Scirocco
Scaling Integrated Care in Context

D7.1 Five Action Plans

Guidance on the operational plan for knowledge transfer

WP7 Knowledge Transfer

Co-funded by
the Health Programme
of the European Union

The SCIROCCO project is co-funded by the Health Programme of the European Union under Grant Agreement No.: 710033 (CHAFEA)

Document information

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Delivery date – 30 May 2019

Dissemination level

P Public

P	Public

Statement of originality

This deliverable contains original unpublished work except where clearly indicated otherwise. Acknowledgement of previously published material and of the work of others has been made through appropriate citation, quotation or both.

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Executive Summary

The overall aim of this Deliverable is to explore to what extent an approach of matching the regions with complementary strengths and weaknesses in integrated care can provide a strong basis for effective knowledge transfer and exchange of good practices to facilitate the adoption and scaling-up of integrated care. It is based on the real-life testing of the SCIROCCO tool in the process of twinning and coaching. This reflects the overarching objective of SCIROCCO project which is to facilitate scaling-up and knowledge transfer in integrated care amongst the European regions and countries.

To this end, this report describes:

- SCIROCCO methodology for twinning and coaching
- Twinning and coaching activities in 5 SCIROCCO regions
- Action Plans of 5 SCIROCCO regions to create local conditions for the adoption of integrated care.

The effective knowledge transfer depends on the creation of constructive relationships between regions and organisations. The SCIROCCO tool facilitates building of these relationships by helping regions to understand their local conditions enabling adoption of integrated care, including their strengths and weaknesses. The Tool thus provides a local understanding of the areas of improvement which can be addressed through knowledge transfer activities with other regions and organisations.

The twinning and coaching activities were conducted in five SCIROCCO regions; Basque Country, Norrbotten Region in Sweden, Olomouc Region in Czech Republic, Puglia Region in Italy and Scotland. The knowledge transfer was informed either by the maturity of particular healthcare system or maturity requirements of selected good practices. This was facilitated by SCIROCCO online self-assessment tool and commonly agreed twinning and coaching methodology. The outcomes of the process were captured in the form of Action Plans which inform the creation of local conditions for the adoption and scaling-up of integrated cate, including the agreed priority actions and policy recommendations. The testing of SCIROCCO twinning and coaching methodology also informed the further refinement and improvement of SCIROCCO self-assessment tool.

List of Abbreviations

WP	Work Package
EIPonAHA	European Innovation Partnership on Active and Healthy Ageing
MM	Maturity Model
ACP	Advanced Care Planning
H@H	Hospital at Home
TSOs	Third Sector Organisations

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1. Introduction

1.1 Purpose of this report

The purpose of this document is to analyse the outcomes of SCIROCCO twinning and coaching activities in five European regions. Knowledge transfer is widely recognised as an enabler of improvement and capacity of regions and organisations to adopt integrated care. However, the maturity of local conditions enabling the adoption of integrated care, including the existing gaps and weaknesses, needs to be recognised and analysed in order to facilitate effective knowledge transfer and exchange of good practices. Understanding the local strengths and weaknesses informs the clustering of regions and organisations with complementary needs and priorities which results into much more effective and targeted exchange of learning and information

To this end, the following tasks were performed:

- Development of SCIROCCO methodology for twinning and coaching
- Development of functionalities of the SCIROCCO tool to facilitate knowledge transfer
- Definition of priorities for the knowledge transfer in 5 SCIROCCO regions
- Identification of local teams of experts to participate in knowledge transfer
- Twinning and coaching activities in 5 SCIROCCO regions, including the organisation of the study visits
- Development of local Action Plans to reflect on the potential of transferability of learning as a result of knowledge transfer
- Organisation of focus group meetings in 5 SCIROCCO regions to capture the experience of stakeholders on twinning and coaching process
- Improvement and enhancement of the SCIROCCO tool and twinning and coaching methodology

The twinning and coaching activities were conducted between May and September 2018, using v0.3 of SCIROCCO Maturity Model (Annex 1). The outcomes of this WP directly informed three Work Packages (WPs) as illustrated in the figure below:

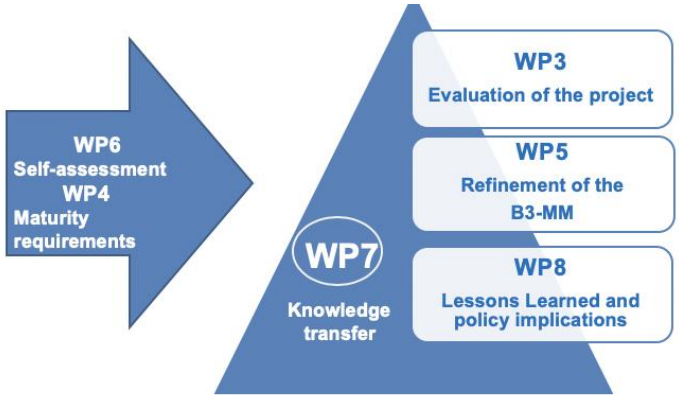

Figure 1: Links of WP with other WPs

2. Objectives

SCIROCCO aims to develop, validate and test a tool that can support the adoption and scaling up of good practices and act as a facilitator for decision-makers when planning the deployment of innovative integrated care solutions. As such, SCIROCCO explores how the regions with complementary strengths and weaknesses can deliver two major benefits: a strong basis for successful twinning and coaching that facilitates shared learning and effective knowledge transfer; and practical support for the scaling-up of good practices that promote active and healthy ageing and participation in the community.

Figure 2: SCIROCCO Maturity Model

Within the framework of the SCIROCCO project, WP7 intends to:

- Provide a refined and tested methodology and tool to facilitate effective knowledge transfer and learning on integrated care.
- Organise twinning and coaching activities to support the transferability of learning on how to create local conditions for the adoption of integrated care.
- Inform the decision-makers about the potential of the SCIROCCO tool to facilitate the adoption and scaling up of integrated care in Europe.

This work intends to contribute to the existing knowledge on the potential of twinning and coaching processes to enable the creation of local conditions for the adoption of integrated care models, including exchange of lessons learned and success factors.

3. Methodology

3.1 Objectives of the twinning and coaching

The objectives of the twinning and coaching process are to:

- Facilitate the process of knowledge transfer and information sharing among the European regions and organisations using the SCIROCCO tool;
- Facilitate multi-disciplinary dialogues of transferring[1] and receiving[2] regions and organisations to inform the transferability of learning.
- Capture the learning about the local conditions enabling adoption of integrated care and assess the feasibility of transferring the learning to different local contexts;
- Provide basis for improving maturity of particular healthcare system for the adoption of integrated care;
- Inform about the priority actions, including policy recommendations on how to create and/or improve local context for integrated care.

For the purpose of SCIROCCO project, the twinning and coaching is informed by:

- understanding of the maturity requirements of good practices for their adoption and transferability informed by the SCIROCCO tool;
- understanding of the maturity of local context for adoption of a particular good practice and/or improvement of a particular domain of integrated care informed by the SCIROCCO tool.

3.2 Twinning and coaching informed by the maturity requirements of good practices

The transferability and scaling-up of good practices require the knowledge about the key requirements that are necessary for the successful adoption of a particular good practice. These are the key features that good practice needs from its environment in order to be implemented. This in turn informs the potential adopters about the conditions which need to be created locally in order to transfer a particular integrated care solution. The understanding of local conditions and features that are necessary for the adoption of a good practice in a particular context can facilitate much more effective knowledge transfer and learning between transferring and receiving regions.

The methodology designed to conduct twinning and coaching activities informed by the maturity requirements of good practices consists of three key phases:
Phase 1: Planning for the twinning and coaching
Phase 2: Knowledge transfer activities
Phase 3: Capturing the outcomes of twinning and coaching

Phase 1: Planning for the twinning and coaching

[1] For the purpose of SCIROCCO project the transferring region is defined as a region/authority which has already made progress on implementing integrated care and which possesses essential know-how and good practice. This region/authority will act as a "coaching" partner in the knowledge transfer activities.
[2] For the purpose of SCIROCCO project, the receiving region is defined as a region/authority which is ready to embark on the transition to integrated care and seek support and know-how in order to deploy a particular good practice and/or improve a specific domain of integrated care. This region/authority will act as the "learning" partner in the knowledge transfer activities.

The following figure illustrates Phase 1 of the SCIROCCO step-based twinning and coaching process informed by the maturity requirements of good practices:

Figure 3: Phase 1 of SCIROCCO twinning and coaching methodology

1. Select a good practice of strategic interest for your region or organisation

The twinning and coaching process is initiated by the selection of good practice which is of strategic priority for the receiving region. This can be done by individuals or as a result of collective decision.

2. Assess the requirements of good practice for its adoption and transferability using the SCIROCCO tool

In the second step, the assessment of maturity requirements of selected good practice needs to be defined. The objective is to understand the key features necessary for the transferability of particular integrated care solution. The assessment process is conducted by the owner of good practice and it is facilitated by the SCIROCCO tool. An illustrative example is provided in the figure below:

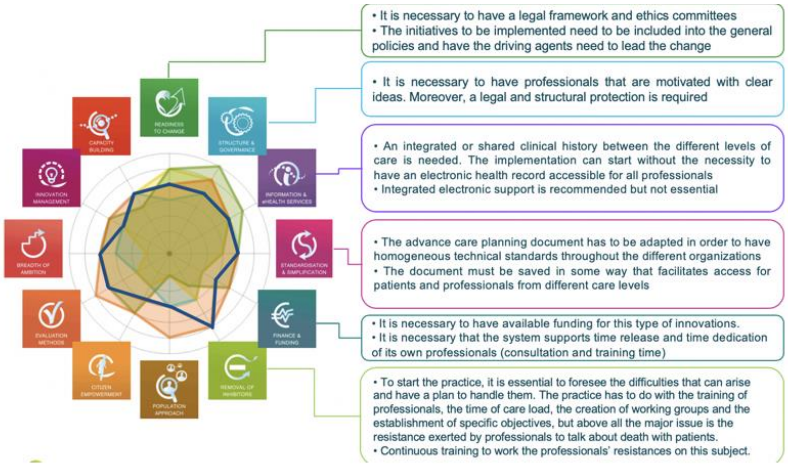

Figure 4: Maturity requirements of good practice - illustrative example

3. Assess the readiness of the healthcare system for the adoption of a good practice using the SCIROCCO tool

In the third step, the assessment of maturity of local context needs to be defined. The objective is to understand the maturity of local conditions in the receiving region in order to assess the feasibility of transferring a selected good practice. In other words, the receiving region needs to assess to what extent the local environment is ready in order to succeed in adopting selected integrated care solution. The assessment process is conducted by local multi-disciplinary team and it is facilitated by the SCIROCCO tool. An illustrative example is provided in the figure below:

Figure 5: Maturity of healthcare system - illustrative example

4. Learn about the requirements of the healthcare system to adopt a particular good practice using the SCIROCCO tool

In the fourth step, the receiving region compares the requirements of good practice for its transferability with the maturity of local context. This informs the receiving region how much efforts, if any, would be needed to succeed with the implementation of such a practice. The visualisation of this comparison allows the potential receiver to review in detail what features/aspects of local healthcare system needs to be improved or put in place to succeed with the transferability of good practice (Figure 6).

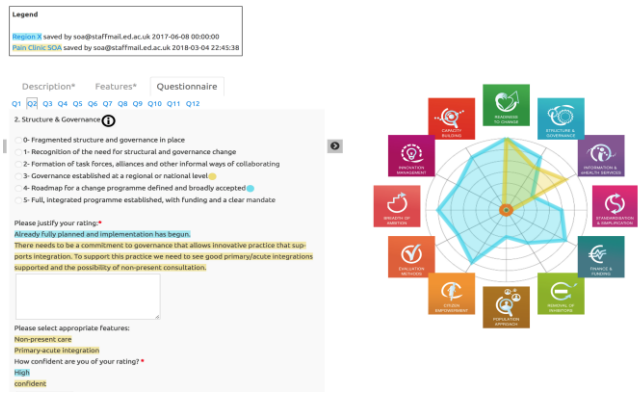

Figure 6: Comparison of maturity requirements of good practice and local context

5. Initiate the twinning and coaching process

In the final step, once both assessments are compared and reviewed, the receiving region can initiate the twinning process and contact the transferring region. This is facilitated by the "invite" functionality of the SCIROCCO tool.

Phase 2: Knowledge transfer activities

The following figure illustrates Phase 2 of the SCIROCCO step-based twinning and coaching process informed by the maturity requirements of good practices:

Figure 7: Phase 2 of SCIROCCO twinning and coaching methodology

6. Contact the owner of good practice

Once invitation is accepted by the transferring region, knowledge transfer process is initiated. An initial meeting is organised to better understand the priorities of receiving region and scope the focus of the twinning and coaching process.

7. Identify local experts

Both, transferring and receiving regions identify their local experts to participate in the knowledge transfer process. The visual comparison of requirements of good practice and maturity of local context (Step 4) helps to facilitate the local dialogues by highlighting the gaps that will be addressed during the learning process. This also helps to identify the experts with the right skills, knowledge and expertise.

8. Organise an introductory webinar

An introductory webinar is organised for the experts from receiving and transferring regions to build the connections and relationships. The regions also share some preliminary documents about good practice and healthcare systems and have some preliminary discussions on the emerging similarities and potential gaps. This will ensure a more productive and targeted learning during the visit on site.

9. Organise a study visit

The local coordinators prepare the programme of the study visit to the transferring region based on the agreed priorities and areas of interest. The study visit is organised for two days and consists of the following sessions:

- Site visit where the good practice is implemented
- Introduction to the organisation and structure of healthcare system in the transferring region
- Introduction to the good practice, including the detailed explanation of the maturity requirements for its transferability
- Facilitated discussion on the maturity requirements of good practice and how they fit to the local context of receiving region.

The discussion on the feasibility of transferring good practice to the local context of receiving region is facilitated by the SCIROCCO tool (Figure 8).

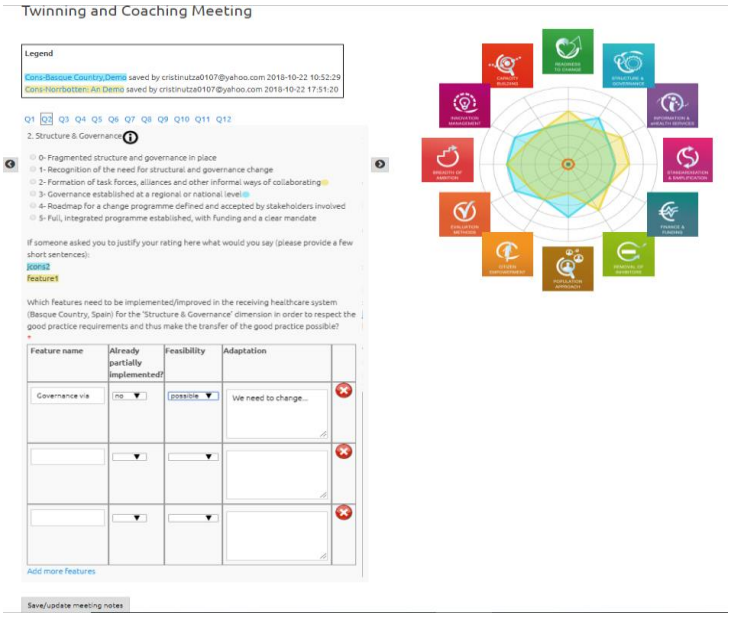

Figure 8: Facilitated discussion of experts on transferability of good practice

The experts from both receiving and transferring regions discuss in detail:

- each dimension of the SCIROCCO tool and reflect to what extent particular dimension influences a successful adoption of good practice
- features of each dimension of the SCIROCCO tool and to what extent these features are present in the local context of receiving region
- feasibility and rationale of transferring the features that are necessary for the transferability of good practice and are currently missing in the local context of receiving region
- adaptation of selected features for the transferability to meet the requirements of local context in the receiving region
- potential support of transferring region in creating the conditions for the transferability of learning to the receiving region.

The outcomes of the discussion inform receiving region about the features of healthcare system that are critical for the transferability of good practice and should be prioritised in order to succeed with its implementation.

10. Capture the experience of regions in the twinning and coaching process

In the final step of knowledge transfer activities, the focus group meetings were designed in order to capture the experience of stakeholders on using the SCIROCCO tool to facilitate the twinning and coaching activities (Annex II). The focus group meetings took place on the second day of each study visit organised in SCIROCCO regions. Key issues covered in the focus groups, included questions related to:

- Experience of the twinning and coaching using the SCIROCCO tool.
- Outcomes and impacts of the twinning and coaching activities.
- Suggestions for enhancement of SCIROCCO twinning and coaching methodology.

The outcomes of the focus group meetings inform about the further improvement and enhancement of the SCIROCCO tool as a tool to facilitate knowledge transfer and exchange of good practices in integrated care.

Phase 3: Capturing the outcomes of twinning and coaching

The following figure illustrates Phase 3 of the SCIROCCO step-based twinning and coaching process informed by the maturity requirements of good practices:

Figure 9: Phase 3 of SCIROCCO twinning and coaching methodology

11. Capture the learning from the knowledge transfer activities

In this step, the receiving region reviews outcomes of the knowledge transfer activities, particularly the features required for the transferability of learning.

12. Organise a local meeting in the receiving region

A follow up meeting with experts participating in the knowledge transfer activities is organised in receiving region. The objective of this meeting is to reflect on the outcomes of knowledge transfer activities and agree on the local priority actions for the transferability of learning.

13. Develop an Action Plan

The outcomes of the knowledge transfer activities are captured in the form of local Action Plans. The Action Plans are co-designed by transferring and receiving regions. The main objective of the Plans is to inform the decision-makers about the agreed priority actions that are necessary for the adoption of integrated care solution, including the feasibility and adaptation of learning, anticipated outcomes and timeline. For more information on the structure of Action Plans please see Annex III and Section 5 Action Plans.

14. Populate the Action Plan in the SCIROCCO tool

Once the Action Plan is completed it can be uploaded on the SCIROCCO tool and shared with all relevant stakeholders. This functionality also allows the update of the Action Plans and tracking the progress with the adoption of integrated care solution.

15. Disseminate the learning from the knowledge transfer activities

The outcomes of knowledge transfer activities are promoted locally and across the regions. The objective is to increase awareness about the benefits of knowledge transfer for the improvement of capacity of regions and organisation to implement integrated care.

3.3 Twinning and coaching informed by the maturity of local context

The transferability and scaling-up of integrated care solutions require the knowledge about the maturity of local conditions enabling the adoption of integrated care. The maturity of healthcare systems for integrated care informs about the potential strengths and weaknesses of particular environment to adopt and scale up integrated care and thus help to understand the priorities for improvement. The understanding of local conditions can help to match the regions with complementary strengths and weaknesses and thus facilitate much more effective knowledge transfer and learning between transferring and receiving regions.

The methodology designed to conduct twinning and coaching activities informed by the maturity requirements of local context consists of three key phases:

Phase 1: Planning for the twinning and coaching

Phase 2: Knowledge transfer activities

Phase 3: Capturing the outcomes of twinning and coaching

Phase 1: Planning for the twinning and coaching

The following figure illustrates Phase 1 of the SCIROCCO step-based twinning and coaching process informed by the maturity of healthcare systems:

Figure 10: Phase 1 of SCIROCCO twinning and coaching methodology

1. Assess the maturity of healthcare system

The twinning and coaching process is initiated by the assessment of maturity of local conditions enabling adoption and scaling up of integrated care. The objective is to understand the key strengths and weaknesses in integrated care. This can be done by individuals or as a result of collective decision and the process is facilitated by the SCIROCCO tool. An illustrative example is provided in the figure below:

Figure 11: Maturity assessment of healthcare system - illustrative example

2. Identify the area(s) of integrated care for improvement

The outcomes of the assessment process inform the areas for the improvement and/or gaps which can be addressed through the knowledge transfer and effective mutual learning. The SCIROCCO tool enables the interested region(s)/organisation(s) to identify one or more areas for the improvement as illustrated in the figure below:

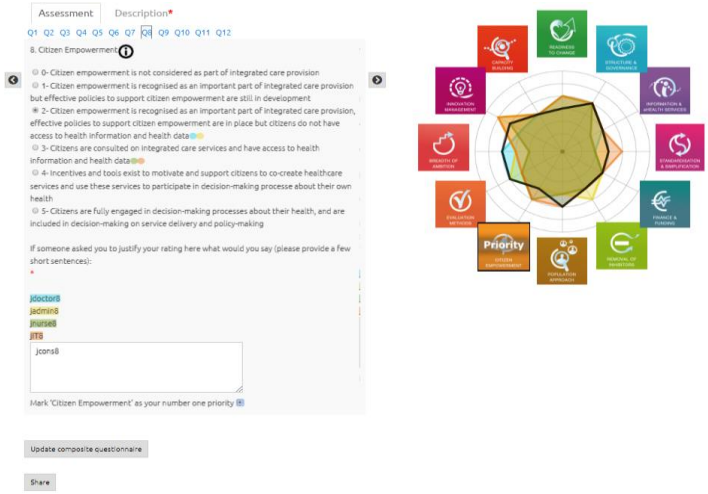

Figure 12: Identification of areas for improvement - illustrative example

3. Seek support for the improvement from other region(s)

In the third step, the interested region(s)/organisation(s) can seek for the support on how to improve particular area of integrated care (as identified in step 2) by identifying region(s) with higher maturity along a particular dimension of integrated care as illustrated in the figure below:

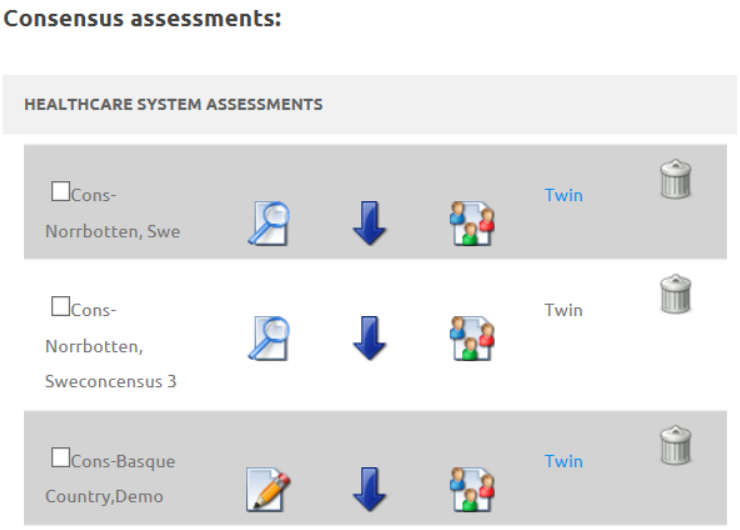

Figure 13: Seek support from other regions - illustrative example

4. Learn about the maturity of other region(s)

The region(s) and organisation(s) seeking the support can learn about the maturity of other region(s) and organisation(s) and compare and contrast to what extent their strengths and weaknesses are complimentary or different as illustrated in the figure below. This in turns help to facilitate much more effective partnerships for potential twinning and coaching.

