the stakeholders who have to be engaged.

Assessment scale

0 – Integrated services arise but not as a result of planning or the implementation of a strategy

1 – The citizen or their family may need to act as the integrator of service in an unpredictable way

2 – Integration within the same level of care (e.g., primary care)

3 – Integration between care levels (e.g., between primary and secondary care)

4 – Integration includes both social care service and health care service needs

5 – Fully integrated health & social care services.

The broad set of changes needed to deliver integrated care at a regional or national level presents a significant challenge. It needs multi-year programmes with excellent change management, funding and communications, and the power to influence and (sometimes) mandate new working practices. This means alignment of purpose across diverse organisations and professions, and the willingness to collaborate and put the interest of the overall care system above individual incentives.

Assessment scale

0– Fragmented structure and governance in place

1– Recognition of the need for structural and governance change

2– Formation of task forces, alliances and other informal ways of collaborating

3– Governance established at a regional and national level

4– Roadmap for a change programme defined and broadly accepted

5– Full, integrated programme established, with funding and a clear mandate

Changing systems of care so that they can offer better integration requires initial investment and funding; a degree of operational funding during transition to the new models of care; and on-going financial support until the new services are fully operational and the older ones are de-commissioned. Ensuring that initial and on-going costs can be financed is an essential activity that uses the full range of mechanisms from regional/national budgets to 'stimulus' funds, European Union investment funds, public-private partnerships (PPP) and risk-sharing mechanisms).

Assessment scale

0 – No additional funding is available to support the move towards integrated care

1 – Funding is available but mainly for the pilot projects and testing

2 – Consolidated innovation funding available through competitions/ grants for individual care providers and small-scale implementation

3 – Regional/national (or European) funding or PPP for scaling-up is available

4 – Regional/national funding for on-going operations is available

5 – Secure multi-year budget, accessible to all stakeholders, to enable further service development.

Readiness for Integrated Care

Region of South Denmark

Hungary

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SPOTLIGHT ON MATURITY
DIMENSIONS OF INTEGRATED CARE

14.15 – 15.00

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EHEALTH SERVICES STANDARDISATION INNOVATION MANAGEMENT

GEORGE CROOKS
DIGITAL HEALTH AND CARE INSTITUTE

Co-funded by the Health Programme of the European Union

Integrated care requires, as a foundational capability, sharing of health information and care plans across diverse care teams that lead progressively to systems for enabling continuous collaboration, measuring and managing outcomes, and enabling citizens to take a more active role in their care. This means building on existing eHealth services, connecting them in new ways to support integration, and augmenting them with new capabilities, such as enhanced security and mobility.

Assessment scale

0– ICT systems are not designed to support integrated care

1– ICT & eHealth services to support integrated care are being piloted

2– ICT & eHealth services to support integrated care are deployed but there is no region wide coverage

3– ICT & eHealth services to support integrated care are planned and deployed widely at large scale but use of these services is not mandated

4– Mandated or funded use of regional/national eHealth infrastructue across the healthcare system

5– Universal, at scale regional/national eHealth services used by all integrated care stakeholders

When considering eHealth services and how they can support the information sharing and collaboration needs of integrated care, the task can be made easier if the number of different systems in use, and the formats in which they store data, can be simplified. Practically, this means trying to consolidate data centres, standardising on fewer systems, and agreeing on what informatics standards will be used across a region or country.

Assessment scale

0 – No standards in place or planned that support integrated care services

1 – Discussion of the necessity of ICT to support integrated care and of any standards associated with that ICT

2 – An ICT infrastructure to support integrated care has been agreed together with a recommended set of information standards – there may still be local variations

3 – A recommended set of agreed information standards at regional/national level; some shared procurements of new systems at regional/national level; some large-scale consolidations of ICT underway

4 – A unified set of agreed standards to be used for system implementations specified in procurement documents; many shared procurements of new systems; consolidated data centres and shared services widely deployed

5 – A unified and mandated set of agreed standards to be used for system implementations fully incorporated into procurement processes; clear strategy for regional/national procurement of new systems; consolidated datacentres and shared services (including the cloud) is normal practice.

Many of the best ideas are likely to come from clinicians, nurses and social workers who understand where improvements can be made to existing processes. These innovations need to be recognised, assessed and, where possible, scaled up to provide benefit across the system. At the same time, universities and private sector companies are increasingly willing to engage in open innovation, and innovative procurement, in order to develop new technologies, test process improvements and deliver new services that meet the needs of citizens.

Assessment scale

0 – No innovation management in place

1 – Innovation is encouraged but there is no overall plan

2 – Innovations are captured and there are some mechanisms in place to encourage knowledge transfer

3 – Formalised innovation management process is planned and partially implemented

4 – Formalised innovation management process is in place and widely implemented

5 – Extensive open innovation combined with supporting procurement & the diffusion of good practice is in place

Readiness for integrated care

East Mazovia, Poland

Ile de France, Paris region

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COFFEE BREAK

15.00 – 15.20

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SPOTLIGHT ON MATURITY DIMENSIONS OF INTEGRATED CARE

15.20 – 16.05

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READINESS TO CHANGE
CAPACITY BUILDING
REMOVAL OF INHIBITORS

HELEN SCHONENBERG, PHILIPS
ACT@SCALE PROJECT

Co-funded by
the Health Programme
of the European Union

If the existing systems of care need to be re-designed to provide a more integrated set of services, this will require change across many levels, the creation of new roles, processes and working practices, and new systems to support information sharing and collaboration across care teams. This will be disruptive and may be viewed negatively by workers, press and public, so a clear case needs to be made for those changes, including a justification, a strategic plan, and a vision of better care.