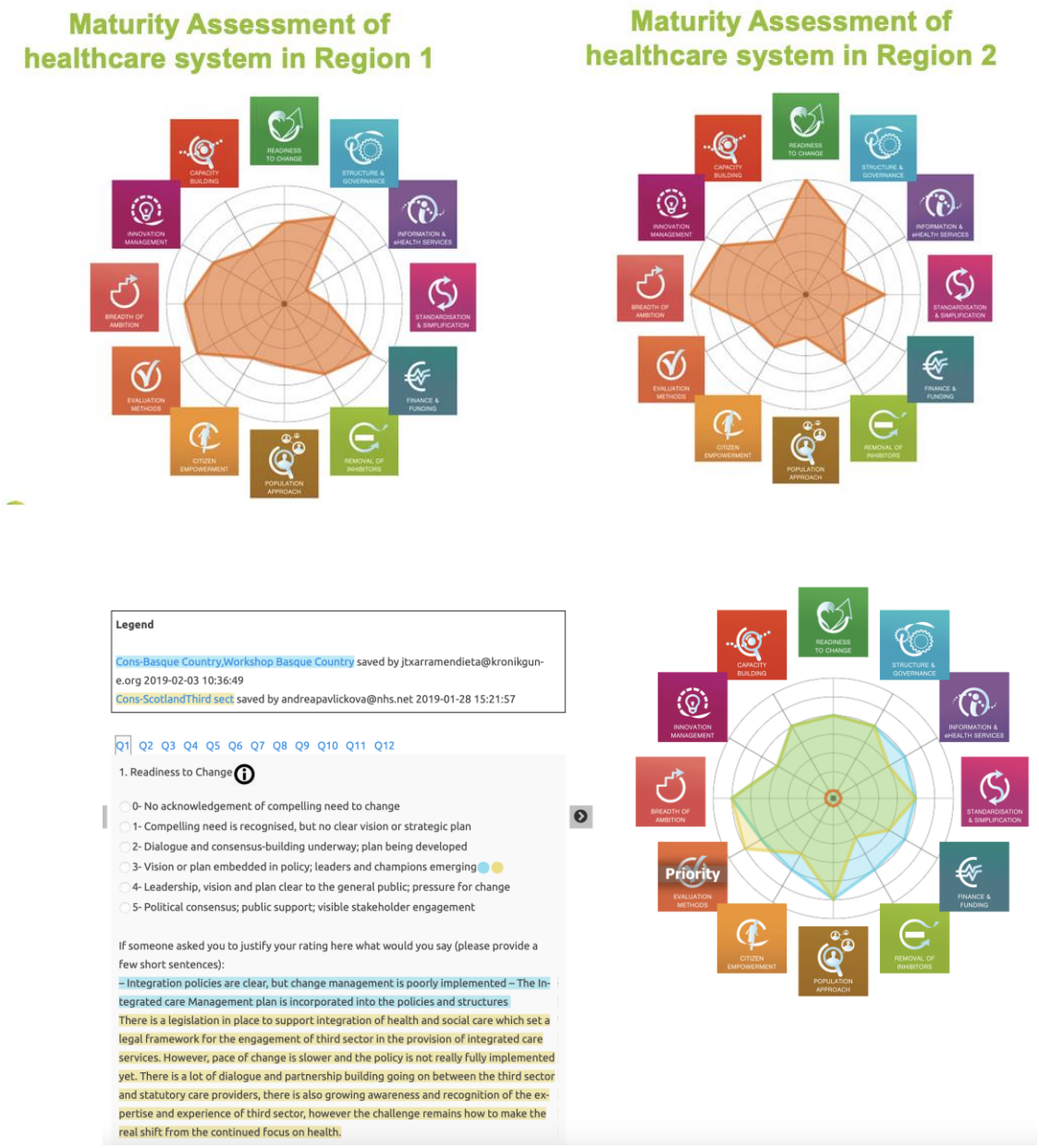

Figure 14: Comparison of maturity - illustrative example

5. Initiate the twinning and coaching

In the final step, once both assessments are compared and reviewed, the receiving region can initiate the twinning process and contact the transferring region. This is facilitated by the "invite" functionality of the SCIROCCO tool.

Phase 2: Knowledge transfer activities

The following figure illustrates Phase 2 of the SCIROCCO step-based twinning and coaching process informed by the maturity assessment of healthcare systems:

Figure 15: Phase 2 of SCIROCCO twinning and coaching methodology

6. Contact the region(s)/organisation(s) of interest

Once invitation is accepted by the transferring region, knowledge transfer process is initiated. An initial meeting is organised to better understand the priorities of receiving region and scope the focus of the twinning and coaching process.

7. Identify local experts

Both, transferring and receiving regions identify their local experts to participate in the knowledge transfer process. The visual comparison of maturity of local context in the transferring and receiving region (Step 4) helps to facilitate the local dialogues and identify the experts with the right skills, knowledge and expertise.

8. Organise an introductory webinar

An introductory webinar is organised for the experts from receiving and transferring regions to build the connections and relationships. The regions also share some preliminary documents about good practice and healthcare systems and have some preliminary discussions on the emerging similarities and potential gaps. This will ensure a more productive and targeted learning during the visit on site.

9. Organise a study visit

The local coordinators prepare the programme of the study visit to the transferring region based on the agreed priorities and areas of interest. The study visit is organised for two days and consists of the following sessions:

- Site visit (if relevant)
- Introduction to the organisation and structure of healthcare system in the transferring region
- Introduction to the identified area(s) for improvement, including the detailed explanation of its maturity required for the potential transferability

- Facilitated discussion on the maturity of local context in both receiving and transferring regions to allow better understanding of the feasibility of transfer.

The discussion on the feasibility of transferring featured of the local systems in the transferring region is facilitated by the SCIROCCO tool (Figure 16).

Dimension		Score	Features
STRUCTURE & GOVERNANCE	Maturity of healthcare system in receiving region - Norrbotten	3	• A national strategy for eHealth has been developed and implemented; • The Region has come far concerning eHealth solutions but there is a need for the municipalities to reach the same level of progress to be able to reach the good results of integrated care and overcome organisational boundaries. • There is a structure for collaboration between the region and the municipalities. • Further development of eHealth is defined in our regional programs such as the Regional Development Strategy, and the Regional Innovation Strategy. However, the Strategies still exist only at a strategic level and implementation is lacking. A clear roadmap and specific mandates are needed to ensure their implementation.
	Maturity of healthcare system in transferring region – Scotland	4	• Roadmap for a change programme defined and accepted by stakeholders involved. • There is a structure and governance in place but implementation is not perfect. • Governance is fully resourced at national level, but the messages does not go down and there is much inequality at lower levels.

Is the domain important for the improvement of Innovation Management? YES	Features	Covered (Y/N)	Feasibility	Adaptation
	Structure and Governance for innovation and collaboration; supported by dedicated funding	Yes	Yes	Adaptation would be required around the funding for innovation in Norrbotten; incentives are needed
	Clear roadmap with specific mandates fort all stakeholders involved	Yes	Yes	Lacking clear definition of mandates to carry out innovation management
	Regulation to allow data sharing for innovation	No	No?	

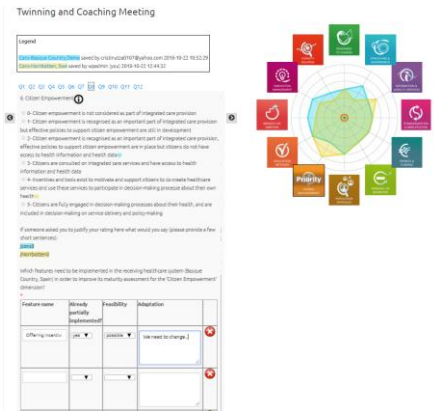

Figure 16: Facilitated discussion of experts - illustrative example

10. Capture the experience of region(s)/organisation(s) in twinning and coaching

In the final step of knowledge transfer activities, the focus group meetings were designed in order to capture the experience of stakeholders on using the SCIROCCO tool to facilitate the twinning and coaching activities (Annex II). The focus group meetings took place on the second day of each study visit organised in SCIROCCO regions. Key issues covered in the focus groups, included questions related to:

- Experience of the twinning and coaching using the SCIROCCO tool.
- Outcomes and impacts of the twinning and coaching activities.
- Suggestions for enhancement of SCIROCCO twinning and coaching methodology.

The outcomes of the focus group meetings informed about the further improvement and enhancement of the SCIROCCO tool as a tool to facilitate knowledge transfer and exchange of good practices in integrated care.

Phase 3: Capturing the outcomes of twinning and coaching

The following figure illustrates Phase 3 of the SCIROCCO step-based twinning and coaching process informed by the maturity assessment of healthcare systems:

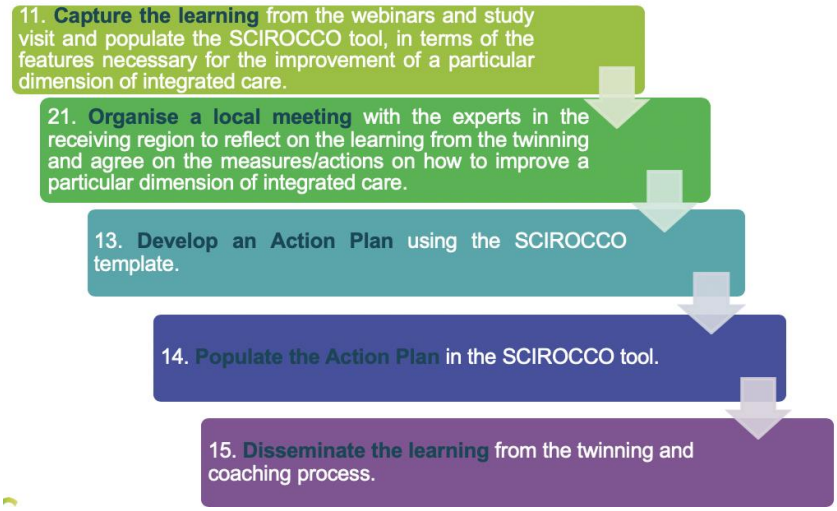

Figure 17: Phase 3 of SCIROCCO twinning and coaching methodology

11. Capture the learning from the knowledge transfer activities

In this step, the receiving region reviews outcomes of the knowledge transfer activities, particularly the features required for the transferability of learning.

12. Organise a local meeting in the receiving region

A follow up meeting with experts participating in the knowledge transfer activities is organised in receiving region. The objective of this meeting is to reflect on the outcomes of knowledge transfer activities and agree on the local priority actions for the transferability of learning.

13. Develop an Action Plan

The outcomes of the knowledge transfer activities are captured in the form of local Action Plans. The Action Plans are co-designed by transferring and receiving regions. The main objective of the Plans is to inform the decision-makers about the agreed priority actions that are necessary for the adoption of integrated care solution, including the feasibility and adaptation of learning, anticipated outcomes and timeline. For more information on the structure of Action Plans please see Annex III and Section 5 Action Plans.

14. Populate the Action Plan in the SCIROCCO tool

Once the Action Plan is completed it can be uploaded on the SCIROCCO tool and shared with all relevant stakeholders. This functionality also allows the update of the Action Plans and tracking the progress with the adoption of integrated care solution.

15. Disseminate the learning from the knowledge transfer activities

The outcomes of knowledge transfer activities are promoted locally and across the regions. The objective is to increase awareness about the benefits of knowledge transfer for the improvement of capacity of regions and organisation to implement integrated care.

4. Twinning and Coaching in SCIROCCO Regions

The twinning and coaching activities in the SCIROCCO regions were organised in the form of study visits. In addition, the tools such as webinars, teleconferences and various other online meetings were also necessary to shape the focus of knowledge transfer activities.

In the SCIROCCO project, it was agreed to conduct one twinning and coaching activity in each of the five SCIROCCO regions. Specifically, each region played the role of receiving and transferring region[3] and in some cases more than two regions participated in the knowledge transfer activities. In addition, the regions had a choice to choose the type of twinning and coaching process as described in the Section 3 Methodology. The following Table provides a detailed overview of twinning and coaching activities in all five SCIROCCO regions:

Table 1: Overview of SCIROCCO twinning and coaching activities

Improvement of particular dimension of healthcare system	**Receiving region**	**Transferring region**	**Study visit**
Innovation Management	Norrbotten Region	Scotland	25-26 June 2018
eHealth services	Olomouc Region	Norrbotten Region	12-14 September 2018
Good Practice	**Receiving Region**	**Transferring Region**	**Study visit**
Advanced care planning in Integrated Care Organisation https://www.scirocco-project.eu/basque-country-b3-advance-care-planning-in-an-integrated-organisation/	Norrbotten	Basque Country	12-13 June
Hospital@Home:Telemonitoring, teleconsultation and telecare project for patients with Heart Failure, COPD and Diabetes https://www.scirocco-project.eu/p6-puglia-italy-telehomecare-telemonitoring-teleconsultation-and-telecare-project-aimed-at-patients-with-heart-failure-chronic-obstructive-pulmonary-diseases-and-diabetes/	Scotland Olomouc Region	Puglia Region	12-14 June 2018
Third Sector: Building Healthier and Happier Communities https://www.scirocco-project.eu/scotland-1-building-healthier-and-happier-communities-bhhc/	Basque Country Puglia Region	Scotland	4-5 September 2018

[3] The only exception was the Olomouc Region in Czech Republic which played only the role of receiving region due to low maturity scoring across all SCIROCCO dimensions. As such, it was agreed that Olomouc Region will benefit more in the role of receiving region.

4.1 Improvement of innovation management in Norrbotten Region

Innovation management is one of 12 domains of SCIROCCO Maturity Model and its online self-assessment tool. The main objective of this domain is to support the recognition and uptake of the innovative ideas to provide benefits across health care system. Many of the best ideas are likely to come from the clinicians, nurses and social workers who understand where improvements can be made to existing processes. 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. There is also value in looking outside the system to other regions and countries that are dealing with the same set of challenges, to learn from their experiences. Overall, this means managing the innovation process to get the best results for the systems of care and ensuring that good ideas are encouraged and rewarded. The maturity along this dimension is measured as follows:

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 and the diffusion of good practice is in place.

During the self-assessment process of the maturity of healthcare system for integrated care in Norrbotten Region in Sweden, it was concluded that innovation management is one of the weaknesses in integrated care (maturity level 2).

Innovations are captured and there are some mechanisms in place to encourage knowledge transfer. However, there is no very much formalised innovation management process. In addition, there are no formal organisations with the functions which can work across the innovation landscape and procurement is pretty much removed from the process. As a result, Norbotten Region identified this domain as the area of potential improvement which can be addressed through effective knowledge transfer.

Specifically, Scotland was invited to participate in the twinning and coaching activities (maturity level 3). There were two main features of Scotland's healthcare system which were particularly appealing for the stakeholders from Norrbotten Region. These were namely methodology for innovation management and stakeholder involvement and engagement in this process.

The twinning and coaching was initiated in May 2018, followed by the study visit organised in Scotland on 25-26 June 2018. In total 15 stakeholders from Norrbotten Region and Scotland participated in the study visit with the objectives to:

- Learn about Innovation Management in Scotland identified by the SCIROCCO tool as a domain for improvement in the Norrbotten Region;
- Share the learning and exchange expertise on innovation management in Norrbotten Region and Scotland;
- Discuss feasibility of the improvement of Innovation Management domain in the Norrbotten Region;
- Test the SCIROCCO tool as a tool to facilitate effective knowledge transfer;
- Capture the experience of European regions in using the SCIROCCO tool to facilitate the knowledge transfer and exchange of good practices.

The topics for more detailed discussion during the site visit included:

- Involvement of regional health and social care authorities, universities and private sector companies and other sectors in the innovation process (i.e., 'open innovation');
- Use of innovative procurement approaches (Pre-Commercial Procurement, Innovation Public Procurement, Public Private Partnerships, Shared Risk, Outcome-Based Payment) in the innovation process;
- Creation of culture for innovation (widely adopted culture).

Table 2: Programme of study visit to Scotland, 26 June 2018

Time	Activity
10.00	Welcome from the hosting organisation (Digital Health and Care Institute)
10.05	Meeting objectives
10.10	Rationale for the twinning & coaching between Norrbotten and Scotland: • Brief introduction to the maturity assessment of healthcare systems for integrated care in Norrbotten region and Scotland
10.30	Introduction to Digital Health and Care Institute (DHI)
10.45	DHI Innovation model and methodology
11.00	Innovation management in Scotland • Involvement of regional health and social care authorities, universities and private sector companies and other sectors in the innovation process (i.e., 'open innovation') and creating the culture of change.
12.00	Lunch
13.00	Use of open innovation approaches – How the Digital office is using Open Innovation in municipalities
14.00	• Facilitated discussion on the maturity of healthcare system in Norrbotten region and Scotland: • How does the local environment for integrated care enable the innovation management? • Maturity of healthcare system for integrated care in Norrbotten region versus the maturity of Scotland - how far they fit? • What needs to change/improve in the local environment to enable the improvement of the innovation management in Norrbotten?

Time	Activity
	• Does the improvement of the innovation management relate to other dimensions of the SCIROCCO tool / aspects of integrated care? • How feasible/difficult is the transfer of the key features of Scotland's healthcare system and innovation management particularly, to the local environment? • The feature is easy to transfer – there is a clear way of providing the feature in the receiving health system. • The feature is possible to transfer with some level of efforts – this might be to identify a sketch of how the feature could be implemented • Showstopper – there are some really very difficult issues to be resolved in order to transfer a particular feature. The outcomes of the discussion should inform the areas of improvement for the innovation management in Norrbotten Region.
15.15	Coffee break
15.45	Next steps: Development of Action Plans and Priority Action Areas for Norrbotten
16.00	Capturing the Experience of Regions with Twinning & Coaching: Focus group meeting to capture the experience and feedback of the participants on the knowledge transfer process.
17.00	End of meeting

4.2 Improvement of eHealth services in Olomouc Region

eHealth services is one of 12 domains of SCIROCCO Maturity Model and its online self-assessment tool. The main objective of this domain is to support of 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. The maturity along this dimension is measured as follows:

Assessment scale

0 – There are no eHealth services to support integrated care in place

1 – There is recognition of need but there is no strategy and/or plan on how to deploy eHealth services to support integrated care

2 – There is a mandate and plan(s) to deploy regional/national eHealth services across the healthcare system but not yet implemented

3 – eHealth services to support integrated care are piloted but there is no yet region wide coverage

4 – eHealth services to support integrated care are deployed widely at large scale

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

During the self-assessment process of the maturity of healthcare system for integrated care in Olomouc Region in Czech Republic, it was concluded that the dimension of ehealth services is one of the weaknesses in integrated care (maturity level 1).

Innovations are captured and there are some mechanisms in place to encourage knowledge transfer. However, there is no very much formalised innovation management process. In addition, there are no formal organisations with the functions which can work across the innovation landscape and procurement is pretty much removed from the process. As a result, Norbotten Region identified this domain as the area of potential improvement which can be addressed through effective knowledge transfer.

Specifically, Norrbotten Region in Sweden was invited to participate in the twinning and coaching activities (maturity level 4). There were two main features of Norrbotten's healthcare system which were particularly appealing for the stakeholders from Olomouc Region. These were namely patient access to medical records and ICT infrastructure to support exchange and sharing of information.

The twinning and coaching was initiated in June 2018, followed by the study visit organised in Norrbotten on 12-13 September 2018.

Figure 18: Study visit to Norrbotten, 12-13 September 2018

In total 19 stakeholders from Olomouc and Norrbotten Regions participated in the study visit with the objectives to:

- Learn about eHealth services in Norrbotten identified by the SCIROCCO tool as a domain for improvement in the Olomouc Region;
- Share the learning and exchange expertise on eHealth services in Olomouc and Norrbotten Region;
- Discuss feasibility of the improvement of eHealth domain in Olomouc Region;
- Test the SCIROCCO tool as a tool to facilitate effective knowledge transfer;
- Capture the experience of European regions in using the SCIROCCO tool to facilitate the knowledge transfer and exchange of good practices.

The topics for more detailed discussion during the site visit included:

- Role of eHealth in health system transformation;
- Approach to building infrastructure for sharing health data between various healthcare providers, concept of shared EHR (Electronic Health Records) and the role of state and Norrbotten Region. How is sustainability of the infrastructure assured?
- Standards for exchange health data and sematic, content of shared EHR;

- Reliability of health data (EHR) and motivation (incentives if any) of healthcare professionals to provide complete and accurate information in time;
- Data protection measures;
- Experience with implementation of 'Digital first' policy (moving phone and face-to-face services to digital services to reduce dependence on staff and promote self-service);
- Digital divide and how to address it;
- Access of patients to EHR;
- ICT applications supporting patients with chronic diseases, e.g. at home, both from clinical and technical viewpoints;
- Coordination of patient journey across different healthcare providers;
- ICT to support health and social care integration;
- Video conference services and provision of healthcare in distance;
- Qualifications of healthcare professionals to provide eHealth services;
- Procurement of eHealth services;
- Services supporting patient empowerment and keeping elderly at home, including evidence on the impact of these services;
- Future plans in eHealth in Norrbotten.

Table 3: Programme of study visit to Norrbotten, 12-13 September 2018

Time	Activity (12 September 2018)
10.00	Welcome from the hosting organisation and introduction to Region Norrbotten
10.15	Meeting objectives and rationale for the twinning & coaching between Norrbotten and Czech Republic: Brief introduction to the maturity assessment of eHealth services in Norrbotten region and in Czech Republic
10.30	Introduction to eHealth services in Region Norrbotten
12.00	Lunch
13.00	Use of eHealth services in clinical practice
14.00	Time for questions for "twinning & coaching"
14.30	Coffee break and refreshment
15.00	Data protection
15.30	Infrastructure for sharing health data between various healthcare providers.
16.00	Qualifications of personnel in telemedicine services
16.30	End of meeting

Time	Activity (13 September 2018)
8.45	Study visit at Sunderby Hospital Access to health data: 1177.se
9.45	Study visit and information: Susanne Sundvall and Ulrika Åström
10.45	Coffee
10.45	Project: Remo age
11.00	Facilitated discussion
12.00	Lunch
13.00	Innovation in Norrbotten Region
13.45	Good practice: Distance spanning healthcare
14.00	Summary of key learnings: Development of Action Plans and Priority Action Areas for Olomouc Region
14.30	Coffee
15.00	Facilitated discussion on the maturity of eHealth services in Norrbotten and Olomouc Region: • How does the local environment for eHealth services enable the use of eHealth solutions? • Maturity of eHealth services in Region Norrbotten versus the maturity of Olomouc Region - how far they fit? • What needs to change/improve in the local environment to enable the improvement of eHealth services in Olomouc Region? • Does the improvement of eHealth services relate to other dimensions of the SCIROCCO tool/aspects of integrated care? • How feasible/difficult is the transfer of the key features of Norrbotten's healthcare system and eHealth particularly, to the local environment of Olomouc Region? The outcomes of the discussion should inform the areas of improvement of eHealth services in Olomouc Region.
16.00	Capturing the Experience of Regions with Twinning & Coaching: Focus group meeting to capture the experience and feedback of the participants on the knowledge transfer process
16.30	End of the study visit in Region Norrbotten

4.3 Advanced Care Planning in the Basque Country

Advanced Care Planning was one of 30 Good Practices collected in SCIROCCO project in order to assess their feasibility for the transferability and scaling-up.

ACP is a voluntary process of discussion between an individual and care providers about future care, irrespective of discipline. The aim is to guarantee patients' right to take decisions about their own care as well as to have those decisions respected when time comes. The goal of this Good Practice is to promote ACP approach to the Basque population, particularly to chronic conditions population. The idea is to adjust end of life care to meet patients' preferences and improve decision making processes. Three stages were defined when designing the Good Practice:

- Diagnostic stage in order to identify the population that could benefit from the ACP
- Therapeutic stage in order to develop the intervention
- Evaluative stage in order to assess both the impact of the Good Practice and the Good Practice itself.

The core intervention consists of two individual semi structured interviews with the patient and one or two members of patient family and/or friends. The interviews are carried out by the patient's General Practitioner (GP) and the community nurse. The first meeting aims mainly at introducing the subject (Advanced Directives) and inviting the patient to reflect on his/her preferences regarding the care. The second interview then focuses on the discussions of the specific issues related to the patient and his/her clinical characteristics and situation. Participants write down an advance directive according to their values, health conditions and preferences. The GP and/or community nurse assist with this process. Every healthcare professional can access the Advance Directive using the Basque Country's Integrated Electronical Health Record. As ACP is considered an evolutive process, the patient can change opinion and modify its preferences whenever is needed.

Norrbotten Region identified this Good Practices as of strategic priority and expressed the interest to explore to what extent the features of the Practice can be transferred and adapted to the local environment. The ambition of the Norrbotten Region is to design a common system for advanced care planning where patients can take an active role and communicate with healthcare professionals as required. As a result, there is a need to educate healthcare professionals about a new way of thinking and delivering care; respecting the central position of the patients and their right to take an informative decision on the issues related to the advanced care. As such, a proper detailed review of the patients' needs, and available solutions needs to be conducted and implemented. However, this requires additional flow of information to enable patients and healthcare professionals to follow through the healthcare chain. Current systems need to be changed and redesign in order to offer patients the possibility to receive a safe and coordinated healthcare, across the organisational boundaries and where the patients are seen as an obvious part in planning of care process that concern them. Social care, health care and rehabilitation models need to be changed to accommodate citizens' needs and wishes.

As a result, the twinning and coaching was initiated in April 2018, followed by the study visit organised in the Basque Country on 12-13 June 2018.

Figure 19: Study visit to Basque Country, 12-13 June 2018

In total 15 stakeholders from Norrbotten Region and Basque Country participated in the study visit with the objectives to:

- Learn about ACP Good Practice in Basque Country;
- Share the learning and exchange expertise on advanced care planning in the Basque Country and Norrbotten Region;
- Discuss feasibility of the improvement of advanced care planning in Norrbotten Region;
- Test the SCIROCCO tool as a tool to facilitate effective knowledge transfer;
- Capture the experience of European regions in using the SCIROCCO tool to facilitate the knowledge transfer and exchange of good practices.

The topics for more detailed discussion during the site visit included:

- Palliative care plans
- Health and social care integration and ICT support
- Organisation of primary care and the role of advanced care planning

Table 4: Programme of study visit to Basque Country, 12-13 June 2018

Time	Activity (12 June 2018)
9.30	Welcome
9:45	Review of the objectives and agenda
10.00	Healthcare integration in the Basque Country
10.20	Framework Contract Programme
11.10	Palliative care plan in the Basque Country
11.35	Integrated electronical health record

Time	Activity (12 June 2018)
12.00	Rationale for the twinning & coaching between Norrbotten Region and the Basque Country • Introduce the rationale for twinning & coaching • Explain the rationale for the study visit, e.g. why is Basque Country's good practice of interest for Norrbotten.
12.20	ICO Araba (context of the good practice)
14.00	Presentation on the Advanced Care Planning in an the ICO Araba
15:00	Assessment of the Advanced Care Planning in an the ICO Araba
15.15	Brief presentation on the maturity of integrated care in Norrbotten region
15.30	Facilitated discussion on the maturity requirements of Advanced Care Planning in ICO Araba Good Practice and how they fit the healthcare system in Norrbotten; discussion on what would be the requirements of local healthcare systems to adopt / transfer this good practice. • How does the local environment for integrated care enable the adoption of the Good Practice? • Maturity of healthcare system for integrated care in Norrbotten region versus the requirements of the Good Practice - how far they fit? (Norrbotten region) • How feasible/difficult is the transfer of the key requirements to the local environment? The outcomes of this activity will inform the development of Action Plans.
16.15	Experience of experts with twinning & coaching The objective of this activity is to interview the experts participating in the twinning & coaching and capture their experience with the process.

Time	Activity (13 June 2018)
9.00	Review of agenda
9.10	Visit to primary care centre
10.30	Next steps: Development of Action Plans The objective of this activity is to outline the next steps and introduce the template and process for the development of Action Plans. The Actions Plans will be developed after the study visit.

4.4 Hospital@Home in Puglia Region

Hospital@Home was one of 30 Good Practices collected in SCIROCCO project in order to assess their feasibility for the transferability and scaling-up.

Hospital@Home Good Practice is designed as a technological support for already structured activities in home care. The main objective is to reduce hospitalisation and re-hospitalisation rate and to improve the quality of care for patients at home. In addition, the objective is to:

- Reduce the number of patients with heart disease, diabetes and other chronic diseases in the process of instability
- Activate protected de-hospitalisation
- Optimise the therapy and diagnosis according to international guidelines.

The Good Practice has also an ambition to validate new telemedicine models applied for diagnostic and therapeutic pathways for the management of chronicity. The aim is to implement a new type of telemonitoring, based on continuous collaboration and patient monitoring by different professionals and different users.

Patients, opportunely selected, are telemonitored by their General Practitioners by using the innovative home and health monitoring technological solution (H&H Hospital@Home). This solution is able to detect the main clinical and instrumental parameters in addition to the therapeutic administration, based on oxygen and bronco-aspiration. It is allocated at the patients' home and it is permanently interconnected with the General Practitioner and/or Specialist, by computer, telephone, tablet and other devices.

At the same time, there is a central monitoring room at the hospital in Ceglie Messapica (Brindisi) for all patients and all devices located at their home. All clinical parameters of patients are stored on a dedicated server, respecting the rules for the respect of privacy. The system allows the healthcare professionals (neurologists, pulmonologist, cardiologists, diabetologists, etc) to monitor and speak with patients remotely. The patients can also activate the visit of the healthcare professionals in their homes. In addition to real-time monitoring of physiological parameters, the healthcare professionals can also monitor the physical and technical characteristics of home device. As a result, it is possible to deliver therapy to the patient remotely. In particular, it is possible to deliver oxygen therapy and endocavitary aspiration. Healthcare professional determines the limit of the range of physiological parameter values and when the parameter is beyond the limit, the system draws the operator's attention through the alert.

Both, Scotland and Olomouc Region identified this Good Practices as of strategic priority and expressed the interest to explore to what extent the features of the Practice can be transferred and adapted to their local environments.

For Scotland, this opportunity to learn about the Hospital@Home Good Practice showed clear similarities of Puglia Region and Scotland's vision of how to transform care delivery. The main focus in both regions is to look for the primary care led solutions which would help to shift the balance of care from hospital to community settings, increase capacity and reduce the demands on health and social care services. As such, a number of opportunities for learning were identified in Scotland, namely:

- Opportunity to improve engagement of GPs (General Practitioners) in the delivery of technology enabled care solutions. The proposed solutions need to have a minimum impact on the routine working practice of GPs. Otherwise GPs often feel protective of their own roles and are thus a main barrier to implement a change. GPs need to drive a change and advocate for the new solutions.
- Opportunity to improve the funding of care transformation. The resources need to follow transformation of services to community settings.
- Opportunity to better promote benefits and impact of technology enabled care solutions in order to facilitate their "buying". Systematic evaluation and quality data collection is a key component of successful Hospital@Home services in Puglia.
- Opportunity to better target citizens who would benefit most from technology enabled care solutions. The population approach and use of predictive modelling need to become part of routine care and service design.

For Olomouc Region, this opportunity to learn about the Hospital@Home Good Practice would contribute to the improvement of a number of outcomes:

- Decreased a need for hospital beds;
- Improved care of chronically ill, including those discharged from hospitals;
- Reduced number of reduce the number of unstable patients with chronic diseases.

As a result, the twinning and coaching was initiated in April 2018, followed by the study visit organised in Puglia Region on 13-14 June 2018.

Figure 20: Study visit to Puglia Region, 13-14 June 2018

In total 22 stakeholders from Puglia Region, Olomouc Region and Scotland participated in the study visit with the objectives to:

- Learn about Hospital@Home Good Practice in Puglia Region;
- Share the learning and exchange expertise on Hospital@Home services in Puglia Region, Olomouc Region and Scotland;
- Discuss feasibility of the improvement of Hospital@Home services in Olomouc Region and Scotland;
- Test the SCIROCCO tool as a tool to facilitate effective knowledge transfer;

- Capture the experience of European regions in using the SCIROCCO tool to facilitate the knowledge transfer and exchange of good practices.

The topics for more detailed discussion during the site visit included:

- Organisational model for home and mobile health monitoring/management of patients with chronic conditions in Puglia
- Financing and reimbursement of the remote monitoring services in Puglia
- Technological solution of the good practice;
- Workforce requirements, e.g. training, education, profile of workforce, etc;
- Cost-effectiveness and sustainability of the good practice;
- Outcomes/impact of the good practice, e.g. clinical, economic, etc;
- Transferability/Scaling up of the good practice.

Table 5: Programme of study visit to Puglia Region, 13-14 June 2018

Time	Activity
08.30	Travel to site visit
09.45	Welcome from the hosting organisation
10.00	Live demo of the telemonitoring service
13.00	Lunch
13.45	Meeting objectives
13.50	Healthcare integration in Puglia
14.10	Home and Mobile Health Monitoring in Puglia
14.30	TeleHomeCare Good Practice: • Compelling need • Organisational model • Resources (ICT, human, economic) • Key innovative elements • Outcomes/Impact • Sustainability • Lessons learned/Issues during the implementation
15.00	Reflections from the visiting regions
15.15	Coffee break
15.30	Rationale for the twinning & coaching between Olomouc region, Puglia and Scotland: • Background to the twinning & coaching process • Rationale for the study visit, e.g. why is Puglia's good practice of interest for Scotland and Olomouc.
15.45	Key requirements for the transferability of the TeleHomeCare:

Time	Activity
	• Application of the SCIROCCO tool to understand the maturity requirements for the adoption and scaling-up of the TeleHomeCare Good Practice
16.00	Facilitated discussion on the maturity requirements of TeleHomeCare Good Practice and how they fit the healthcare system in Olomouc region and Scotland: • How does the local environment for integrated care enable the adoption of TeleHomeCare Good Practice? • Maturity of healthcare system for integrated care in Olomouc region versus the requirements of the Good Practice - how far they fit? (Zdenek Gutter) • Maturity of healthcare system for integrated care in Scotland versus the requirements of the Good Practice – how far they fit? (Donna Henderson/Andrea Pavlickova) The outcomes of the discussion should inform which dimensions of the SCIROCCO tool/ aspects of integrated care system are critical for the transferability and adoption of TeleHomeCare Good Practice in Olomouc region and Scotland.
17.00	End of meeting

4.5 Third Sector: Building Healthier and Happier Communities

Building Healthier and Happier Communities was one of 30 Good Practices collected in SCIROCCO project in order to assess their feasibility for the transferability and scaling-up.

The “third sector” in Scotland is made up of non-governmental and non-profit organisations, from grassroot community groups and village hall committees to social enterprises and registered national charities. It is often also described as the voluntary sector, not-for-profit, charity sector, social economy, social enterprise sector, NGOs (non-government organisation) or civil society. It has an annual turnover of €5.96 billion. As of December 2017, Scotland’s third sector was made up of over 40,000 organisations, including:

- 23, 300 registered charities;
- 20, 000 grassroot community groups, sports and art clubs
- 163 housing associations
- 5,2000 Social enterprises
- 432 community interest companies
- 107 credit unions.

The traditional idea of charities as benevolent organisations simply there to help the poor is being replaced by a modern, progressive, third sector which carries out an enormous range of activities to improve people’s lives. It does it by:

- Supporting people through social care, health services and employability programmes;
- Empowering people by campaigning and advocating for minority and disadvantaged groups in our society;
- Bringing people together through social activities, local clubs and community centres;
- Enabling better health and wellbeing through medical research, addiction services, sport facilities and self-help groups;
- Improving our environment through conversation of our land and heritage, and regeneration of our communities.

There are 130,000 directly paid staff in the third sector – a figure comparable with NHS Scotland – collectively making it one of the Scotland's biggest employers. In relation to the health and social care agenda in Scotland, there are 5 main national membership organisations that represent third sector interests:

- Coalition of Care and Support Providers (CCPS) – to represent, promote and safeguard the interests of third sector and non-for-profit social care and support providers in Scotland.
- The Alliance – to support people of all ages who are disabled or living with long terms conditions to have a strong voice and enjoy their right to live well, as equal and active citizens.
- Voluntary Health Scotland – organisation working to improve health and address health inequalities
- Scottish Council for Voluntary Organisations (SCVO) – championing Scotland's vibrant charities, voluntary organisations and social enterprises.
- Scottish Federation of Housing Associations and Glasgow and West of Scotland Housing Forum
- Third Sector Interfaces (TSIs) – local voluntary sector umbrella organisations in each of the 32 local health and social care partnerships.

In Scotland, there is a legal framework in place for the engagement of third sector in the provision of integrated care. The Public Bodies (Joint Working) (Scotland) Act 2014 is the legislative framework for the integration of health and social care services which requires the integration of the governance, planning and resourcing of adult social care services, adult primary care and community health services and some hospital services. Other areas such as children's health and social care services, and criminal justice social work can also be integrated. As a result, the Act creates a number of new public organisations, known as integration authorities (31 integration authorities) and aims to break down the barriers to joint working between NHS boards and local authorities. Under this model an Integration Joint Board (IJB) is set up and the NHS boards and local authorities delegate the responsibility for planning and resourcing service provision for delegated adult health and social care services to the IJBs.

The IJB must include representatives of the local authority, NHS Board, a carer representative, a GP representative, a nurse representative, a secondary medical care practitioner, a service user representative, a staff-side representative, a third sector representative, an officer who is responsible for financial administration the Chief Officer and the Chief Social Worker. As

such, a third sector organisation is directly involved in the strategic planning and locality planning of the integrated care provision, however, the representatives of third sector do not have voting rights which often creates some uncertainty.

The third and independent sectors are contributing to the success of integration in range of ways:

- Delivering health and/or social care support
- Enabling access to people who use services and their communities, to support their engagement
- Providing access to data, and our ability to gather intelligence useful for monitoring and evaluation, and planning purposes
- Bringing expertise around barriers and needs from the wide diversity of groups of people who use services
- Facilitating communications and the gathering and collating of intelligence via umbrella groups and intermediaries.

In relation to service delivery, the third sector provide 69% of the total social services. The task is to harness this capacity, and to help the third sector grow in order to achieve the "radically reformed way of working and to make the most of the third sector contribution to the integration agenda.

Both, Basque Country and Puglia Region identified this Good Practices as of strategic priority and expressed the interest to explore to what extent the features of the Practice can be transferred and adapted to their local environments.

For the Basque Country, this opportunity to learn about Building Healthier and Happier Communities links to a clear need to create a framework that defines the relationship between the health, social and third sectors in the Basque Country, including:

- Agreement on common objectives and creating a vision of "working together"
- Prioritisation of activities
- Involvement of sectors in the decision-making bodies related to integrated care
- Identification of added value of "working together" approach and breaking down the silos
- Promotion of intersectoral communication and collaborations
- Promotion of citizen participation in health matters.

Involving the third sector in the provision of integrated care would guarantee the most appropriate response to the needs of citizens at a right time; providing the citizens with resources and capacity to make and act upon their own decisions. In addition, involving the third sector in the provision of integrated care would also mean greater efficiency and use of resources and capacities in the Basque's society.

The Third Social Sector benefits from a better knowledge of people needs due to its proximity, empathy and active listening of citizens and promoting their active participation in the society. In turn, this would mean bringing citizens closer to the administration which would potentially lead to an improvement in the provision of coordinated and integrated care.

For Puglia Region, this opportunity to learn about Building Healthier and Happier Communities links to the need to align and unify the work of third sector organisations. There are several third sector organisations (TSOs), however, their activities seem to be rather fragmented and not strongly aligned with a common integrated care vision. Scotland's experience can help the Puglia Region to systematise the activities of the third sector by creating a more homogeneous regulatory and organisational framework in order to improve the involvement of TSOs.

In Scotland there are many TSOs working in social care, providing support for vulnerable and marginalised groups who frequently face poverty, social care needs and poor health. There are also organisations working in prevention, particularly in the area of food and healthy eating initiatives. Working closely with communities is a key remit of the third sector approach. In many case, organisational structure and aims are defined by the needs of a particular community in order to fill the gaps in the service provision. Third sector initiatives are very often based on the development of social networks which are very powerful tool to improve social capital and reduce isolation. This in turn results in the improvement of health outcomes.

There is now a consensus that health and social care services in Puglia Region need urgent attention. Knowledge and ability to respond to this need is often hampered due to complicated communication channels. As organisations embedded in service users' communities, TSOs are often able to overcome these communication barriers. This Action Plan will aim to demonstrate that TSOs have the potential to meet the growing needs and positively contribute to the improvement of integrated care services in Puglia region.
As a result, the twinning and coaching was initiated in June 2018, followed by the study visit organised to Scotland on 4-5 September 2018.

Figure 21: Study visit to Scotland, 4-5 September 2018

In total 14 stakeholders from Basque Country, Puglia Region and Scotland participated in the study visit with the objectives to:

- Learn about Building Healthier and Happier Communities Good Practice in Scotland;
- Share the learning and exchange expertise on third sector services in Basque Country, Puglia Region and Scotland;
- Discuss feasibility of the improvement of third sector services in Basque Country, Puglia Region and Scotland;
- Test the SCIROCCO tool as a tool to facilitate effective knowledge transfer;
- Capture the experience of European regions in using the SCIROCCO tool to facilitate the knowledge transfer and exchange of good practices.

The topics for more detailed discussion during the site visit included:

- Organisation and involvement of voluntary sector in the delivery of integrated health and social care
- Activities of voluntary sector to raise awareness about the potential of digital solutions to support well-being and health
- Citizen empowerment and digital literacy
- Community empowerment and the role of voluntary sector.

Table 6: Programme of study visit to Scotland, 4-5 September 2018

Time	Activity (4 September 2018)
09.00	Welcome and meeting objectives
09.00	Introduction to SCVO (Scottish Council for Voluntary Organisations)
10.45	Site visit to GRACE (Group Recovery Aftercare Community Enterprise) Welcome from the hosting organisation
11.00	GRACE integrated peer-led assessment model to support health and well-being: • Awareness raising activities about the potential of digital solutions • Digital literacy • Citizen empowerment • Live demos of the services • Q&A
13.45	Site visit to Carr Gomm Welcome from the hosting organisation
14.00	Introduction to Carr Gomm: • Overview of the structure • Examples of the contractual services with a specific focus on Rosebank Allotments Service • Q&A

Time	Activity (4 September 2018)
14.45	Community empowerment: • Link workers programme • Benefits of social prescribing approach • NHS Lothian Trauma Service • Independent Advice and Support Service (Self-Directed Support) • Q&A
16.00	Digital offerings: • Access to data and digital support • Access to digital information • Social networks
17.30	End of meeting

Time	Activity (5 September 2018)
09.15	Welcome and meeting objectives
09.20	Introduction to CCPS (Coalition of Care and Support Providers): • Third sector involvement in care and support provision in Scotland • Overview of third sector national H&SC intermediary landscape • Third sector engagement with integration of H&SC • Legal framework for engagement • Digital agenda – current activities; benefits and challenges; CCPS digital programme
10.15	Facilitated discussion on the key features/requirements needed in the local healthcare systems of the Basque Country and Puglia Region to transfer the learning about Scotland's Good Practice on the involvement of voluntary sector in the delivery of integrated care: • What needs to change/improve in the local environment to enable the transferability and adoption of learning about Scotland's Good Practice? • How feasible/difficult is the transfer of the key requirements of Scotland's Good Practice to the local environment?
11.30	Capturing the Experience of Regions with Twinning & Coaching: Focus group meeting
12.30	End of meeting

5. Action Plans

The outcomes of the knowledge transfer activities were captured in the form of local Action Plans. The main objective of the Plans was to inform the decision-makers about the agreed priority actions that were necessary for the adoption of integrated care solution and/or improvements of particular aspect of healthcare system. The development of the Action Plans was primarily informed by the outcomes of the study visits where the local experts had the opportunity to discuss in details the features required for the transferability of particular Good Practices and/or improvement of the dimension of integrated care, including the feasibility of the transfer and necessary adaptation of these features in the local environment. In addition, the Action Plans outlined the policy implications of the agreed actions, including responsible actors and timeline.

The Action Plans were co-designed by transferring and receiving regions. In total, seven Action Plans were developed as a result of SCIROCCO twinning and coaching activities as follows:

- Action Plan to create conditions for the adoption of integrated care in Norrbotten Region – Improvement of Innovation Management – **Annex V**
- Action Plan to create conditions for the adoption of integrated care in Olomouc Region – Improvement of eHealth services **- Annex VI**
- Action Plan to create conditions for the adoption of integrated care in Norrbotten Region – Transferability of the Good Practice "Advanced Care Planning in an Integrated Care Organisation in the Basque Country" – **Annex VII**
- Action Plan to create conditions for the adoption of integrated care in Scotland – Transferability of "Hospital@Home" Good Practice in Puglia Region – **Annex VIII**
- Action Plan to create conditions for the adoption of integrated care in Olomouc Region – Transferability of "Hospital@Home" Good Practice in Puglia Region – **Annex IX**
- Action Plan to create conditions for the adoption of integrated care in Basque Country – Improvement of engagement of third sector in the provision of integrated care in Scotland – **Annex X**
- Action Plan to create conditions for the adoption of integrated care in Puglia Region – Improvement of engagement of third sector in the provision of integrated care in Scotland – **Annex XI**

6. Discussion

The maturity of health care systems and requirements of Good Practice (for its adoption and transferability) need to be recognised in order to facilitate effective knowledge transfer and learning to inform the adoption and scaling-up of integrated care. The maturity of a healthcare system is shaped by the local conditions enabling adoption of integrated care solutions. A flexible and easy-to-apply approach to comprehend the local conditions and requirements for improvement and/or adoption of particular Good Practice was therefore applied in SCIROCCO regions.

Twinning and coaching process was conducted in each of the five SCIROCCO regions, Basque Country, Norrbotten Region, Olomouc Region, Puglia Region and Scotland. Specifically, each region played the role of receiving and transferring region and in some cases more than two regions participated in the knowledge transfer activities. In addition, the regions had a choice to choose the type of twinning and coaching process as described in the Section 3 Methodology.

All five regions applied the SCIROCCO twinning and coaching methodology and tested the SCIROCCO tool in real-life settings. The use of commonly agreed methodology ensured the consistency of the knowledge transfer process however some local adaptations were required. These were mainly due to linguistic issues of engaging local experts in this process. As a result, some of the documentation prepared for twinning and coaching required translation as well as participation of translators during the study visits and online meetings.

The scope of the twinning and coaching process was defined by each individual region reflecting the local need and strategic priorities for integrated care as described in Section 4. This has also informed the structure and the size of twinning and coaching teams locally. Engagement in the regions varied, in terms of use of different communication channels and also in length of the process.