Assessment scale

0– No acknowledgment of compelling need to change

1– Compelling need is recognised, but no clear vision or strategic plan

2– Dialogue and consensus-building underway; plan being developed

3– Vision or plan embedded in policy; leaders and champions emerging

4– Leadership, vision and plan clear to the general public; pressure for change

5– Political consensus; public support; visible stakeholder engagement

Even with political support, funded programmes and good eHealth infrastructure, many factors can still make integrated care difficult to deliver, by delaying change or limiting how far change can go. These include legal issues with data governance, resistance to change from individuals or professional bodies, cultural barriers to the use of technology, perverse financial incentives, and lack of skills. These factors need to be recognised early, and a plan developed to deal with them, so as to minimise their impact.

Assessment scale

0 – No awareness of the effects of inhibitors on integrated care

1 – Awareness of inhibitors but no systematic approach to their management is in place

2 – Strategy for removing inhibitors agreed at a high level

3 – Implementation Plan and process for removing inhibitors have started being implemented locally

4 – Solutions for removal of inhibitors developed and commonly used

5 – High completion rate of projects & programmes; inhibitors no longer an issue for service development

Capacity building is the process by which individual and organisations obtain, improve and retain the skills and knowledge needed to do their jobs competently. As the systems of care are transformed, many new roles will need to be created and new skills developed. These will range from technological expertise and project management, to successful change management. The systems of care need to become 'learning systems' that are constantly striving to improve quality, cost and access. They must build their capacity so as to become more adaptable and resilient.

Assessment scale

0 – Integrated care services are not considered for capacity building

1 – Some systematic approaches to capacity building for integrated care services are in place

2 – Cooperation on capacity building for integrated care is growing across the region

3 – Systematic learning about integrated care and change management is in place but not widely implemented.

4 – Systematic learning about integrated care and change management is widely implemented; knowledge is shared, skills retained and there is a lower turnover of experienced staff.

5 – A 'person-centred learning healthcare system' involving reflection and continuous improvement.

Readiness for Integrated Care

Region of Flanders, Belgium

Puglia region, Italy

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NEXT STEPS
TWINNING & COACHING

PROF STUART ANDERSON

CRISTINA ALEXANDRU

UNIVERSITY OF EDINBURGH

Co-funded by the Health Programme of the European Union

Outline

- The Maturity Model provides a way of assessing the *Maturity* of a Health System to adopt Integrated Care.
- The Scirocco project is also developing a way of assessing the *Maturity Requirements* of an *Integrated Care Good Practice*
- Both provide a basis for Twinning and Coaching activities.

Comparing Health Systems

- Two regions having done self-assessment can compare and start to set the twinning agenda.
- Justifications for each dimension provide a starting point for exchange of expertise.
- Tool can track changes over time to visualise development.

Maturity Requirements

- A good practice **depends** on *features* in the environment to allow its implementation.
- These *features* are concrete aspects of the health system.
- Once *features* have been identified we need to map them to maturity levels. Mapping every *feature* to a maturity level gives us the *maturity requirement* of the good practice.
- We identify *features* dimension by dimension.
- Example: a pain clinic in the Basque Country…

Dimension 1: Readiness to Change

- Features of Pain Clinic relevant to this dimension:
  - Ready to use EPR as primary source of information
  - Ready to use teleconsultation
  - Ready to work across primary/secondary healthcare
  - Ready to involve family
- How do these features map to a Maturity Requirement for this dimension:
  - Here we see a champion emerging pushing readiness to change so the requirement is **at least 3**: “ Vision or plan embedded in policy; leaders and champions emerging.”

Complete the Questionnaire

- Continue this process for each dimension
- Use the consensus process devised for Health Systems using a multidisciplinary team.
- Record the list of features for each dimension *and* the justification for the mapping from features to maturity level.
- We end up with a maturity requirement diagram for the Pain Clinic.

Final Questionnaire

- The final *maturity requirement* diagram looks like this.
- Each member of the multidisciplinary team should complete their diagram.
- Then there should be a consensus meeting to merge the individual diagrams into a consensus diagram.

Comparing with a Health System Maturity

- Here the blue diagram is one for the pain clinic.
- The yellow diagram is the consensus diagram for a Health System
- There are clear areas where there would need to be change in the Health System to accommodate the pain clinic good practice.

Support Twinning and Coaching

- In the diagram there are clear omissions in the Health System if it is to support the good practice
- In the maturity requirements we record *features* and justify how they map to maturity levels
- The coaching and twinning discussion might look at how key features (*or features equivalent to them*) required by the good practice could be realised in the Health System.
- Disaggregating consensus diagrams could also help discussion between specialists.

Summary

- The Maturity model can help support Twinning and Coaching
- Provides information on dimensions that could be the focus for dialogue and transfer.
- Provides a means to structure the discussion on transferring a particular good practice.
- This is work in progress. Next version of the tool will provide more explicit support for Teaming and Coaching

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CLOSE

DONNA HENDERSON

HEAD OF EUROPEAN ENGAGMENT

NHS 24, SCOTLAND

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