The twinning and coaching process was facilitated by the SCIROCCO tool. Some adaptations were also required in the SCIROCCO self-assessment tool to reflect the need for new functionalities such as:

- Functionality to compare and contrast the outcomes of the assessment processes, for both the maturity of healthcare systems and maturity requirements of Good Practices;
- Functionality to invite the interested stakeholders and organisation to participate in the twinning and coaching;
- Functionality to discuss the feasibility of the features for the transferability and adaptation to local settings;
- Functionality to download and upload Action Plans.

The outcomes of the twinning and coaching process were visualised in the form of spider diagrams and tables. Most of the twinning and coaching were conducted within four months,

followed by the study visits organised in 4 SCIROCCO regions4. The twinning and coaching consisted of three key phases applicable to both types of twining and coaching activities:

- Phase 1: Planning for the twinning and coaching
- Phase 2: Knowledge transfer activities
- Phase 3: Capturing the outcomes of twinning and coaching

In general, the twinning and coaching process was perceived as a very comprehensive and useful way of capturing knowledge on local conditions enabling the adoption and scaling-up of integrated care. The experience of local stakeholders and outcomes of the assessment process emphasised that the main added value of this process was the multi-disciplinary dialogue and discussions during the study visits rather than the quantitative maturity measures. Using the SCIROCCO tool, it provided the basis for the structured and focused discussion of very diverse stakeholders which is particularly useful for defining the actions and measures required to improve the identified weaknesses and gaps in the systems and/or adopt a particular Good Practice.

The twinning and coaching activities in 5 SCIROCCO regions provided a strong basis for mutual learning and exchange of good practices on how to create and improve local conditions for the adoption and scaling-up of integrated care. Understanding the complementarity of regions and/or organisations' strengths and weaknesses and maturity requirements of Good Practice is therefore absolutely crucial for a much more tailored and effective knowledge transfer and improvement planning.

The testing of the SCIROCCO tool in the knowledge transfer process showed its potential to facilitate effective learning and exchange of information in order to improve local conditions enabling the adoption and scaling-up of integrated care.

4 Olomouc Region did not organsie study visit as the Region plays the role of the receiving region in both identified twinning and coaching activities.

7. Twinning and coaching guide

The outcomes of the WP7 activities can be summarised in a number of recommendations to help regions in the process of twinning and coaching and effective knowledge transfer:

1. Knowledge transfer is an enabler of capacity-building support and improvement in the adoption and scaling-up of integrated care.

2. Effective knowledge transfer requires dedicated support to ensure that the flow of appropriate information and learning between receiving and transferring entities is tailored to the local context and maturity of the particular healthcare system seeking support.

3. The maturity of healthcare systems and requirements of the good practice (for its adoption and transferability) need to be recognised in order to facilitate effective evidence-based knowledge transfer.

4. The SCIROCCO tool can help to match regions with complementary strengths and weaknesses and tailor knowledge transfer to address a particular need and/or gap in integrated care.

5. The SCIROCCO tool can help potential adopters to understand the actions that more progressive regions have taken in order to be successful and the contextual requirements for the transferability of these actions.

6. The SCIROCCO tool can guide potential adopters through the learning process and identify commonalities and differences in the maturity of their local context for integrated care. This is critical to assess the feasibility of transfer and the degree of adaptation required.

7. The twinning and coaching process offers participating regions valuable reflections and learning on how to implement a particular good practice and/or improve particular aspect of integrated care.

8. The twinning and coaching should be considered as a mutual process of learning rather than a one-way relationship. The learning process inspires potential adopters on what can be done to make the progress with their existing systems and services, but it also provides the re-assurance and prestige for transferring regions.

9. The twinning and coaching process is a complex process involving different layers, cultures and stakeholders of the system. The SCIROCCO tool can help to facilitate multi-disciplinary discussions and build constructive relationships enabling mutual learning and improvement.

10. The twinning and coaching process, if managed effectively, can inform priority actions that are necessary in order to create the right local conditions for the adoption and scaling-up of integrated care, including policy implications.

Annex I SCIROCCO Maturity Model (v3.0)

1. Readiness to Change

Objectives:

If the existing systems of care[5] 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.
- Considering the need to address the risk of health inequities.
- 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.

Assessment scale:

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.

2. Structure & 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 efficient 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 technology enabled care services 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.
- Considering the need to address the risk of health inequities.
- Establishing organisations with the mandate to select, develop and deliver eHealth services.

5 The term care refers to both health and social care.

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 or national level
4 – Roadmap for a change programme defined and accepted by stakeholders involved.
5 – Full, integrated programme established, with funding and a clear mandate.

3. eHealth Services

Objectives:
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.

- Essential components to enable information-sharing, based on secure and trusted services.
- 'Digital first' policy (where possible, move phone and face-to-face services to digital services to reduce dependence on staff and promote self-service).
- Availability of fundamental building blocks to enable eHealth services ('ICT infrastructure').
- Data protection and security designed into patient records, registries, online services etc.
- Enabling of new channels for healthcare delivery and new services based on advanced communication and data processing technologies.
- Address the risk of the Digital health divide.

Assessment scale:
0 – There are no eHealth services to support integrated care in place.
1 – There is recognition of need but there is no strategy and/or plan on how to deploy eHealth services to support integrated care.
2 – There is a mandate and plan(s) to deploy regional/national eHealth services across the healthcare system but not yet implemented.
3 – eHealth services to support integrated care are piloted but there is no yet region wide coverage.
4 – eHealth services to support integrated care are deployed widely at large scale.
5 – Universal, at-scale regional/national eHealth services used by all integrated care stakeholders.

4. Standardisation & Simplification

Objectives:
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 technical standards will be used across a region or country.

- Simplification of infrastructure; fewer integration points to manage; easier interoperability and procurement.
- Consolidation of applications and data centres into fewer sites.

- Regional standardisation on fewer (or single) solutions.
- Ability to view and exchange medical data from different systems across diverse care settings.

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 is initiated
2 – An ICT infrastructure to support integrated care has been agreed together with a recommended set of technical standards – there may still be local variations or some systems in place are not yet standardised
3 – A recommended set of agreed technical 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 technical specification of new systems in regional/national procurement of new systems; consolidated datacentres and shared services (including the cloud) is normal practice.

5. Funding

Objectives:
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 and/or reimbursement schemes for on-going operations is available
5 – Secure multi-year budget and/or reimbursement schemes, accessible to all stakeholders, to enable further service development.

6. Removal of Inhibitors

Objectives:
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.

- Actions to remove barriers: legal, organisational, financial, skills taking into account the need to address the risk of health inequities.
- Changes to the law concerning e.g., medical acts, information governance, data sharing –factors which may hold up innovation.
- Creation of new organisations or collaborations to encourage cross-boundary working ('normative integration').
- Changes to reimbursement to support behavioural change and process change.
- Education and training to increase understanding of innovations and technology enabled care solutions in order to speed up solution delivery.

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

7. Population Approach

Objectives:
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.

- Understanding and anticipating demand; meeting needs better and addressing health inequalities.
- Improving the resilience of care systems by using existing data on public health, health risks, and service utilisation.
- Taking steps to divert citizens into more appropriate and convenient care pathways based on user preferences.
- Predicting future demand and taking steps to reduce health risks though technology-enabled public health interventions.

Assessment scale:
0 – Population health approach is not applied to the provision of integrated care services
1 - Population-wide risk stratification considered but not started
2 - Risk stratification approach is used in certain projects on an experimental basis
3 - Risk stratification used for specific groups i.e. those who are at risk of becoming frequent service users –
4 -A population risk approach is applied to integrated care services but not yet systematically or to the full population
5 – Whole population stratification deployed and fully implemented.

8.Citizen Empowerment

Objectives:
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, considering the need to address the risk of health inequities.

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 engaged in decision-making processes about their health and are included in decision-making on service delivery and policy-making.

9. Evaluation Methods

Objectives:
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, e.g. 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 of integrated care to regional or national level.

- Establishing baselines (on cost, quality, access etc.) in advance of new service introduction.
- Systematically measuring the impact of new services and pathways using appropriate methods (e.g., observational studies, incremental improvement, clinical trials).
- Generating evidence that leads to faster adoption of good practice.

Assessment scale:
0 – No evaluation of integrated care services is in place or in development
1 – Evaluation of integrated care services is planned to take place and be established as part of a systematic approach
2 – Evaluation of integrated care services exists, but not as a 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).

10. Breadth of Ambition

Objectives:
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. Similarly, integration may include all levels of the system or may be limited to clinical information sharing. The long-term goal should be fully integrated care services which provide a complete set of seamless interactions for the citizen, leading to better care and improved outcomes.

- Integration supported at all levels within the healthcare system – at the macro (policy, structure), meso (organisational, professional) and micro (clinical) levels.
- Integration between the healthcare system and other care services (including social, voluntary, informal, family services).
- Seamless transition for the patient between and within care services.

Assessment scale:
0 – Coordination activities 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) is achieved
3 – Integration between care levels (e.g., between primary and secondary care) is achieved
4 – Improved coordination of social care service and health care service needs is introduced
5 – Fully integrated health & social care services are in place and functional.

11. Innovation Management

Objectives:
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. There is also value in looking outside the system to other regions and countries that are dealing with the same set of challenges, to learn from their experiences. Overall, this means managing the innovation process to get the best results for the systems of care, and ensuring that good ideas are encouraged and rewarded.

- Adopting proven ideas faster.
- Enabling an atmosphere of innovation from top to bottom, with collection and diffusion of best practice.
- Learning from inside the system, as well as from other regions, to expand thinking and speed up change.
- Involving regional health and social care authorities, universities and private sector companies and other sectors in the innovation process (i.e., 'open innovation').
- Using innovative procurement approaches (Pre-Commercial Procurement, IPP, PPP, Shared Risk, Outcome-Based Payment)

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.

12. Capacity Building

Objectives:
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. As demands continue to change, skills, talent and experience must be retained. This means ensuring that knowledge is captured and used to improve the next set of projects, leading to greater productivity and increasing success.

- Increasing skills; continuous improvement.
- Building a skill base that can bridge the gap and ensure that the capacity needs are understood and addressed by ICT where appropriate
- Providing tools, processes and platforms to allow organisations to assess themselves and build their own capacity to deliver successful change.
- Creating an environment where service improvements are continuously evaluated and delivered for the benefit of the entire care system.

Assessment scale:
0 – Integrated care services are not considered for capacity building
1 – Some 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 –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.

Annex II SCIROCCO Focus Group guidelines

Capturing the experience of twinning and coaching

The following questions were developed in the frame of WP8: *Lessons learned and policy implications* in order to capture the experience of twinning and coaching between regions. They are about several stages in conducting the twinning & coaching process (i.e., "the study visit"): the actual experience of doing the twinning and coaching, and the reflections that you have immediately at the end of the twinning and coaching study visit. All the questions listed here were asked of people from BOTH the transferring and the receiving region in the same focus group.

Background to twinning & coaching

- What were your expectations of the study visit?
- How did you get involved in the twinning and coaching activities i.e., the study visit?

Role of the SCIROCCO tool in twinning and coaching

- In your view, how does the SCIROCCO tool influence knowledge transfer that can take place between a transferring region and a receiving region?
- In your view, how does the SCIROCCO tool influence the structure of discussion during a study visit?

Insights, outcomes and potential benefits

- What are the key points that the study visit has raised:
  - In relation to integrated care in your region?
  - More generally, in relation to health systems delivery?
- Which of the key points discussed or lessons learned during the study visit do you think will be most likely to be addressed in your region in the approach to integrated care?
- As a result of your twinning and coaching experience:
  - Are there any outcomes you think your decision-makers should be aware of?
  - Are you planning to raise any of these with your decision-makers? (E.g. the priority actions needed for the adoption of a particular good practice.)

Ways of enhancing, and difficulties with, twinning & coaching

- What worked well when sharing the knowledge/experiences on integrated care between the regions during the study visit?
- What difficulties did you experience in sharing knowledge and experiences on integrated care between the regions during the study visit?
- What do you think will help to overcome the difficulties experienced?
- Do you have any suggestions for improvements regarding the study visit?
- Do you have any other comments with regard to your participation in the study visit?

Specific comments on the SCIROCCO tool

- What features of the SCIROCCO tool did you find difficult to use or understand?
- What features of the SCIROCCO tool did you find easy to use or understand?
- How well did the SCIROCCO tool support matching two healthcare systems or a healthcare system and a good practice?
- How well did the SCIROCCO tool support matching two healthcare systems or a healthcare system and a good practice?
- How well did the notion of features on the SCIROCCO tool support you during your study visit?
- In your region, can you describe how the SCIROCCO tool could be used in the future?
- Do you have any suggestions for improvements regarding the SCIROCCO tool?

Annex III SCIROCCO Action Plan informed by the maturity requirements of Good Practices

SCIROCCO Twinning & Coaching

Action Plan to create conditions for the adoption of integrated care in XY region

Transferability of the XY Good Practice

Background: The objective of the Action Plan is to reflect on the possibility to transfer and adopt the learning about the XY Good Practice to local settings in XY region, including the feasibility of the transfer and recommendations on policy priority actions that would enable the creation of local conditions for the adoption of integrated care.

The Action Plan builds on the outcomes of the study visit organised in XY on XY. The study visit was an opportunity to learn about the Good Practice and discuss its potential transferability by comparing and contrasting the requirements of the Good Practice with the maturity of local health and social care system for integrated care. This process was facilitated by SCIROCCO self-assessment tool which provided the basis for the twinning and coaching activities.

The Action Plan are co-designed jointly with the transferring and receiving region as follows:

- Section 1: Needs of the adopting region – Receiving region
- Section 2: Description of the integrated care solution – Transferring region
- Section 3: Maturity requirements of the integrated care solution – Transferring region
- Section 4: Benefits and opportunities of integrated care solution – Receiving region
- Section 5: Conditions for the adoption of integrated care solution - Receiving region
- Section 6: Adaptation of local environment to enable the transferability of learning – Receiving region
- Section 7: Priority actions to enable conditions for the transferability of learning - Receiving region

1. Needs of the receiving region

1.1 ***Receiving region***: Please describe the needs/challenges of your local health and social care system:

Max 200 words

2. Integrated care solution to address the needs of the receiving region

2.1 ***Transferring region***: Please provide the name and brief description of the innovative Good Practice:

Max 250 words

2.2 ***Transferring region***: Please describe the challenges/problems that the Good practice is supposed to solve:

Max 100 words

2.3 ***Transferring region***: Please describe key innovative elements of the Good Practice; please describe how the practice improved the situation compared to previous practice:

Max 150 words

2.4 ***Transferring region***: Please describe costs/investments needed for the deployment of the Good Practice:

Max 150 words

2.5 ***Transferring region***: Please describe impact/outcomes observed:

Max 150 words

For a full description of the Good Practice please see

3. Maturity Requirements of the Integrated Care Solution

Transferring region: Please provide the key maturity requirements for the adoption and transferability of the Good Practice. Please insert the spider diagram highlighting the features of the Good Practice that need to be considered for the transferability of the Good Practice.

4. Benefits and opportunities of the integrated care solution in XY region

Receiving region: Please describe what benefits and opportunities would the adoption of XY integrated care solution offer in XY region.

Max 250 words

5. Conditions for the adoption of integrated care solution in XY region

5.1 Maturity of local health and social care system in XY region

Receiving region: Please insert the spider diagram outlining the maturity of your local health and social care system for the adoption of integrated care solution, highlighting the strengths and weaknesses of the local system.

5.2 Conditions enabling the adoption of integrated care solution in XY region

Receiving region: Please insert the spider diagram overlaying the maturity of healthcare system with the requirements of the Good Practice.

5.3 Feasibility of transfer

Dimension	Feature(s) of the Good Practice	Feature(s) of the healthcare system	Feasibility of the transfer	Rationale
Readiness to Change				

5.4 Priority areas for the adoption and transfer of the integrated care solution

Receiving region: Please prioritise the features of the Good Practice to be considered for the transfer.

List of the prioritised features of the Good Practice (maximum 3 features)

6. Adaptation of local environment to enable the transferability of learning

Receiving region: Please describe what needs to change/improve in the local health and social care system to enable the creation of conditions for adoption of prioritised features of the integrated care solution.

Features of the Good Practice	Adaptation of the features in the local environment/Changes required

7. Priority actions to enable conditions for the transferability of learning

Receiving region: Please provide three priority actions that are necessary to create the local conditions for the adaptation of local environment to enable the adoption of integrated care solution, including

Priority Action	Objective of the Action	Anticipated outcomes	Policy implications, including the responsible actor and anticipated duration

*8. Contact details for the **receiving region***

Name: Address: Region: Type of the organisation: Main contact person:

*9. Contact details for the **transferring region***

Name: Address: Region: Type of the organisation: Main contact person:

Annex IV SCIROCCO Action Plan informed by the maturity of healthcare systems

SCIROCCO Twinning & Coaching Process

Action Plan to create conditions for the adoption of integrated care in XY region

Improvement of XY dimension6 of integrated care

Background: The objective of the Action Plan is to reflect on the possibility to transfer and adopt the learning about the XY dimension of integrated care to local settings in XY region, including the feasibility of the transfer and recommendations on policy priority actions that would enable the creation of local conditions for the adoption of integrated care.

The Action Plan builds on the outcomes of the study visit organised in XY on XY. The study visit was an opportunity to learn about the XY dimension and discuss a potential transferability of learning by comparing and contrasting the maturity of the healthcare system in X region with the maturity of local health and social care system in Y region. This process was facilitated by SCIROCCO self-assessment tool which provided the basis for the twinning and coaching activities.

The Action Plan are co-designed jointly with the transferring and receiving region as follows:

- Section 1: Needs of the adopting region - Receiving region
- Section 2: Description of the integrated care solution – Transferring region
- Section 3: Maturity requirements of the integrated care solution - Transferring region
- Section 4: Benefits and opportunities of integrated care solution - Receiving region
- Section 5: Conditions for the adoption of integrated care solution – Receiving region
- Section 6: Adaptation of local environment to enable the transferability of learning – Receiving region
- Section 7: **Priority actions to enable conditions for the transferability of learning -** Receiving region

1. Needs of the receiving region

Receiving region: Please describe the needs/challenges of your local health and social care system in XY domain of integrated care:

Max 200 words

2. Dimension of integrated care that addresses the needs of the receiving region

Transferring region: Please describe the dimension of integrated care that can address the needs in XY region:

Max 200 words

6 Please note that "dimension" in this case refers to 12 dimensions of integrated care captured in SCIROCCO Maturity Model https://www.scirocco-project.eu/maturitymodel/

Transferring region: Please describe the current progress in XY dimension of integrated care, including:

challenges/problems addressed by the dimension of integrated care:

Max 100 words

key innovative elements; please describe how the progress in XY dimension of integrated care improved the situation compared to previous status-quo

Max 200 words

impact/outcomes observed

Max 100 words

(Optional) For more information about the XY dimension of integrated care please see www.xy.com

3. Maturity of healthcare system for integrated care

Transferring region: Please describe the maturity of your health and social and care system and highlight a dimension that can be considered to improve the maturity of healthcare system for integrated care in XY region. Please insert the spider diagram with the assessment outcomes and highlight the scoring and justification for the dimension of integrated care that is being transferred.

4. Benefits and opportunities of improving XY dimension in XY region

Receiving region: Please describe what benefits and opportunities would the improvement of XY dimension of integrated care offer in XY region:

Max 250 words

5. Conditions for the improvement of XY dimension of integrated care in XY region

5.1 Maturity of local health and social care system in XY region

Receiving region: Please insert the spider diagram outlining the maturity of your local health and social care system for the adoption of integrated care, highlighting the strengths and weaknesses of the local system.

5.2 Conditions enabling the improvement of XY dimension of integrated care in XY region

Receiving region: Please insert the spider diagram overlaying the maturity of your healthcare system with the maturity of healthcare system of the originator region and highlight the key components of the XY dimension that you wish to improve.

5.3 Feasibility of the transfer

Dimension	Feature(s) of the healthcare system of the transferring region	Feature(s) of the healthcare system in the receiving region	Feasibility of the transfer	Rationale
Readiness to Change				

5.4 Priority areas for the transferability of learning

Receiving region: Please prioritise the features of the XY dimension of integrated care to be considered for the improvement.

List of the prioritised features (maximum 3 features)

6. Adaptation of local environment to enable transferability of learning

Receiving region: Please describe what needs to change/improve in the local health and social care system to enable the creation of conditions for the improvement of XY dimension of integrated care:

Features of the originator's healthcare system	Adaptation of the features in the local environment of transferring region/Changes required

7. Priority actions to enable conditions for the transferability of learning

Receiving region: Please provide three priority actions that are necessary to create the local conditions for the improvement of XY dimension of local environment for integrated care, including its objectives, anticipated outcomes and policy implications:

Priority Action	Objective of the Action	Anticipated outcomes	Policy implications, including the responsible actor and anticipated duration

8. Contact details for the receiving region

Name:
Address:
Region:
Type of the organisation:
Main contact person:

9. Contact details for the transferring region

Name:
Address:
Region:
Type of the organisation:
Main contact person:

Annex V Action Plan to create conditions for the adoption of integrated care in Norrbotten Region – Improvement of Innovation Management[7]

Background: The objective of the Action Plan is to reflect on the possibility to transfer and adopt the learning about the innovation management in Scotland to local settings in Norrbotten Region, including the feasibility of the transfer and recommendations on policy priority actions that would enable the creation of local conditions for the improvement of innovation management as one of the dimensions necessary for the adoption of integrated care.

The Action Plan builds on the outcomes of the study visit organised in Scotland on 26 June 2018. The study visit was an opportunity to learn about the innovation management in Scotland and discuss a potential transferability of learning by comparing and contrasting the maturity of the healthcare system in Norrbotten Region with the maturity of local health and social care system in Scotland. As such, the Action Plan can inform the health and social care authorities about the future strategies and policies related to the innovation management in the provision of integrated care in Norrbotten Region. This process was facilitated by SCIROCCO self-assessment tool which provided the basis for the twinning and coaching activities.

The Action Plan are co-designed jointly by Scotland as transferring region and Norrbotten as receiving region as follows:

- Section 1: Needs of the adopting region – Receiving region
- Section 2: Description of the integrated care solution – Transferring region
- Section 3: Maturity requirements of the integrated care solution – Transferring region
- Section 4: Benefits and opportunities of integrated care solution – Receiving region
- Section 5: Conditions for the adoption of integrated care solution – Receiving region
- Section 6: Adaptation of local environment to enable transferability of learning – Receiving region
- Section 7: Priority actions to enable conditions for the transferability of learning - Receiving region

7 Innovation Management is one of 12 dimensions of integrated care captured in SCIROCCO Maturity Model https://www.scirocco-project.eu/maturitymodel/

1. *Needs of the receiving region - Norrbotten Region*

Norrbotten Region has the ambition to improve current health care system that is under development and change. More people survive severe diseases such as cancer or heart disease, and many are living a longer life with chronic illness such as diabetes and rheumatism. Together we can work for a better healthcare and better welfare, but there is an urgent need to flip methods. At the Department for Development in the Region, there is a digital function where individuals, employees, regional municipality of entrepreneurs and researchers in northern Sweden work together in order to develop innovative digitally enabled solutions that would underpin the improvement and necessary changes in the current health care system in order to cope with increased needs and demands of citizens8. The challenge remains on how to address a gap between emerging innovations and its implementation, monitoring and evaluations. As such, there is a real opportunity to learn from other regions and organisations in Europe how to manage innovation processes better and more effectively.

2. *Dimension of integrated care that addresses the needs of Norrbotten Region*

2.1 Transferring region: Innovation management in Scotland

Health innovation is an exciting and dynamic area with a range of stakeholders from all sectors working collaboratively to position Scotland as a world leader in health innovation, contribute to a thriving economy and support faster adoption of innovation across health and social care. Innovation is defined in Scotland as the invention, development, production and use of products, medicines, therapeutics, approaches and supporting services which create the opportunity to make major improvements to health and healthcare.

Scotland is already recognised as an innovation nation, boasting a world class NHS, world-renowned universities and research strengths, high levels of investment in R&D and a number of internationally innovative health companies operating in Scotland. The recently refreshed 2017 Scottish Life Sciences Strategy sets out strategic priorities for the sector to fulfil Scotland's ambitions to be a world-leading entrepreneurial and innovative nation.

The Scottish Government has outlined its commitment to innovation with recently published Scotland Can Do – Boosting Scotland's Innovation Performance: An Innovation Action Plan for Scotland (January 2017) and more specifically to health innovation within the Health and Social Care Delivery Plan (December 2016) and recently published Digital Health and Care Strategy (April 2018).

A range of initiatives and partnerships are already well established (Innovation Ecosystem) as part of the overall drive to support health innovation and its formalisation in Scotland including:

Scotland's Innovation Centres

Over the last 5 years six Innovation Centre's directly aligned to Life Sciences, with core funding of around €113m have been established. These centres are designed to link

8 www.ideplats.se

academia and industry to turn innovation into commercial value, making Scotland more competitive within the UK and internationally.

- Stratified Medicine Scotland Innovation Centre - http://www.stratmed.co.uk
- Industrial Biotechnology Innovation Centre - http://www.ibioic.com
- Digital Health and Care Institute - https://dhi-scotland.com
- Scottish Aquaculture Innovation Centre - http://scottishaquaculture.com
- Centre for Sensor and Imaging Systems - https://censis.org.uk
- The Data Lab - https://www.thedatalab.com

For the purpose of this Action Plan and the knowledge transfer with Norrbotten, the activities of the Digital Health and Care Institute were mainly explored.

The Health Innovation Partnership (HIP)
A unique liaison service that identifies, supports and coordinates the formation of specific partnerships between NHS Scotland and the Life Sciences industry to advance health and social care challenges. A Digital Health and Social Care Innovation Partnership is also led by NHS 24.

Scottish Health Technologies Group
An advisory group set up to provide assistance to NHS Scotland boards when considering selected health technologies, excluding medicines which will be reviewed by the Scottish Medicine Consortium.

Health Innovation Assessment Portal (HIAP – Scotland)
Encourages prospective providers of new and/or innovative products and solutions to put them forward enabling NHS Scotland to assess how the solution might support strategic aims, and associated costs and benefits.

Innovation Hubs/Clusters
Local Innovation hubs within NHS Boards to support the development and implementation of innovative ideas created locally. Since 2013, each NHS Board has also an Innovation Champion. Innovation Champions serve as internal and external contact points on innovation and as drivers around the innovation agenda. Scottish Government works with the Innovation Champions through quarterly meetings and ongoing engagement.

Innovation Challenges
Scottish Enterprise work in partnership with Innovate UK and a range of public sector organisations to fund and promote a series of innovation challenges currently faced by the UK's public sector. More detail on current innovation challenges is also available via the NHS Scotland Innovation Community website.

Transferring region: **Current progress in the innovation management in Scotland**

Challenges/problems addressed by the innovation management:

Innovation is the key to delivering a new model of healthcare that meets the challenges and expectations of the modern society. It is widely recognised in Scotland that doing the same

things we always done, in the same way we have always done, is no longer an option for the sustainability of health and social care system due to the ageing population and increased number of people with chronic conditions. When properly targeted and applied, innovative ideas and technologies can transform patient care within the NHS and other stakeholders involved. As such, innovation helps to deliver patient care while simultaneously improving quality and efficiency, releasing savings through increased productivity.

Key innovative elements of the innovation management:

There are several key innovative elements of the innovation management in Scotland:

- Recognised need for innovation embedded in national policies and strategies.
- National commitment to support national uptake and scaling-up of innovative solutions.
- Innovation governance and structure; there is an Innovation Ecosystem in place in order to align and joined up the activities at local and national level.
- Dedicated funding to support the uptake and quick spread of innovation at national level e.g. Innovation Fund, Technology Enabled care programme, Test of Change and/or European funding.

Impact/outcomes observed

The following outcomes have been observed:

- Creation of conditions to enable the uptake and widespread of innovations, building on what we have and spreading what works.
- Facilitation of learning and exchange of innovative ideas in order to join up and align the innovation activities at national and local levels in order to avoid duplications and reinventing the wheel.
- National and local commitment to innovation embedded in policies, planning and implementation of care services; innovation is introduced as part of the service redesign rather than stand-alone approach
- Improved leadership and collaboration of all stakeholders involved in the innovation management.
- Large-scale deployment of some innovative solutions in health and social care delivery; e.g. scaling-up of home and mobile health monitoring solutions, cCBT services, Attend Anywhere and others.

For more information about the innovation management in Scotland please see the following links:

- Scottish Life Science Strategy
  https://www.scottish-enterprise-mediacentre.com/resources/2017-life-sciences-scotland-strategy
- Scotland Can Do – Boosting Scotland's Innovation Performance: An Innovation Action Plan for Scotland https://www2.gov.scot/Resource/0043/00438045.pdf
- Health and Social Care Delivery Plan
  https://www2.gov.scot/Resource/0051/00511950.pdf
- Digital Health and Care Strategy
  https://www.gov.scot/publications/scotlands-digital-health-care-strategy-enabling-connecting-empowering/
- Scottish health technologies Group
  http://www.healthcareimprovementscotland.org/our_work/technologies_and_medicines/shtg.aspx
- Health Innovation Assessment Portal (HIAP-Scotland)
  https://www.hiap-scotland.org/Home/Index
- Innovation Hubs/Clusters
  http://www.in0v8.scot.nhs.uk/open-innovation/nhs-innovation-champions
- Innovation Challenges
  https://www.scottish-enterprise.com/learning-zone#f:sectors-facet=%5BTechnology%20and%20engineering,Life%20sciences%5D

3. *Maturity of Scotland's healthcare system for integrated care*

Transferring region: Maturity of Scotland's health and social and care system, highlighting an Innovation Management dimension of integrated care, is captured in the spider diagram below and detailed justification is provided in the following Table:

Figure 1: Maturity of Scotland's healthcare system

Dimension	Score	Description	Justifications & Reflections
Readiness to Change	3	Vision or plan embedded in policy; leaders and champions emerging	Vision and plan for integrated care is very well embedded in policy; there is a legislation which joins up formally health and social care delivery. There are leaders and champions emerging both at national and local levels. There is still al lack of the support from generic public which prevents from a higher scoring.
Structure & Governance	4	Roadmap for a change programme defined and accepted by stakeholders involved	There is a roadmap for a change programme defined and accepted by stakeholders involved. In addition, a structure and governance for integrated care is in place but implementation is still not perfect. Governance is fully resourced at national level, but there is much diversity at lower levels.
eHealth Services	2	There is mandate and plan(s) to deploy regional/national eHealth services across the healthcare system but not widely implemented	There is a mandate and plan to deploy regional/national eHealth services across the healthcare system but not yet implemented. There are local solutions/pilots but there is no governance to upscale. The main barrier remains the culture around the data sharing.
Standardisation & Simplification	1	Discussion of the necessity of ICT to support integrated care and of any standards associated with that ICT is initiated	There is a lot of recognition of the need of ICT to support integrated care, and of the need for standards. Nothing is in place for social care. Discussion is underway.
Funding	2	Consolidated innovation funding available through competitions/grants for individual care providers and small-scale implementation.	There is a consolidated innovation funding available through competitions/grants for individual care providers and small-scale implementation. There is a national Integrated Care Fund which replaced the Change Fund. There is also some EU funding supporting integration (focus on the transition in the system rather than scaling-up); TEC funding
Removal of Inhibitors	3	Implementation Plan and process for removing inhibitors have started being implemented locally	Implementation Plan and process for removing inhibitors have started being implemented locally. There is some vision embedded in the integration legislation as to how to remove the barriers. Other incentive to remove the inhibitors includes the investments in local agencies and local support to implement services. Innovation centres were created as part of the Plan. Lot of training for different

Dimension	Score	Description	Justifications & Reflections
			professions to change towards integration.
Population Approach	2	Risk stratification approach is used in certain projects on an experimental basis	Risk stratification approach is used in certain projects on experimental basis. SPARRA is the most common risk stratification tool used which looks at responses through health and social care integration for patients who are at risk of re-admission. However, the tool only looks at patients at risks. The Integrated Resource Framework captures both health and social care data, with a focus on frequent service users.
Citizen Empowerment	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.	Citizen empowerment is recognised as an 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. There are only very small examples of where patients have access to their data e.g. for diabetes, younger cancer patients. There is an option for online GP appointment, but it is not being widely marketed and used.
Evaluation Methods	2	Evaluation of integrated care exists, but not as part of a systematic approach	Evaluation of integrated care services exists, but not as part of a systematic approach. The third sector services are evaluated according to a common model through a coordinated approach. There are more requirements for the evaluation for third sector organisations than for the statutory organisations. Unless there is a need to motivate continuous investments (as for the voluntary sector), a very systematic evaluation is not performed.
Breadth of Ambition	4	Integration includes both social care service and health care service needs	Improved coordination of social care services and healthcare needs is introduced. The ambition is about the full integration of health and social care. There is an integrated budget and integrated governance. However, some social care services are not clearly in or out of the integrated health and social care according to the legislation.
Innovation Management	3	Formalised innovation management process is	Formalised innovation management process is planned and partially implemented. There has been a degree of focus on investment in technology

Dimension	Score	Description	Justifications & Reflections
		planned and partially implemented	innovation. In third sector, there are a lot of ideas but no clear plan for the update of innovation.
Capacity Building	3	Systematic learning about integrated care and change management is in place but not widely implemented	Learning about integrated care and change management is in place but not widely implemented. The National Quality Strategy is focused on health only. However, a lot of money was invested in training management on integrated care over its 5—7 years.

4. *Benefits and opportunities of improving innovation management in Norrbotten Region*

The Swedish municipalities and County Councils define innovation as new solutions that respond to the needs and demands of citizens' everyday life. The value of innovation arises in its utilisation and application of an idea in the practice, when new ideas and solutions are embraced, spread and become a routine part of our working methods. This will in turn create economic, social or environmental benefits for the society.

The same applies for the healthcare system. The need for innovation and innovative solution of working are greatly recognised as a priority for the Norrbotten's healthcare system. The region is very much mature in innovation and its spread is encouraged at every level of health and social care. However, the overall strategy and plan how to manage the innovation and scale-up innovative solutions on large scale remains a challenge. Improved innovation management can lead to a number of benefits for Norrbotten's healthcare system including:

- Improved access to care that is tailored to the individual needs of citizens;
- Improved efficiency of working methods and workforce organisation;
- Improved cost-effectiveness and cost-efficiency of health and social care.

5. *Conditions for the improvement of innovation management in Norrbotten Region*

5.1 Maturity of local health and social care system in Norrbotten Region

Receiving region: Maturity of Norrbotten Region's health and social care system, highlighting the strengths and weaknesses of the local system is captured in the spider diagram below:

Figure 2: Maturity of healthcare system in Norrbotten Region

5.2 Conditions enabling the improvement of innovation management in Norrbotten Region

Receiving region: Maturity of healthcare system in Scotland and Norrbotten Region is captured in the spider diagram below:

Figure 3: Comparison of maturity of Scotland's healthcare system with the maturity of healthcare system in Norrbotten

5.3 Feasibility of transferring the learning about innovation management in Scotland to local context in Norrbotten Region

Dimension	Score Scotland	Feature(s) of Scotland's healthcare system	Score Norrbotten	Feature(s) of Norrbotten's healthcare system	Feasibility of transfer and rationale
Readiness to Change	3	Vision and plan for integrated care is very well embedded in policy; there is a legislation which joins up formally health and social care delivery. There are leaders and champions emerging both at national and local levels. There is still al lack of the support from generic public which prevents from a higher scoring.	3	Several innovational projects are running but there is a lack of collaboration and learning between the projects which often result in the different levels of existing knowledge and performance of innovation management in the region. Models for managing change are established. From a political point of view there is an acknowledgement of the unsustainability of current healthcare system to address the need to change have been adopted to some extent. Also, on an operational level several initiatives have been implemented and are running.	Yes; the transferability is feasible with lot of efforts. It is necessary to have a legal framework for innovation in place in order to ensure that new methods are in line with Norrbotten Region's policies.
Structure & Governance	4	There is a roadmap for a change programme defined and accepted by stakeholders involved. A structure and governance for integrated care is in place but implementation is still not perfect. Governance is fully resourced at national level, but there is much diversity at lower levels.	3	A clear roadmap and specific mandates are needed to ensure implementation of innovation management.	No; the transferability is not feasible. The development and implementation of clear roadmap for innovation management would be required, including the need for motivated leaders with a strong knowledge of benefits of introducing innovation management.
eHealth Services	2	There is a mandate and plan to deploy regional/national eHealth services across the healthcare system but not yet implemented. There are local solutions/pilots but there is no governance to upscale. The main barrier remains the culture around the data sharing.	3	National innovative ICT solutions to increase patients´ access to their medical records have been developed and implemented in Region Norrbotten. Regional ICT solutions to share patient related information between different care providers have been developed and implemented. The Region has also very well progressed with building on	Yes; the transferability is feasible with no need for major adaptation There is a mature innovation infrastructure in place in Norrbotten, including integrated electronic health record.

Dimension	Score Scotland	Feature(s) of Scotland's healthcare system	Score Norrbotten	Feature(s) of Norrbotten's healthcare system	Feasibility of transfer and rationale
				existing platforms and infrastructure and creating new services to empower patients and ensure their ability to participate in the decision-making on their care as well as supporting self-care. However, scalability of these solutions remains the issue.	
Standardisation & Simplification	1	There is a lot of recognition of the need of ICT to support integrated care, and of the need for standards. Nothing is in place for social care. Discussion is underway.	3	There is a lack of common standards between the healthcare providers at local and regional level and often even among the providers at the same level.	Yes; the transferability is feasible with some efforts. The innovation management plan needs to be adapted in order to be compatible with technical standards of all organisations involved.
Funding	2	There is a consolidated innovation funding available through competitions/grants for individual care providers and small-scale implementation. There is a national Integrated Care Fund which replaced the Change Fund. There are also some EU funding supporting integration and TEC Programme funding.	2	External funding is most often limited to pilot innovational projects rather than up-scaling. Internally, within the organisation, the budget is set for a year. Sometimes there is an opportunity to receive funding for early phases of the projects externally and internally but mostly for testing and piloting of the services.	No; the transferability is not feasible. There is a limited funding available for the implementation of innovative solutions.
Removal of Inhibitors	3	Implementation Plan and process for removing inhibitors have started being implemented. There is some vision embedded in the integration legislation on how to remove the barriers. Other incentives include investments in local agencies and local support to implement services. Innovation centres were created as part of the Plan. Lot of training for different professions to change towards integration.	1	There is no specific model or existing project in Norrbotten with a clear mandate to remove inhibitors; there are different models used with different results.	No; the transferability is not feasible. There is no strategy or plan in place for the removal of inhibitors in innovation management. The dedication and continuous training of healthcare professionals seem to be crucial inhibitor in the Norrbotten's local context.

Dimension	Score Scotland	Feature(s) of Scotland's healthcare system	Score Norrbotten	Feature(s) of Norrbotten's healthcare system	Feasibility of transfer and rationale
Population Approach	2	SPARRA is the most common risk stratification tool used which looks at responses through health and social care integration for patients who are at risk of re-admission. However, the tool only looks at patients at risks. The Integrated Resource Framework captures both health and social care data, with a focus on frequent service users.	2	Models to identify patients at risks are applied in Norrbotten and standardised care plans are implemented for some categories of patients. Both the population health unit as well as care divisions in the Region continuously perform certain risk analysis, followed by statistics and particular types of actions.	Yes; the transferability is feasible with no need for major adaptation. The stratification process has been initiated in Norrbotten.
Citizen Empowerment	2	Citizen empowerment is recognised as an important part of integrated care provision, effective policies to support citizen empowerment are in place but citizens do not have access to health data. There are only small examples of where patients have access to their data e.g. for diabetes, younger cancer patients. There is an option for online GP appointment, but it is not being widely marketed and used.	4	Citizens do have access to health information and health data through "Health care in numbers and open comparisons', but this solution is not used systematically for decision-making. Not all data is made available yet.	Yes; the transferability is feasible with some efforts. Citizens have access to their health data; the involvement of patients and citizens organisations needs to be better recognised in Norrbotten's local context.
Evaluation Methods	2	Evaluation of integrated care services exists, but not as part of a systematic approach. The third sector services are evaluated according to a common model through a coordinated approach. Unless there is a need to motivate continuous investments, a very systematic evaluation is not performed.	1	No common evaluation model or innovation management is used in Region Norrbotten. There are some evaluations methods applied, but not as a part of a systematic approach.	Yes; the transferability is feasible with lot of efforts. In order to successfully implement innovation management, there needs to be a system that supports a systematic evaluation.
Breadth of Ambition	4	Improved coordination of social care services and healthcare needs is introduced. The ambition is the full integration of health and social care. There is an integrated budget and integrated governance.	4	There are fully integrated health and care services but the collaboration and services between different health and social care providers can still improve.	Yes; the transferability is feasible with no need for major adaptation. There is an integration between primary and hospital care levels established in the region.

Dimension	Score Scotland	Feature(s) of Scotland's healthcare system	Score Norrbotten	Feature(s) of Norrbotten's healthcare system	Feasibility of transfer and rationale
Innovation Management	3	Formalised innovation management process is planned and partially implemented, including investment in technology innovation.	2	Innovation is encouraged but there is no overall plan to formalise innovation processes. Procurement remains a challenge.	Yes; the transferability is feasible with some efforts. There needs to be some improvement in developing mechanisms to support innovations and transfer knowledge as necessary.
Capacity Building	3	Learning about integrated care and change management is in place but not widely implemented. The National Quality Strategy is focused on health only. However, a lot of money was invested in training management on integrated care over years.	2	There is still at the point where we need better support for creating a learning organisation and supporting "change managers" continuously.	Yes; the transferability is feasible with lot of effort. The need for continuous learning needs to be embedded in the routine practice.

5.4 *Priority areas for the transferability of learning*

Receiving region: List of the prioritised features to be considered for the transferability of learning in order to improve innovation management in Norrbotten Region is outlined in the Table below:

List of the prioritised features of Scotland's healthcare system for improvement of innovation management
Readiness to Change • Recognised need for change • A defined plan for implementation of innovation • A clear leadership to promote the implementation of new innovations Innovation management • An overall plan • Formalised innovation management process

6. *Adaptation of local environment to enable transferability of learning*

Receiving region: List of suggested changes to enable the creation of conditions for the improvement of innovation management in Norrbotten Region, informed by the learning about the features of Scotland's healthcare system is outlined in the Table below:

Features of Scotland's healthcare system	Adaptation of features to Norrbotten's context
Readiness to Change • Recognised need for change • A defined plan for implementation of innovation • A clear leadership to promote the implementation of new innovations	• Develop implementation plan for the adoption of innovation, endorsed by the policy-makers, including the clear assignments of roles and leaderships of all stakeholders involved in the implementation of new innovation processes. • Raise awareness about the benefits of innovations to leaders and implementers.
Innovation management • An overall plan • Formalised innovation management process.	• Raise awareness about the need for innovation and new way of working. • Develop instruments to support innovations.

7. *Priority actions to enable conditions for the transferability of learning*

Receiving region: List of the proposed actions to enable conditions for improvement of innovation management in Norrbotten Region, including objectives, anticipated outcomes and policy implications is outlined in the Table below:

Priority Action	Objective of the Action	Anticipated outcomes	Policy implications, including the responsible actor and anticipated duration
Develop an implementation plan for innovation management	Stimulate innovations that extend the current organisational barriers, including organisation of responsible actors, leadership, processes and anticipated duration.	Clear leadership in implementing innovation	In order to improve innovation management, the following policy actions need to be considered: • Guidelines and a strategy for innovation management needs to be embedded in the existing policies and strategies related to development of methods and technologies in order to secure the leadership for implementation. The innovation management could be integrated as a part of new Strategy for Future Health Care in Region Norrbotten. • Adaptation of the innovation management at a regional level. New guidelines and standards are required for the entire nation, to facilitate regional decisions on implementation of innovation management.
Improve education of leaders	Join the efforts in providing the same level of education to all leaders involved in innovation management.	Common vision, skills and support to implement innovation management	Strategies and guidelines for training on the use of innovative methods need to be developed and implemented in e-learning platforms.
Visualise good examples of innovation to workforce and wider citizens	Improve citizen empowerment and engagement in the decision-making processes in the planning and implementation of health and social care interventions.	Implementation of person-centred, coordinated health and social care interventions	Documents and policies that statutes how the dissemination of innovative solutions need to be visualised.

8. *Contact details for the receiving region – Norrbotten Region*

Name: Ann-Charlotte Kassberg, Lisa Lundgren
Position: Project manager, Director of projects
Region: Norrbotten Region
Organisation: Development Department of Norrbotten Region
Main contact person: Ann-charlotte.kassberg@norrbotten.se

9. *Contact details for the transferring region - Scotland*

Name: Andrea Pavlickova
Position: International Engagement Manager
Region: Scotland
Organisation: Scottish Government
Contact details: andreapavlickova@nhs.net

Annex VI Action Plan to create conditions for the adoption of integrated care in Olomouc Region – Improvement of eHealth services

Background: The objective of the Action Plan is to reflect on the possibility to transfer and adopt the learning about the adoption of eHealth services in Norrbotten Region in Sweden to local settings in Olomouc Region in Czech Republic, including the feasibility of the transfer and recommendations on policy priority actions that would enable the creation of local conditions for the adoption of integrated care.

The Action Plan builds on the outcomes of the study visit organised in Norrbotten Region on 12-14 September 2018. The study visit was an opportunity to learn about the eHealth services dimension and discuss a potential transferability of learning by comparing and contrasting the maturity of the healthcare system in Norrbotten Region with the maturity of local health and social care system in Olomouc Region. This process was facilitated by SCIROCCO self-assessment tool which provided the basis for the twinning and coaching activities.

The Action Plan are co-designed jointly by Norrbotten as the transferring region and Olomouc as receiving region as follows:

- Section 1: Needs of the adopting region – **Receiving region**
- Section 2: Description of the integrated care solution – **Transferring region**
- Section 3: Maturity requirements of the integrated care solution - **Transferring region**
- Section 4: Benefits and opportunities of integrated care solution – **Receiving region**
- Section 5: Conditions for the adoption of integrated care solution – **Receiving region**
- Section 6: Adaptation of local environment to enable transferability of learning – **Receiving region**
- Section 7: Priority actions to enable conditions for the transferability of learning - **Receiving region**

1. *Needs of the receiving region – Olomouc Region*

The healthcare system in the Czech Republic is derived from Bismarckian model and is based on universal health insurance. The healthcare system is medically driven and focuses on institutional care. The system has been achieving some acceptable results but similarly as in other European countries, sustainability becomes a challenge and there is a need for a change in the way the care is currently delivered. There are three key stakeholders in the healthcare system: government, insurance companies and healthcare providers. However, the activities of these stakeholders are not coordinated and aligned to one particular strategy addressing the challenges of ageing population which often cause fragmentation. In addition, most of the proposed changes are politically sensitive and there is a lack of political willingness to address them. The healthcare system is also underfinanced which results in the lack of healthcare professionals. The role of ICT as an enabler of service redesign is not well recognised and digital healthcare services are not developed. Some progress has been made though for example by preparing a new Electronic Health Act, concept of sharing of health data and eHealth strategy (2016). The objective of these initiatives is to increase the interest and involvement of citizens in the digital agenda and raise their awareness about the benefits of technology enabled solutions in the area such as prevention or management of chronic diseases. However, the need for change becomes apparent in the form of poorer quality and accessibility of healthcare services.

Given a strong healthcare coordination role of regions in Sweden, there is an opportunity to learn about the effective use of ICT and eHealth services as an integral part of healthcare delivery and discuss the potential improvement of these services in Olomouc Region and wider Czech Republic. The major issue for the Olomouc Region is to recognise the widespread of eHealth services as a routine part of the healthcare delivery and patient journey. The key difference remains the position and recognition of eHealth agenda (digital first concept) in Norrbotten Region compared to Olomouc Region and wider Czech Republic where the progress in this area has been made mostly on the voluntary basis of involved stakeholders. Most of the care pathways are still managed on the basis of paper exchange or verbal updates of patients and healthcare professionals and there is no ICT infrastructure to allow electronic exchange of data, including access to electronic health records. In addition, legislation is lacking to support a wider implementation of eHealth services in the Region.

2. *Dimension of integrated care that addresses the needs of Olomouc region*

2.1 Transferring region: eHealth services in Norrbotten Region

National ICT solutions to increase patients´ access to their medical records have been developed and implemented in Norrbotten Region on a large scale. There are also national ICT solutions to support patients´ participation in the management of their own care but not fully implemented yet. A share of patient related information between different care providers is facilitated at the regional level. Norrbotten Region has also very well progressed with building the ICT solutions on existing platforms and infrastructure and has thus created new services to empower patients and ensure their ability to participate in the decision-making on their care as well as supporting self-care. However, scalability of these solutions still remains the issues.

Transferring region: Current progress in the implementation of eHealth services in Norrbotten

Challenges/problems addressed by eHealth services:

Introduction of ICT solutions, including eHealth services is the key to delivering a new model of healthcare that meets the challenges and expectations of the modern society. It is widely recognised in Norrbotten Region that lack of digitalisation in the healthcare delivery is no longer an option for the sustainability of health and social care system due to the ageing population and increased number of people with chronic conditions. When properly designed and applied as routine care, ICT solutions and eHealth services can transform patient care in the Region. As such, implementation of eHealth solutions helps to deliver patient care while simultaneously improving quality and efficiency, releasing savings and demands through increased productivity.

Key innovative elements of implementing eHealth services in Norrbotten Region:

A need to introduction technology enabled solutions is widely recognised among all stakeholders involved. There is a clear plan and strategy in place to support widespread implementation of eHealth services. Patients are widely supported and encouraged to manage their own care and participate actively in the decision-making process through the access to electronic health records and relevant health information.

Impact/outcomes observed

VAS – In house developed electronic health system is widely implemented and scaled-up. There is one system in place used by all departments in the region. Digitalisation in Norrbotten Region is embedded as part of routine care and routine ways of working. “Digital first” agenda is well recognised and applied in the practice.

3. *Maturity of Norrbotten Region’s healthcare system for integrated care*

Transferring region: Maturity of Norbotten Region’s health and social and care system, highlighting an eHealth dimension of integrated care, is captured in the spider diagram below and detailed justification is provided in the following Table:

Figure 1: Maturity of Norbotten Region’s healthcare system

Dimension	Score	Description	Justification & Reflections
Readiness to Change	3	Vision or plan embedded in policy; leaders and champions emerging	Models for managing change are established. From a political point of view there is an acknowledgement of the unsustainability of current healthcare system to address the need to change have been adopted to some extent. Also, on an operational level several initiatives have been implemented and are running.
Structure& Governance	3	Governance established at regional or national level.	A national strategy for eHealth is developed and implemented in addition to Regional Development Strategy and Regional Innovation Strategy. There is a need for the municipalities to reach the same level of progress to use eHealth services as at the regional level. There is a structure in place to facilitate collaboration between the region and municipalities to overcome organizational boundaries. A clear roadmap and specific mandates of different stakeholders involved needs to be defined are to ensure successful implementation of eHealth services.
eHealth Services	3	eHealth services to support integrated care are piloted but there is no yet region wide coverage.	National innovative ICT solutions to increase patients´ access to their medical records have been developed and implemented in Region Norrbotten. Regional ICT solutions to share patient related information between different care providers have been developed and implemented. The Region has also very well progressed with building on existing platforms and infrastructure and creating new services to empower patients and ensure their ability to participate in the decision-making on their care as well as supporting self-care. However, scalability of these solutions remains the issue.
Standardisation & Simplification	3	A recommended set of agreed technical standards at regional/national level; some shared procurements of new systems at regional/national level; some large-scale consolidations of ICT underway	A recommended set of agreed information standards at regional/national level exist at the regional level which support the development and implementation of a common system to exchange patient related data between the region and municipalities.
Funding	2	Consolidated innovation funding available through competitions/grants for individual care providers and small-scale implementation.	External funding is most often limited to pilot eHealth projects rather than up-scaling. Internally, within the organisation, the budget is set for a year. Sometimes there is an opportunity to receive funding for early phases of the projects externally and internally but mostly for testing and piloting of the services.
Removal of inhibitors	1	Awareness of inhibitors but no systematic approach to their management is in place.	There is no specific model or existing project in Norrbotten with a clear mandate to remove inhibitors; there are different models used with different results.

Dimension	Score	Description	Justification & Reflections
Population Approach	2	Risk stratification approach is used in certain projects on an experimental basis.	Models for identifying the patients at risks and standardised care plans are implemented for some categories of patients.
Citizen Empowerment	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.	Incentives and tools that motivate and support citizens to co-create healthcare services and use these services to participate in decision-making process about their own health are in place. Citizens do have access to health information and health data.
Evaluation Methods	1	Evaluation of integrated care services is planned to take place and be established as part of a systematic approach.	No common evaluation model or innovation management is used in Region Norrbotten. There are some evaluations methods applied, but not as a part of a systematic approach.
Breadth of Ambition	4	Integration includes both social care service and health care service needs.	There are fully integrated health and social care services with collaboration established on all three levels of care but the integration of care services can still improve.
Innovation Management	2	Innovations are captured and there are some mechanisms in place to encourage knowledge transfer.	Innovation is encouraged but there is no overall plan to formalise innovation processes. Procurement remains a challenge.
Capacity Building	2	Cooperation on capacity-building for integrated care is growing across region.	There is still at the point where we need better support for creating a learning organisation and supporting “change managers” continuously.

4. Benefits and opportunities of improving eHealth services in Olomouc Region

A number of opportunities for improvement of eHealth services in Olomouc Region and the Czech Republic were identified at both strategic and implementation level.

Electronic exchange of health information between a variety of healthcare providers is an inherent part of implementation of eHealth services in Norrbotten Region as well as across Sweden. As the implementation of this concept in Olomouc Region does not progress sufficiently, compared to other EU countries, further efforts will need to be made around the promotion of benefits of using eHealth services as part of the routine operation of all healthcare providers. As a result, both the healthcare system as well as patients will benefit from this opportunity in terms of accessing the accurate health data in the right time and right place.

The study visit to Norrbotten Region inspired the visiting clinicians which suggested to promote and inherit this concept of data exchange in order to improve current workflow. This new concept should be tested in Moravia in Olomouc Region for the patients with advanced heart failure. In addition, the University Hospital in Olomouc Region is planning to upgrade its ICT system and introduce a concept of data exchange. Outcomes of the twinning activities with Norrbotten Region will directly inform these developments.

5. Conditions for the improvement of eHealth services in Olomouc Region

5.1 Maturity of local health and social care system in Olomouc Region

Receiving region: Maturity of health and social care system in Olomouc Region, highlighting the strengths and weaknesses of the local system is captured in the spider diagram below:

Figure 2: Maturity of healthcare system in Olomouc Region

5.2 Conditions enabling the improvement of eHealth services in Olomouc Region

Receiving region: Maturity of healthcare system in Olomouc and Norrbotten Region is captured in the spider diagram below:

Figure 3: Comparison of maturity of Olomouc's healthcare system and maturity of healthcare system in Norrbotten Region

5.3 Feasibility of transferring the learning about eHealth services in Norrbotten Region to local context in Olomouc Region

Dimension	Score Norrbotten	Feature(s) of Norrbotten healthcare system	Score Olomouc	Feature(s) of Olomouc healthcare system	Feasibility of the transfer and rationale
Readiness to Change	3	Several innovational projects are running but there is a lack of collaboration and learning between the projects which often result in the different levels of existing knowledge and performance of innovation management in the region. Models for managing change are established. From a political point of view there is an acknowledgement of the unsustainability of current healthcare system to address the need to change.	1	There is a leadership in place, however, the concept of integrated care is not reflected in legislation, hence the vision of policy makers is lacking as well.	Yes; the transferability of is feasible with lot of efforts. This is a very complex feature to be introduced as there has been lack of political willingness to address the need for eHealth services for long time. However, awareness raising activities may active a change and the need for change has already been recognised by many experts and managers actively participating in health and social care. New eHealth strategy was developed and is going to be implemented in the next three years.
Structure & Governance	3	A clear roadmap and specific mandates are needed to ensure implementation of innovation management.	0	Roadmap for change programme is missing hence it is difficult to create a shared vision and organisational structure for integrated care; the structure is fragmented. Some rare integrated care initiatives are active at the level of municipalities but there is no national/regional structure in place.	Yes; the transferability is feasible with lot of efforts. The first step to be introduced can be around the awareness raising about the need and benefits of eHealth services, similarly as in case of Domain 1. Developing the roadmap for change is a part of the project mentioned above.
eHealth Services	3	Innovative ICT solutions to increase patients´ access to their medical records have been implemented. Regional ICT solutions to share patient related information between different care providers have been implemented. The Region has also very well progressed with building on existing platforms and infrastructure and creating new services to empower patients and ensure their ability to participate in the decision-making as well as supporting self-care. However, scalability remains the issue.	0	There is a national eHealth strategy approved (in November 2016) and gradually being implemented, however electronic health records are not available. As such, electronic sharing of health information across the care providers is a challenge and not really happening between health providers of diverse ownerships be they general practitioners, hospitals, clinics or other providers.	Yes; the transferability is feasible with lot of efforts. ICT infrastructure to allow data exchange is part of new eHealth strategy but its implementation is weak. Sharing of health data with social care is not planned. The ICT platforms are not yet designed or projected. Patient's empowerment focuses mainly on access to electronic health records.

Dimension	Score Norrbotten	Feature(s) of Norrbotten healthcare system	Score Olomouc	Feature(s) of Olomouc healthcare system	Feasibility of the transfer and rationale
Standardisation & Simplification	3	There is a lack of common standards between the healthcare providers at local and regional level and often even among the providers at the same level.	1	There is some initial work around the standards; the need for standards is recognised.	Yes; the transferability is feasible with lot of efforts. Effective health data sharing is recognised as a strong element supporting integration; national standards will then have to be agreed as part of new eHealth Strategy.
Funding	2	External funding is most often limited to pilot innovation projects rather than up-scaling. Internally, the budget is set for a year. Sometimes there is an opportunity to receive funding for early phases of the projects externally and internally but mostly for testing and piloting of the services.	1	Lack of funding is the biggest barrier to implement any changes in the care models; sustainability remains an issue. Regardless of the funding some innovation is still happening at small scale.	Yes; the transferability is feasible with lot of efforts. Considering lack of coordination of key stakeholders of Czech national healthcare system and political sensitivity of eHealth agenda it is very difficult to commit the right budget and investments in this area/
Removal of inhibitors	1	There is no specific model or existing project in Norrbotten with a clear mandate to remove inhibitors.	1	Culture plays a major role here; it is very difficult to change the day-to-day routine of healthcare professionals.	Yes; the transferability is feasible with lot of efforts. Payment scheme does not well motivate the removal of inhibitors.
Population Approach	2	Models to identify patients at risks are applied in Norrbotten and standardised care plans are implemented for some categories of patients. Both the population health unit as well as care divisions in the Region continuously perform certain risk analysis, followed by statistics and particular types of actions.	1	There are very limited risk stratification initiatives in place.	Yes; the transferability is feasible with some efforts. There is a considerable progress made with the development of Czech Central Health Statistic Institution with the objective to provide better, more accurate data to be used for the business intelligence. The date become available and they can be used also for risk stratification.
Citizen Empowerment	4	Citizens do have access to health information and health data through "Health care in numbers and open comparisons', but this solution is not used systematically for decision-making. Not all data is made available yet.	0	Citizen empowerment is recognised in national strategy Health 2020 but its implementation remains a challenge. Healthcare by law still focuses on care and not on support of citizens in improving their health. There is a lack of capacity to support citizen empowerment initiatives.	Yes; the transferability is feasible with some efforts. There is some work under the preparation at the University Hospital Olomouc (UHO) around the development of ICT tools to support citizen empowerment. Some elements supporting patient empowerment, especially for better information about the health status and communication with care providers are subjects of

Dimension	Score Norrbotten	Feature(s) of Norrbotten healthcare system	Score Olomouc	Feature(s) of Olomouc healthcare system	Feasibility of the transfer and rationale
					several initiatives in wider Czech Republic.
Evaluation Methods	1	No common evaluation model or innovation management is used in Region Norrbotten. There are some evaluations methods applied, but not as a part of a systematic approach.	0	There is no systematic evaluation in place; the health insurances pay usually for the cheapest or otherwise justified services. Olomouc already uses MAST (a model derived from HTA) for internal purposes of UHO – usually projects.	Yes; the transferability is feasible with some efforts. Some evaluation tools are already at the place; broad spectrum of data is collected and processed by central institution. but the introduction of systematic evaluation would require further efforts at national level.
Breadth of Ambition	4	There are fully integrated health and care services but the collaboration and services between different health and social care providers can still improve.	1	There is some level of interactions/coordination of care at the level of hospitals.	Yes; the transferability is feasible with lot of efforts. A new reform of primary care has been developed at the Ministry of Health and it is expected that it will include some important elements enabling coordination of care, particularly of chronically ill patients.
Innovation Management	2	Innovation is encouraged but there is no overall plan to formalise innovation processes. Procurement remains a challenge.	1	Municipality in Olomouc Region widely recognised the need and benefits of innovation. However, the implementation of concrete actions is very difficult.	Yes; the transferability is feasible with lot of efforts. Problems of the current healthcare system regarding the care of chronically ill are mapped by acting experts and politicians but many relevant amendments addressing the need for change and innovations in the current care models are politically sensitive and require broader consensus in the whole society.
Capacity Building	2	There is still at the point where we need better support for creating a learning organisation and supporting “change managers” continuously.	1	Training of healthcare professionals is on-going; the training on integrated care is already included in the curricula at the Universities, particularly Palacky University Olomouc.	Yes; the transferability is feasible with some efforts. There is training of healthcare professionals in place, even though some Curricula should be upgrade. There is a lot of ad hoc education at the pilot phase which should be expanded to continuous learning and training.

5.4 Priority areas for the transferability of learning

Receiving region: List of the prioritised features to be considered for the transferability of learning in order to improve eHealth services in Olomouc Region is outlined in the Table below:

List of the prioritised features of Olomouc's healthcare system for improvement of eHealth services
eHealth services • Implementation of national ICT solutions to increase the patients´ access to their medical records • Implementation of regional ICT solutions to share patient related information between different health and social care providers • Existence of platforms, infrastructure and services to empower patients to participate in the decision-making on their care as well as supporting self-care

6. Adaptation of local environment to enable transferability of learning

Receiving region: List of suggested changes to enable the creation of conditions for the improvement of eHealth services in Olomouc Region, informed by the learning about the features of Norrbotten's healthcare system is outlined in the Table below:

Features of the Norrbotten's healthcare system	Adaptation of features to Olomouc' local context
eHealth services • Implementation of national ICT solutions to increase the patients´ access to their medical records • Implementation of regional ICT solutions to share patient related information between different health and social care providers • Existence of platforms, infrastructure and services to empower patients to participate in the decision-making on their care as well as supporting self-care	• Raise awareness and promote the benefits of eHealth services in order to speed up the implementation of new national eHealth strategy. • Develop mechanisms to reduce the complexity of introducing the concept of eHealth services. The ICT solutions to allow information sharing between various healthcare providers are expected to be soon developed, however, their implementation requires a complex change and is part of two crucial reforms: a) primary care reform which is currently under preparation and; b) introduction of integrated care concept as part of the Structural Reform Support Programme (SRSS) 2017-2020. • Develop mechanisms to improve the communication and collaboration of key stakeholders by creating a joint committee between Ministry of Labour and Social Affairs and the Ministry of Health in order to better coordinate implementation of ICT solutions and raise awareness about the need to extend the sharing of health data to social care providers. This is currently not envisaged in eHealth strategy. • Develop mechanisms to enhance citizens empowerment and proactive approach of citizens to manage their own health and self-care. Currently, the system is very reactive, and citizens have a freedom of choice only in terms of choosing their specialists, GPs or hospital. Changes in the reimbursement system and payment schemes can be seen as one of the incentives.

7. Priority actions to enable conditions for the transferability of learning

Receiving region: List of the proposed actions to enable conditions for improvement of eHealth services in Olomouc Region, including objectives, anticipated outcomes and policy implications is outlined in the Table below:

Priority Action	Objective of the Action	Anticipated outcomes	Policy implications, including the responsible actor and anticipated duration
Improved awareness and recognition of the need for eHealth services	The objective of this action is to increase awareness of the key stakeholders of the benefits of eHealth services in order to speed up the adoption of new eHealth strategy.	Improved implementation of eHealth strategy and better strategic positioning of eHealth agenda as part of the on-going reforms, e.g. in the area of primary care or integrated care.	Positioning of eHealth agenda in Olomouc Region and wider Czech Republic is a very complex and long process. The main issue remains political sensitiveness of this agenda which strongly affects the allocation of budget and planned investments in this area. In addition, the coordination and clear definition of responsibilities of various stakeholders involved in the implementation process need to be addressed in order to manage this change effectively. This in particular involves the collaboration of four key stakeholders: Ministry of Health, insurance companies, healthcare providers and medical societies. However, the introduction of new eHealth strategy in 2016 as a legal framework for the implementation of ICT solutions may help to address this issue. The University Hospital Olomouc plays a very active role in contributing to the implementation of strategy and is one of the key players that can help to implement the priority actions defined in this plan.
Position the role of the University Hospital Olomouc (UHO)	The objective of this action is to raise the profile of the UHO in developing ICT infrastructure for information sharing.	Availability of ICT infrastructure to allow information sharing between healthcare providers.	
Inform about new technology enabled care services	The objective of this action is to raise awareness about new technology enabled care services and their benefits, e.g. video-conferencing system.	Establishment of sustainable videoconferencing infrastructure and network for cardiologists in Moravia in Olomouc Region; four hospitals were selected for the initial testing.	

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Annex VII Action Plan to create conditions for the adoption of integrated care in Norrbotten Region – Transferability of the Good Practice "Advanced Care Planning in an Integrated Care Organisation in the Basque Country"

Background: The objective of the Action Plan is to reflect on the possibility to transfer and adopt the learning about the Good Practice "Advanced care planning in an Integrated Care Organisation" (ACP) in the Basque Country to local settings in Norrbotten Region, including the feasibility of the transfer and recommendations on policy priority actions that would enable the creation of local conditions for the adoption of integrated care.

The Action Plan builds on the outcomes of the study visit organised in Vitoria-Gasteiz in the Basque Country on 12-13 September 2018. The study visit was an opportunity to learn about the Good Practice and discuss its potential transferability by comparing and contrasting the requirements of the ACP Good Practice with the maturity of local health and social care system for integrated care in Norrbotten Region. As such, the Action Plan can inform the health and social care authorities about the future strategies and policies related to the ACP services in Norrbotten region. This process was facilitated by SCIROCCO self-assessment tool which provided the basis for the twinning and coaching activities.

The Action Plan is co-designed jointly with the transferring and receiving region as follows:

- Section 1: Needs of the adopting region – **Receiving region**
- Section 2: Description of the integrated care solution - **Transferring region**
- Section 3: Maturity requirements of the integrated care solution – **Transferring region**
- Section 4: Benefits and opportunities of integrated care solution – **Receiving region**
- Section 5: Conditions for the adoption of integrated care solution – **Receiving region**
- Section 6: Adaptation of local environment to enable the transferability of learning – **Receiving region**
- Section 7: Priority actions to enable conditions for the transferability of learning - **Receiving region**

1. Needs of the receiving region – Norrbotten Region

The ambition of the Norrbotten Region is to design a common system for advanced care planning where patients can take an active role and communicate with healthcare professionals as required. As a result, there is a need to educate healthcare professionals about a new way of thinking and delivering care; respecting the central position of the patients and their right to take an informative decision on the issues related to the advanced care. As such, a proper detailed review of the patients' needs and available solutions needs to be conducted and implemented. However, this requires additional flow of information to enable patients and healthcare professionals to follow through the healthcare chain. Current systems need to be changed and redesign in order to offer patients the possibility to receive a safe and coordinated healthcare, across the organisational boundaries and where the patients are seen as an obvious part in planning of care process that concern them. Social care, health care and rehabilitation models need to be changed to accommodate citizens' needs and wishes.

2. Integrated care solution to address the needs of the receiving region

2.1 Transferring region: Advanced Care Planning in the Basque Country

Advance care planning (ACP) is a voluntary process of discussion between an individual and care provider about future care, irrespective of discipline. The aim is to guarantee patients' right to take decisions about their own care as well as to have those decisions respected when time comes.

The goal of this Good Practice is to promote ACP approach to the Basque population, particularly to chronic conditions population. The idea is to adjust end of life care to meet patients' preferences and improve decision making processes.

Three stages were defined when designing the Good Practice:

- Diagnostic stage in order to identify the population that could benefit from the ACP
- Therapeutic stage in order to develop the intervention
- Evaluative stage in order to assess both the impact of the Good Practice and the Good Practice itself.

The core intervention consists of two individual semi structured interviews with the patient and one or two members of patient family and/or friends. The interviews are carried out by the patient's General Practitioner (GP) and the community nurse. The first meeting aims mainly at introducing the subject (Advanced Directives) and inviting the patient to reflect on his/her preferences regarding the care. The second interview then focuses on the discussions of the specific issues related to the patient and his/her clinical characteristics and situation. Participants write down an advance directive according to their values, health conditions and preferences. The GP and/or community nurse assist with this process.

Every healthcare professional can access the Advance Directive using the Basque Country's Integrated Electronical Health Record. As ACP is considered an evolutive process, the patient can change opinion and modify its preferences whenever is needed.

2.2 *Transferring region*: Current progress of Advanced Care Planning in the Basque Country

Challenges/problems that the Good practice is supposed to solve:

The challenges that Advanced care planning (ACP) addresses are:

- Improvement of the quality of end-of-life care, respecting patients' preferences
- Promotion of citizen participation in shared decision-making
- Improvement of care communication between patients and careers
- Increase of health, social workers and caregivers' competences regarding ACP
- Increase of patient's competences to make end-of-life/care-related decisions

The main barriers when implementing the practice were:

- Lack of information about ACP
- Workload of healthcare professionals
- Lack of healthcare professionals' training in ACP, bioethics and communication.

Key innovative elements of the Good Practice

The main innovative elements of the Good Practice are:

- Structured approach to capture and record patient's preferences in the Basque Country's Integrated Electronic Health Record (Osabide Global) which is accessible to all healthcare professionals. The Region is currently working to extend the accessibility of this Record to social sector professionals as well.
- The patients have access to their Advanced care planning through their Personal Health Folder.
- An online tool to register patient's Advanced care planning before uploading the information to the Basque Integrated Health Record and Personal Health Folder.

Costs/investments needed for the deployment of the Good Practice:

The Good Practice is mainly focused on promoting a cultural change in the healthcare context; however, it is anticipated that it will presumably reduce the costs related to patients' non-chosen treatments.

There is no need for large volume of resources considering a quite substantial improvement of patients' quality of life (and end of life) and care improvement. Providing professionals with the opportunity to access training and the support is certainly an important success of the Good Practice, especially from the long-term perspective and sustainability of such a cultural change.

In terms of the human resources needed, the Good Practice requires:

- One Medical Doctor part-time working as programme coordinator, initial interview conductor, trainer and facilitator
- Four training sessions for interested healthcare professionals
- Time spent in patient-healthcare professional interviews.

Impact/outcomes observed:

The Good Practice has not yet been formally evaluated. Nonetheless, taking into considerations the views and perceptions of participants in the ACP (patients, families, GPs and community nurses), it seems that the Practice has proven to be invaluable. As a result, all stakeholders involved share a common view and perspective on the patients' preferences for the end of life care.

The interviews to reflect and discuss patients' values and preferences have now been systematically introduced into some of the Community Care Teams' agendas.

Healthcare professionals working at secondary/tertiary levels (mainly hospitals) are starting to be familiar with the ACP approach and benefiting from the information about patient's preferences captured in the Integrated Electronic Health Record.

For a full description of the Good Practice:
https://www.scirocco-project.eu/basque-country-b3-advance-care-planning-in-an-integrated-organisation/

3. Maturity Requirements of Advanced Care Planning Good Practice in the Basque Country

3.1 Transferring region: Maturity requirements for the adoption and transferability of the Advanced Care Planning (ACP) Good Practice is illustrated in the spider diagram and Table below:

Figure 1: Maturity requirements of ACP Good Practice

Dimension	Score	Description	Features of the Good Practice
Readiness to Change	3	Vision or plan embedded in policy; leaders and champions emerging	It is necessary to recognise the need for change; have a defined plan and clear leadership to promote the implementation.
Structure & Governance	2	Formation of task forces, alliances and other informal ways of collaboration	It is necessary to have some degree of functional integration between health care levels; working groups in place with clear leadership.
eHealth Services	3	eHealth services to support integrated care are piloted but there is no yet region wide coverage	It is necessary to have and use a fully integrated Electronic Health Record that is accessible to all professionals and the whole population in order to allow interaction between the citizens/patients and healthcare professions. In addition, the use of tele-consultations between primary care and the hospital is required.
Standardisation & Simplification	3	A recommended set of agreed technical standards at regional/national level; some large-scale consolidations of ICT underway	There is a broad development of corporate platforms (databases, platforms for clinical history) in place. The capability to integrated multiple sorts of data from the Integrated Electronic Health Record is required to allow inter-consultations between primary and specialised care.
Funding	1	Funding is available but mainly for the pilot projects and testing	There needs to be some funding available to plan and implement the intervention.
Removal of inhibitors	2	Awareness of inhibitors but no systematic approach to their management is in place	There needs to be a strategy to anticipate and remove the inhibitors.
Population Approach	1	Population-wide risk stratification considered but not started	It is necessary to prioritise the appointments and request for screening according to the patient's morbidity risk
Citizen Empowerment	3	Citizens are consulted on integrated care services and have access to health information and health data.	The Personal Health folder is used as a tool for patient empowerment as it allows patients' interaction with clinicians thus replacing some face-to-face consultations.
Evaluation Methods	2	Evaluation of integrated care exists, but not as part of a systematic approach	It is necessary to evaluate the reduction of the demand on the service, the number and quality of inter-consultations/
Breadth of Ambition	3	Integration between care levels (e.g. between primary and secondary care) is achieved	There needs to be a cohesive structure between primary and specialised care and common communication channels and tools in

Dimension	Score	Description	Features of the Good Practice
			place. In the ideal scenario, social sector would also be integrated.
Innovation Management	2	Innovations are captured and there are some mechanisms in place to encourage knowledge transfer	It is necessary to have some interest of healthcare professionals in innovation to consider the implementation of the Practice, including the enhancement by the decision-makers.
Capacity Building	3	Learning about integrated care and change management is in place but not widely implemented	The system has to provide means for the development and use of the tools to allow training and coaching.

4. Benefits and opportunities of the adoption of Advanced Care Planning in Norrbotten Region

The adoption of Advance Care Planning (ACP) Good Practice in Norrbotten Region would enhance a new way of working in planning and implementation of health and social care interventions for patients in a need for advanced care planning. It would improve the opportunities for the patients to make their own decisions on care, including end-of-life care. This approach would complement new Strategy of Norrbotten Region: The Road to the Future Health and Care[9] which outlines a paradigm shift for healthcare from citizens' perspective. The approach will change working methods and create new services that shape a new care delivery; a healthcare that meets the needs of each person on equal basis. The new ways of working will also facilitate the provision of new skills required for such a change.

9 The road to the Future Health and Care; https://www.norrbotten.se/Vagen-till-framtidens-halsa-och-vard---2035/

5. Conditions for the adoption of Advanced care Planning in Norrbotten Region

5.1 Maturity of local health and social care system in Norrbotten Region

Receiving region: Maturity of Norbotten Region's health and social care system for the adoption of Advanced Care Planning, highlighting the strengths and weaknesses of the local system.

Figure 2: Maturity of healthcare system in Norrbotten Region

5.2 Conditions enabling the adoption of Advanced care Planning in Norrbotten Region

Receiving region: Maturity of healthcare system in Norrbotten Region and maturity requirements of the Advanced Care Planning Good Practice in the Basque Country:

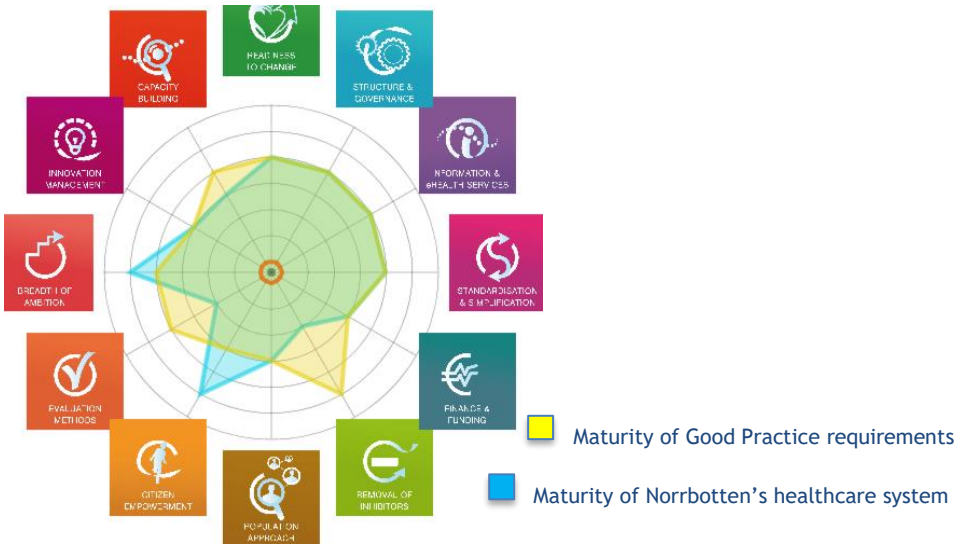

Figure 3: Comparison of maturity requirements of Good Practice with maturity of Norrbotten Region's healthcare system

5.3 Feasibility of the transferring the learning about Advanced Care Planning Good Practice to local context in Norrbotten Region

Dimension	Score Basque Country	Feature(s) of the Good Practice	Score Norrbotten	Feature(s) of Norrbotten's healthcare system	Feasibility of the transfer and rationale
Readiness to Change	3	It is necessary to recognise the need for change; have a defined plan and clear leadership to promote the implementation.	3	Many small projects concerning integrated care are running but there is a lack of collaboration and learning between the projects which often result in the different levels of existing knowledge and performance of integrated care in the region. Models for managing change are established. There is a clear recognition of need for change. From a political point of view there is an acknowledgement of the unsustainability of current healthcare system and visions and policies to address the need to change have been adopted to some extent. Also, on an operational level several initiatives have been implemented and are running.	Yes; the transferability is feasible with lot of efforts. It is necessary to have a legal framework for integrated care solutions and ethics committees in place in order to ensure that new methods are in line with Norrbotten's values and professional ethical codes for employees. In addition. the Good Practice to be implemented needs to be included into the policies and have the driving leaders who recognise the need for change.
Structure & Governance	2	It is necessary to have some degree of functional integration between health care levels; working groups in place with clear leadership.	3	A national strategy for eHealth has been developed and implemented; the Region has progressed well concerning eHealth solutions but there is a need for the municipalities to reach the same level of progress to be able to reach the good results of integrated care and overcome organisational boundaries. There is a structure for collaboration between the region and the municipalities. Further development of eHealth is defined in regional programmes such as the Regional Development Strategy, and the Regional Innovation Strategy. However, the Strategies still exist only at a strategic level and implementation is lacking. A clear roadmap and specific mandates are needed to ensure their implementation.	No; the transferability is not feasible. The implementation of these features in the local context of Norrbotten would require a legal protection that promotes the exchange of information between patients and different social and healthcare providers. It would also need professionals who are motivated and have clear leadership in place who have knowledge of the benefits of more involved patients.

Dimension	Score Basque Country	Feature(s) of the Good Practice	Score Norrbotten	Feature(s) of Norrbotten's healthcare system	Feasibility of the transfer and rationale
Information & eHealth Services	3	It is necessary to have and use a fully integrated Electronic Health Record that is accessible to all professionals and the whole population in order to allow interaction between the citizens/patients and healthcare professions. In addition, the use of tele-consultations between primary care and the hospital is required.	3	There are national ICT solutions to increase the patients´ access to their medical records; regional ICT solutions to share patient related information between different care providers - "1177.se" where patients can read their own healthcare data. The Region has also very well progressed with building on existing platforms and infrastructure and creating new services to empower patients and ensure their ability to participate in the decision-making on their care as well as supporting self-care. However, scalability of these solutions remains the issue.	Yes; the transferability is feasible with no need for major adaptation There is an integrated infrastructure in place to allow sharing of clinical information between the different levels of care in Norrbotten. There is also integrated electronic health record in place.
Standardisation & Simplification	3	The capability to integrated multiple sources of data from the Integrated Electronic Health Record is required to allow inter-consultations between primary and specialised care.	3	There is a lack of common standards between the healthcare providers at local and regional level and often even among the providers at the same level.	Yes; the transferability is feasible with lot of efforts. The Advanced Care Plan needs to be adapted in order to have homogeneous technical standards in all organisations involved. The document needs to be accessible by patients and all healthcare professionals involved.
Finance & funding	1	There needs to be some funding available to plan and implement the intervention.	2	External funding is most often limited to pilot projects rather than up-scaling. Internally, within the organisation, the budget is set for a year. The primary focus is on savings rather than spending. However, sometimes there is an opportunity to receive funding for early phases of the projects externally and internally but mostly for testing and piloting of the services.	No; the transferability is not feasible. There is a limited funding available for the implementation of innovative solutions. In addition, to keep the ACP approach sustainable, the system needs to support time release and time dedication of healthcare professionals to conduct the service but also undertake education and training which would be a challenge for the Norrbotten's healthcare system.

Dimension	Score Basque Country	Feature(s) of the Good Practice	Score Norrbotten	Feature(s) of Norrbotten's healthcare system	Feasibility of the transfer and rationale
Removal of Inhibitors	2	There needs to be a strategy to anticipate and remove the inhibitors.	1	There is no specific model or existing project in Norrbotten with a clear mandate to remove inhibitors; there are different models used with different results. The collaboration between the municipalities and the region is in place that facilitates the removal of inhibitors.	No; the transferability is not feasible. There is no strategy or plan in place for the removal of inhibitors. The dedication and continuous training of healthcare professionals seem to be crucial inhibitor in the Norrbotten's local context.
Population Approach	1	It is necessary to prioritise the appointments and request for screening according to the patient's morbidity risk	2	Models to identify patients at risks are applied in Norrbotten and standardised care plans are implemented for some categories of patients. Both the population health unit as well as care divisions in the Region continuously perform certain risk analysis, followed by statistics and particular types of actions.	Yes; the transferability is feasible with no need for major adaptation. The stratification process has been initiated n Norrbotten in order to identify patients at risks.
Citizen Empowerment	3	The Personal Health folder is used as a tool for patient empowerment as it allows patients' interaction with clinicians thus replacing some face-to-face consultations.	4	Citizens do have access to health information and health data through "Health care in numbers and open comparisons', but this solution is not used systematically for decision-making. Not all data is made available yet.	Yes; the transferability is feasible with some efforts. Citizens have access to their health data; the involvement of patients and citizens organisations needs to be better recognised in Norrbotten's local context.
Evaluation Methods	2	It is necessary to evaluate the reduction of the demand on the service, the number and quality of inter-consultations/	1	No common evaluation model is used in Region Norrbotten. There are some evaluations methods applied, but not as a part of a systematic approach.	Yes; the transferability is feasible with lot of efforts. In order to successfully implement ACP Good Practice, there needs to be a system that supports a systematic evaluation.
Breadth of ambitions	3	There needs to be a cohesive structure between primary and specialised care and common communication tools in place. In the ideal scenario, social sector would also be integrated.	4	There is fully integrated health and social care services with collaboration established on all three levels of care, but the services can still be improved.	Yes; the transferability is feasible with no need for major adaptation. There is integration between primary and hospital care levels.

Dimension	Score Basque Country	Feature(s) of the Good Practice	Score Norrbotten	Feature(s) of Norrbotten's healthcare system	Feasibility of the transfer and rationale
Innovation management	2	It is necessary to have some interest of healthcare professionals in innovation, including the enhancement by the decision-makers.	2	There is no very much formalised innovation management process. Procurement is very much removed from the process today.	Yes; the transferability is feasible with some efforts. The implementation of the Good Practice requires recognition of the need for innovation and new way of working. There needs to be some improvement in developing mechanisms to support innovations and transfer knowledge as necessary.
Capacity Building	3	The system has to provide means for the development and use of the tools to allow training and coaching.	2	There is still at the point where we need better support for creating a learning organisation and supporting "change managers" continuously.	Yes; the transferability is feasible with lot of efforts. The need for continuous learning needs to be embedded in the routine practice.

5.4 Priority areas for the transferability of learning

Receiving region: List of the prioritised features to be considered for the transferability of learning about Advanced Care Planning Good Practice is outlined in the table below:

List of the prioritised features of the Advanced Care Planning Good Practice
Readiness to Change • Recognised need for change; • A defined plan for implementation of Good Practice • A clear leadership to promote the implementation of Good Practice eHealth services • Use of a fully integrated Electronic Health Record that is accessible to all professionals and the whole population in order to allow interaction between the citizens/patients and healthcare professions • Use of tele-consultations between primary care and the hospital

6. Adaptation of local environment to enable the transferability of learning

Receiving region: List of suggested changes to enable the creation of conditions for the adoption of learning about Advanced Care (ACP) Planning Good Practice to the local context of Norbotten Region is outlined in the Table below:

Features of the ACP Good Practice	Adaptation of the features to Norrbotten's context
Readiness to Change • Recognised need for change • A defined plan for implementation of Good Practice • A clear leadership to promote the implementation of Good Practice	• Develop Implementation Plan for the adoption of ACP, endorsed by the policy-makers, including the clear assignments of roles and leaderships of all stakeholders involved in the implementation of new ways of working. • Raise awareness about the benefits of the ACP approach to Good Practice leaders and implementers. • Support the need for a change with empowering of healthcare professionals to implement ACP Good Practice through training and education.
eHealth services • Use of a fully integrated Electronic Health Record that is accessible to all professionals and the whole population in order to allow interaction between the citizens/patients and healthcare professions • Use of tele-consultations between primary care and the hospital	• There is a need for a development of new Health and Social Care Plan and the documentation system that allows citizens and healthcare professionals accessing and developing their health care and social plan that provides a greater scope for patients to decide on coordinated efforts involving several partners.

7. Priority actions to enable conditions for the transferability of learning

Receiving region: List of the proposed actions to enable conditions for the transferability of learning about Advanced Care Planning (AC) Good Practice to the local context of the Norrbotten Region, including objectives, anticipated outcomes and policy implications is outlined in the Table below:

Priority Action	Objective of the Action	Anticipated outcomes	Policy implications, including the responsible actor and anticipated duration.
Develop an implementation plan for the ACP	Introduce new way of working that extends the current organisational barriers, including responsible actors, leadership, processes and anticipated duration.	Clear leadership in implementing new ways of working	In order to implement the ACP Good Practice, the following policy actions need to be considered: 1. the Good Practice needs to be embedded in the existing policies and strategies related to integrated care and digital healthcare in order to secure the leadership for its implementation. The new way of working could be well integrated into the operating care model in Norrbotten Region and as a part of new Strategy for Future Health Care. 2. Adaptation of the Advanced Care Plan to comply with the technical standards across the different organisations. New guidelines and standards are required for the entire nation, to facilitate regional decisions on changing methods. 3. Adaptation of the funding system to support the time release of healthcare professionals. Current system is based primarily on the number of visits needs to change to calculate the value for the patient. This is a system shift that takes time in a hierarchical organisation. First, the systems need to be changed and implemented and after that, managers and employees must be educated and the new approach have to be launched and communicated with citizens.
Improve education of healthcare professionals	Join the efforts in providing the same level of education and training to all healthcare professionals involved.	Common vision, skills and support to implement new way of working	
Introduce a new Health and Social Care Plan	Improve citizen empowerment and engagement in the decision-making processes in the planning and implementation of health and social care interventions.	Implementation of person-centred, coordinated health and social care interventions	

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Annex VIII Action Plan to create conditions for the adoption of integrated care in Scotland – Transferability of "Hospital@Home" Good Practice in Puglia Region

Background: The objective of the Action Plan is to reflect on the possibility to transfer and adopt the learning about the Hospital@Home Good Practice in Puglia Region in Italy to local settings in Scotland, including the feasibility of the transfer and recommendations on policy priority actions that would enable the creation of local conditions for the adoption of integrated care.

The Action Plan builds on the outcomes of the study visit organised in Puglia Region on 13-14 June 2018. The study visit was an opportunity to learn about the Good Practice and discuss its potential transferability by comparing and contrasting the requirements of the Good Practice with the maturity of local health and social care system for integrated care in Scotland. As such, the Action Plan can inform the health and social care authorities about the future strategies and policies related to the Hospital@Home services in Scotland. This process was facilitated by SCIROCCO self-assessment tool which provided the basis for the twinning and coaching activities.

The Action Plan are co-designed jointly with the Puglia Region as a transferring region and Scotland as receiving region as follows:

- Section 1: Needs of the adopting region - **Receiving region**
- Section 2: Description of the integrated care solution - **Transferring region**
- Section 3: Maturity requirements of the integrated care solution - **Transferring region**
- Section 4: Benefits and opportunities of integrated care solution - **Receiving region**
- Section 5: Conditions for the adoption of integrated care solution - **Receiving region**
- Section 6: Adaptation of local environment to enable the transferability of learning - **Receiving region**
- Section 7: Priority actions to enable conditions for the transferability of learning - **Receiving region**

1. Needs of the receiving region - Scotland

Scotland, similarly as other regions and countries in Europe, is facing the impact of ageing population and increased number of people with chronic conditions on health and social care delivery. The focus on hospital-based, disease-based and "silo" curative models further undermine the ability of healthcare system to provide high-quality and financially sustainable care. In Scotland, there is a recognition of the need to move towards a more integrated, person-centred approach that is designed for citizens in a way that co-ordinates services around their needs and puts them in control, thus enabling them to participate in and make informed decisions about their care. A mainstreamed adoption of technological solutions within service redesign is perceived as a major facilitator of such a change.

This ambition is reflected in a number of policies and strategies in Scotland; for example:

- the Public Bodies (Joint Working) Scotland Act 2014[10] which introduced a formal integration of health and social care
- Digital Health and care Strategy: enabling, connecting and empowering (2018)[11] which focuses on the use of technology to reshape and improve services, support person-centred care and improved outcomes.

As such, Scotland is very keen to explore and learn from the experience of others particularly in the area of adoption of technological solutions in the routine care. The Technology Enabled Care (TEC) Programme was set up by the Scottish Government to address the need to focus on primary, community and home-based care rather than acute specialities, with the general objective of ensuring that outcomes for individuals, in home or community settings, are improved through the application of technology as an integral part of quality cost-effective care and support. It has provided national focus, the profile and visibility of technology enabled care has been significantly increased, leading to a greater cohort of individuals championing the use of TEC. However, the mainstreaming of the TEC initiatives into the routine care still remains a challenge, hence the opportunities of how to introduce and maintain these initiatives business as usual need to be further explored.

2. Integrated care solution to address the needs of receiving region

2.1 Transferring region: Hospital@Home Good Practice in the Puglia region

Hospital@Home Good Practice is designed as a technological support for already structured activities in home care. The main objective is to reduce hospitalisation and re-hospitalisation rate and to improve the quality of care for patients at home. In addition, the objective is to:

- Reduce the number of patients with heart disease, diabetes and other chronic diseases in the process of instability
- Activate protected de-hospitalisation
- Optimise the therapy and diagnosis according to international guidelines.

[10] http://www.legislation.gov.uk/asp/2014/9/contents/enacted
[11] Digital Health and Care Strategy https://beta.gov.scot/publications/scotlands-digital-health-care-strategy-enabling-connecting-empowering/

The Good Practice has also an ambition to validate new telemedicine models applied for diagnostic and therapeutic pathways for the management of chronicity. The aim is to implement a new type of telemonitoring, based on continuous collaboration and patient monitoring by different professionals and different users.

Patients, opportunely selected, are telemonitored by their General Practitioners by using the innovative home and health monitoring technological solution (H&H Hospital@Home). This solution is able to detect the main clinical and instrumental parameters in addition to the therapeutic administration, based on oxygen and bronco-aspiration. It is allocated at the patients' home and it is permanently interconnected with the General Practitioner and/or Specialist, by computer, telephone, tablet and other devices.

At the same time, there is a central monitoring room at the hospital in Ceglie Messapica (Brindisi) for all patients and all devices located at their home. All clinical parameters of patients are stored on a dedicated server, respecting the rules for the respect of privacy. The system allows the healthcare professionals (neurologists, pulmonologist, cardiologists, diabetologists, etc) to monitor and speak with patients remotely. The patients can also activate the visit of the healthcare professionals in their homes. In addition to real-time monitoring of physiological parameters, the healthcare professionals can also monitor the physical and technical characteristics of home device. As a result, it is possible to deliver therapy to the patient remotely. In particular, it is possible to deliver oxygen therapy and endocavitary aspiration. Healthcare professional determines the limit of the range of physiological parameter values and when the parameter is beyond the limit, the system draws the operator's attention through the alert.

2.2 *Transferring region*: Current progress of the Hospital@Home Good Practice in Puglia Region

Challenges/problems that the Good practice is supposed to solve:

The five challenges that Hospital@Home Good Practice addresses are:

- Reduction of the number of patients with chronic diseases in the process of instability
- Reduction of hospitalisation and re-hospitalisation
- Activation of protected resignation
- Optimisation of the therapy and diagnosis according to international guidelines
- Promotion of the integrated management of hospital and community.

Key innovative elements of the Good Practice

Hospital@Home Good Practice is based on increased collaboration and involvement of General practitioners, specialists, nurses, patients and their caregivers.

The analysis of data related to the monitoring of about 100 patients allows better understanding of the effectiveness of the remote monitoring system and to what extent it improves the quality of care for patients. Patients are directly supervised by their General Practitioners in a much faster way which in turn increases the performance. We notice a very facilitated dialogue between General Practitioners and Specialists in delivering the service. Finally, the General Practitioners feel more supported by the Specialists when there

is a need for a quick consultation. 60% of patients are over 65 years old. 30% of the patients suffer from heart diseases, 40% patients of COPD and the remaining patients are diagnosed with diabetes. In all of the patients who presented the values of blood oxygen saturation beyond the threshold, oxygen administration by concentrator has allowed to re-establish the normal clinical condition. In approximately 30% of patients is the drug therapy that improved due to telemonitoring.

Costs/investments needed for the deployment of the Good Practice:

The total investment necessary for the adoption of Hospital@Home Good Practice is between €100.00 - €499,999. The main source of funding came from the European Union, specifically European Regional Development Fund (ERDF).

Impact/outcomes observed:

There is an evidence that the Good Practice is economically viable, and it brings benefits to the target group. Further research is needed in order to achieve market impact and make the Good Practice part of the routine care.

The advantages of the use of H@H hospital equipment at home are:

- Reduction of hospital stays
- Greater assistance for the patients delivered directly to their homes
- Improvement of the psychological and physical conditions
- Improvement of the therapeutic plan
- Easier monitoring of physiological parameters
- Easy to use and flexible management system.

The Good Practice has been transferred within the same region. A similar initiative is launched in another area of Italy, based on a slightly different organisation of the care model.

For a full description of the Good Practice please see:
https://www.scirocco-project.eu/p6-puglia-italy-telehomecare-telemonitoring-teleconsultation-and-telecare-project-aimed-at-patients-with-heart-failure-chronic-obstructive-pulmonary-diseases-and-diabetes/

Other useful links include:
http://www.hospitalathome.org/
http://www.hospitalathome.it/index.php?lang=it

3. Maturity Requirements of Hospital@Home Good Practice in Puglia Region

3.1 Transferring region: Maturity requirements for the adoption and transferability of Hospital@Home Good Practice is captured in the spider diagram below and detailed justification is provided in the following Table:

Figure 1: Maturity requirements of Hospital@Home Good Practice

Dimension	Score	Description	Features of the Good Practice
Readiness to Change	4	Leadership, vision and plan clear to the general public; pressure for change	It is important to have leadership; it also needs to be in line with the general vision of policy makers and professionals involved.
Structure & Governance	4	Roadmap for a change programme defined and accepted by stakeholders involved	It is necessary to have a clear roadmap for a change programme, including clear definition of regulation, supported by shared vison with stakeholders.
eHealth Services	3	eHealth services to support integrated care are piloted but there is no yet region wide coverage.	Information sharing among professionals is needed as well as a central monitoring control room to coordinate the monitoring of patients.
Standardisation & Simplification	3	A recommended set of agreed technical standards at regional/national level; some shared procurements of new systems at regional/national level; some large-scale consolidations of ICT underway	The activation of the remote monitoring doesn't need specific ICT standards, but the solution needs to be interconnected with the Regional Platform. The adopted technology needs to comply with the existing standards.
Funding	4	Regional/national funding and/or reimbursement schemes for on-going operations is available	An initial investment for the procurement of the bed side table is needed. Nevertheless, the Good Practice can also be implemented by building an agreement with the IT provider and make the maintenance of the service and training of healthcare professionals as part of the procurement.
Removal of inhibitors	2	Strategy for removing inhibitors agreed at a high level	The key to success is a minimum impact in the routine of healthcare professionals involved. Some in-depth information about the service shared among the stakeholders involved, including patients and care givers can help the removal of possible obstacles or diffidence.

Dimension	Score	Description	Features of the Good Practice
Population Approach	3	Risk stratification used for specific groups i.e. those who are at risk of becoming frequent service users –	Population stratification is not needed. Shared healthcare pathways among the actors of the Care team is envisaged in order to guarantee the correct monitoring of the patients both clinically and psychologically.
Citizen Empowerment	3	Citizens are consulted on integrated care services and have access to health information and health data	Patients enrolled in this good practice are very frail. Stabilised but bed ridden. They need to be informed and trained for the use of the platform, but a big work needs to be done also on the side of care givers. Self-motivation of the patients is critical for the success.
Evaluation Methods	4	Most integrated care initiatives are subject to a systematic approach to evaluation; published results	It is important to have an evaluation habit. The possibility to have a systemic evaluation system helps. The data collection informs a continuous improvement of the ICT software/system used.
Breadth of Ambition	3	Integration between care levels (e.g., between primary and secondary care) is achieved	It is necessary to have integration between hospital care and primary care. The practice can easily take off wherever there is integration between care levels.
Innovation Management	3	Formalised innovation management process is planned and partially implemented	The implementation of the Good Practice is based on an important change of approach in managing frail chronic patients out of hospital. The principle of de-hospitalization must be embedded in the policy vision.
Capacity Building	3	Learning about integrated care and change management is in place but not widely implemented	It is necessary to train professional for the use of the devices and activate continuous learning and training processes.

4. Benefits and opportunities of the adoption of Hospital@Home Good Practice in Scotland

The learning about the Hospital@Home Good Practice showed clear similarities of Puglia Region and Scotland's vision of how to transform care delivery. The main focus in both regions is to look for the primary care led solutions which would help to shift the balance of care from hospital to community settings, increase capacity and reduce the demands on health and social care services.

As such, a number of opportunities were identified in Scotland, namely:

- Opportunity to improve engagement of GPs in the delivery of technology enabled care solutions. The proposed solutions need to have a minimum impact on the routine working practice of GPs. Otherwise GPs often feel protective of their own roles and are thus a main barrier to implement a change. GPs need to drive a change and advocate for the new solutions.
- Opportunity to improve the funding of care transformation. The resources need to follow transformation of services to community settings.
- Opportunity to better promote benefits and impact of technology enabled care solutions in order to facilitate their "buying". Systematic evaluation and quality data collection is a key component of successful Hospital@Home services in Puglia.

- Opportunity to better target citizens who would benefit most from technology enabled care solutions. The population approach and use of predictive modelling need to become part of routine care and service design.

5. Conditions for the adoption of Hospital@Home Good Practice in Scotland

5.1 Maturity of local health and social care system in Scotland

Receiving region: Maturity of Scotland's health and social care system for the adoption of Hospital@Home Good Practice, highlighting the strengths and weaknesses of the local system.

Figure 2: Maturity of Scotland's healthcare system

5.2 Conditions enabling the adoption of Hospital@Home Good Practice in Scotland

Receiving region: Maturity of healthcare system in Scotland and maturity requirements of the Hospital@Home Good Practice in Puglia Region:

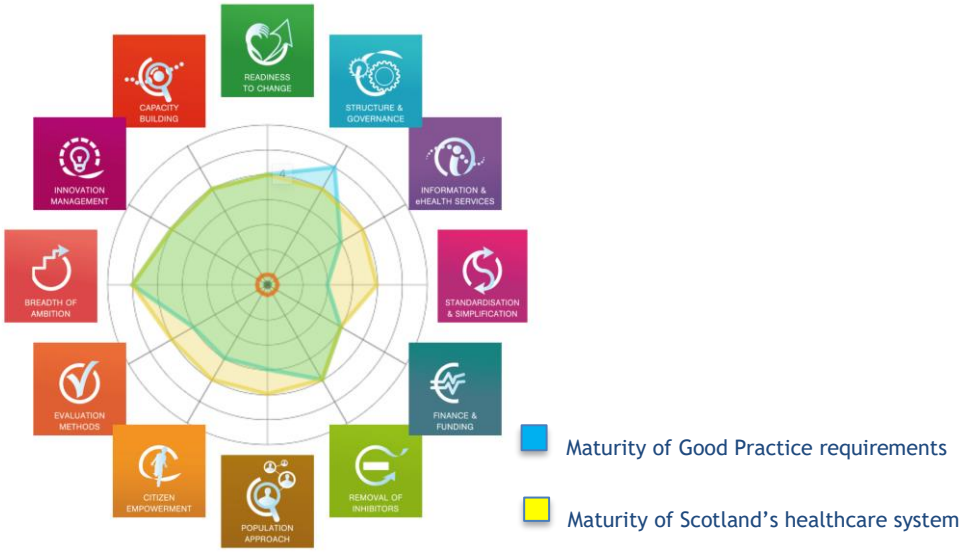

Figure 3: Comparison of maturity requirements of Good Practice with maturity of Scotland's healthcare system

5.3 Feasibility of transferring the learning about Hospital@Home Good Practice to Scotland's local context

Dimension	Score Puglia	Feature(s) of the Good Practice	Score Scotland	Features of Scotland's healthcare system	Feasibility of the transfer and rationale
Readiness to Change	4	Leadership Good Practice implemented in line with general vision of policy-makers	3	Vision or plan embedded in policy Leaders and champions are emerging; Joint efforts towards change	Yes; the transferability is feasible with no need for major adaptation. Most of the features are already incorporated in Scotland's system. Some further work can be done around the engagement of clinical staff and ensure their stability, in most cases they move form project to project.
Structure & Governance	4	Roadmap for change programme Shared vision of stakeholders Organisational structure	4	Roadmap for a change programme defined and accepted by stakeholders involved; There is a structure and governance in place, governance is fully resourced at national level, but the messages do not go down in the same way and there are differences in local implementations.	Yes; the transferability is feasible with no need for major adaptation. Most of the features are already incorporated in Scotland's system. Some further work can be done around the improvement of implementation.
eHealth Services	3	Connection to national/regional platforms to allow information sharing. IT providers are central part of the service redesign and additional work such as maintenance of the service or training is part of the procurement.	2	There is a mandate and plan to deploy regional/national eHealth services across the healthcare system but not yet implemented. There are local solutions but there is no governance to upscale. The main barrier is the culture around the data sharing. Pilots are localised solutions in transition. However, there is continuing funding for initial pilots.	No; the transferability is not feasible; Scotland does not have an Electronic Health Record or national platform to connect all collected data. In addition, there is a difference in the procurement models.
Standardisation & Simplification	3	Connection to national/regional platforms to allow information sharing; no need for specific standards	1	Discussion of the necessity of ICT solutions to support integrated care and of any standards associated with that ICT is initiated; Existence of different standards for health and social care.	Yes; the transferability is feasible with some efforts: There are plans already in place regarding the creation of citizen portal and ensuring interoperability is a key standard

Dimension	Score Puglia	Feature(s) of the Good Practice	Score Scotland	Features of Scotland's healthcare system	Feasibility of the transfer and rationale
					in all new procurement. In addition, current Analogue to Digital agenda, development of national digital platform and Programme to put all NHS boards on Windows 10 and Microsoft 365 will further facilitate standardisation and simplification.
Funding	4	Maintenance of the services is part of the procurement to ensure sustainability	2	Consolidated innovation funding available through competitions/grants for individual care providers and small-scale implementation. A national Integrated Care Fund, some EU funding supporting integration and TEC funding available. Lack of resources to access the funding. Funding for the business as usual remains a continuous challenge.	No; the transferability is not feasible: Some improvement can be done about the business cases on how to support business as usual rather than pilots. However, there is quite a difference in procurement model of Puglia. The engagement with local suppliers would not be possible due to rigorous procurement and financial politics and previous legacy with platforms unable to support large scale deployment. There is currently tendency towards "One for Scotland" which means that even local suppliers need to bid in the procurement processes.
Removal of inhibitors	2	Readiness of healthcare professionals – GPs led clinics, minimal changes to their routine practice and familiarisation of professionals with ICS solutions	3	Implementation Plan and process for removing inhibitors have started being implemented locally; Investments to provide support for local agencies to implement new ways of working; innovation centres were created as part of the plan; Lot of training for different professions to change towards integration.	Yes; the transferability is feasible with lot of efforts; Recruitment of GPs remains a big challenge; there are few exceptions e.g. NHS Lanarkshire where GP practices are greatly involved, there is an on-going dialogue and "selling the story" approach with incentives and support in place. The introduction

Dimension	Score Puglia	Feature(s) of the Good Practice	Score Scotland	Features of Scotland's healthcare system	Feasibility of the transfer and rationale
					of new services/routine need to feel as "normal" rather than add-on. There is some potential in learning about NHS Lanarkshire approach and replicate it across Scotland.
Population Approach	3	Existence of risk stratification tools/approaches	2	Risk stratification approach is used in certain projects on experimental basis; SPARRA looks at responses through health and social care integration for patients who are at risk of re-admission.	Yes; the transferability is feasible with some efforts; Currently available risk stratification approaches and tools need to be adapted reflecting more home and mobile health monitoring aspect and prevention aspect.
Citizen Empowerment	3	Citizens driven service, there is a demand for the service; tools/incentives to support citizen empowerment	2	Lack of access of patients to health data; missing support for very frail patients; Lack of resources for coaching and training of citizens to embed the digital skills; Different level of implementation across health and social care partnerships	Yes; the transferability is feasible with lot of efforts. Some adaptation can be done around the following features: use of social media to increase citizen engagement (sometimes it requires the use of accessible technologies such as local TV and radio); increased resources for training/coaching of patients; improved access to health data and information.
Evaluation Methods	4	Systematic evaluation and data collection	2	Data collection remains an issue; there is a good degree of evaluation for the TEC programme, but results are not published; Lack of data that are connected hence resulting in poor quality of data; Resistance of healthcare professionals to share data; Unless there is a need for continuous investments, systematic evaluation is not performed.	Yes; the transferability is feasible with lot of efforts; Some improvement can be done around publishing of evaluation outcomes, even if data are published it is usually not on time which influences the development of future sustainability plans or business cases. There is also a need to improve connectivity and quality of data to be able to

Dimension	Score Puglia	Feature(s) of the Good Practice	Score Scotland	Features of Scotland's healthcare system	Feasibility of the transfer and rationale
					demonstrate the value and impact of the intervention and make people trusting the data. The resistance of healthcare professionals to share data needs to be better addressed as well.
Breadth of Ambition	3	Integration across primary and hospital care	4	Improved coordination of social care services and healthcare needs; Ambition of the full integration of health and social care; Integrated budget and integrated governance.	Yes; the transferability is feasible with no need for major adaptation. The ambition of Scotland is full health and social care integration which is embedded in the legislation on integrated care.
Innovation Management	3	Change of approach embedded in policy	3	New Digital Healthcare Strategy provides the policy umbrella for innovation in Scotland; different level of innovation initiatives across Scotland but not joined-up; need to clarify and align the innovation priorities	Yes; the transferability is feasible with no need for major adaptation. Some improvement can be done around supporting the collaboration for innovation; e.g. through improved involvement of ICT providers in the system re-design, joining-up the innovation initiatives; New Digital Healthcare Strategy should provide the basis for improved coordination and alignment of innovation activities.
Capacity Building	3	Training of healthcare professionals	3	There is a recognised need for the training and capacity-building around the digital skills; open culture of learning and sharing via different mechanisms; e.g. Learning Network, Digital Healthcare Week and other.	Yes; the transferability is feasible with no need for major adaptation. Some improvement can be done in increasing the resources for capacity-building; we need to continue supporting the culture of open learning and sharing of experience both at national and European level.

5.4 Priority areas for the transferability of learning

Receiving region: List of the prioritised features to be considered for the transferability of learning about Hospital@Home Good Practice to Scotland's local context is outlined in the Table below:

List of the prioritised features of the Hospital@Home Good Practice
Removal of inhibitors • Engagement and recruitment of GPs Citizen empowerment • Citizens driven service, there is a demand for the service • Tools/incentives to support citizen empowerment Evaluation Methods • Systematic evaluation and data collection

6. Adaptation of local environment to enable transferability of learning

Receiving region: List of suggested changes to enable the creation of conditions for the adoption of learning about Hospital@Home Good Practice to Scotland's local context is outlined in the Table below:

Features of the Good Practice	Adaptation of the features in Scotland
Removal of inhibitors • Engagement and recruitment of GPs	• Improve flexibility of engaging with GPs on the individual basis; there is no "one size fits all approach" • Encourage learning about the ways of how to engage with GPs and promote good practices nationally and beyond to facilitate scaling-up of successful stories.
Citizen empowerment • Citizens driven service • Tools/incentives to support citizen empowerment	• Increase public awareness about the benefits of technology enabled care solutions and promote active participation of citizens in the prevention, self-care and management of their care through the education • Embed the education about the importance of citizen empowerment and active participation in schools' curricula • Adapt the language to your targeted audience
Evaluation Methods • Systematic evaluation and data collection	• Improve publishing of evaluation data and demonstrate the impact • Improve real-data collection

7. Priority actions to enable conditions for the transferability of learning

Receiving region: List of the proposed actions to enable conditions for the adoption of learning about Hospital@Home Good Practice to Scotland's local context, including objectives, anticipated outcomes and policy implications is outlined in the Table below:

Priority Action	Objective of the Action	Anticipated outcomes	Policy implications, including the responsible actor and anticipated duration
Engagement with GPs	The objective of this action is to increase the engagement of GPs in the delivery of technology enabled care solutions, promoting the real benefits and opportunities of these solutions.	Increased recruitment of GPs and their readiness to implement technology enabled care solutions	Policy implications: • Digital Health and Social Care Strategy (2018)12 which outlines how Scotland will use technology to reshape and improve services, support person-centred care and improved efficiency of care. There is high level commitment to citizen empowerment and support of independent living through the digital means. • Health and Social Care Delivery Plan13 aims to further enhance health and social care services which are integrated; focus on prevention, anticipation and supported self-management; will make day-case treatment the norm, where hospital treatment is required; and ensure people get back into their home or community environment as soon as appropriate, with minimum risk of re-admission. • Technology Enabled Care Programme14is a Scotland-wide programme designed to significantly increase citizen choice and control in health, well-being and care services. • Strategy for Primary Care15which focuses on the modernisation of primary care and multidisciplinary team working, to reduce pressures on services and ensure improved outcomes for patients with access to the right professional, at the right time, as near to home as possible. Responsible actors: • Health and Social Care Integration Directorate of Scottish Government
Public awareness and engagement of citizens in service redesign	The objective of this action is to organise and promote awareness-raising sessions about the benefits of active engagement of citizens in the service redesign. This includes engagement with educational sector and embedment of the citizen empowerment in teaching's curricula.	Increased awareness and participation of winder public in the service redesign, prevention and management of care	
Systematic evaluation and data collection	The objective of this action is to support publishing of evaluation data in the right time in order to demonstrate the	Availability of robust business models informed by the real-time data	

12 Scotland's Digital Heath and Social Care Strategy - https://www.gov.scot/publications/scotlands-digital-health-care-strategy-enabling-connecting-empowering/
13 Health and Social Care Delivery Plan - https://www.gov.scot/publications/health-social-care-delivery-plan/
14 Technology Enabled Care Programme - https://www.digihealthcare.scot/home/resources/technology-enabled-care-tec/
15 Primary care reform - https://www2.gov.scot/Topics/Health/Services/Primary-Care/Strategy-or-Primary-Care

Priority Action	Objective of the Action	Anticipated outcomes	Policy implications, including the responsible actor and anticipated duration
	value and impact of technology enabled care services. This also includes the quality of data collection in the real-life settings and better use of data collection infrastructure.		• Technology Enabled Care and Digital Healthcare Innovation Division of Scottish Government • Health and Social Care Partnerships • Integration Joint Boards • NHS NSS – Information Service Division • NHS Education for Scotland • Innovation centres • Improvement Scotland • eHealth Leads, clinical champions and TEC leads at local level Anticipated duration: 2019-2023

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Annex IX Action Plan to create conditions for the adoption of integrated care in Olomouc Region - Transferability of "Hospital@Home" Good Practice in Puglia Region

Background: The objective of the Action Plan is to reflect on the possibility to transfer and adopt the learning about the Hospital@Home Good Practice in Puglia Region in Italy to local settings in Olomouc Region in the Czech Republic, including the feasibility of the transfer and recommendations on policy priority actions that would enable the creation of local conditions for the adoption of integrated care.

The Action Plan builds on the outcomes of the study visit organised in Puglia Region in 13-14 June 2018. The study visit was an opportunity to learn about the Good Practice and discuss its potential transferability by comparing and contrasting the requirements of the Good Practice with the maturity of local health and social care system for integrated care in Olomouc Region. As such, the Action Plan can inform the health and social care authorities about the future strategies and policies related to the Hospital@Home services in Olomouc Region. This process was facilitated by SCIROCCO self-assessment tool which provided the basis for the twinning and coaching activities.

The Action Plan are co-designed jointly with the transferring and receiving region as follows:

- Section 1: Needs of the adopting region - **Receiving region**
- Section 2: Description of the integrated care solution - **Transferring region**
- Section 3: Maturity requirements of the integrated care solution - **Transferring region**
- Section 4: Benefits and opportunities of integrated care solution - **Receiving region**
- Section 5: Conditions for the adoption of integrated care solution - **Receiving region**
- Section 6: Adaptation of local environment to enable the transferability of learning - **Receiving region**
- Section 7: Priority actions to enable conditions for the transferability of learning - **Receiving region**

1. Needs of the receiving region – Olomouc Region, Czech Republic

The healthcare system in Czech Republic is medically driven and focuses on institutional care. The system has been achieving some acceptable results but similarly as in other European countries, sustainability becomes a challenge and there is a need for a change and reform in the way the care is currently delivered. There are three key stakeholders in the healthcare system; Government, insurance companies and healthcare providers. However, the activities of these stakeholders are not coordinated and aligned to one particular strategy addressing the challenges of ageing population which often cause fragmentation. In addition, most of the proposed changes are politically sensitive and there is a lack of political willingness to address them. The healthcare system is also underfinanced which results in the lack of healthcare professionals. The role of ICT as an enabler of service redesign is not well recognised and digital healthcare services are not developed. However, the need for change becomes apparent in the form of poorer quality and accessibility of healthcare services.

By reviewing Hospital@Home Good Practice in Puglia, it became apparent that there is a number of Good Practice' features that are currently lacking in Olomouc's care model. Olomouc has also implemented Good Practice focusing on the management of heart diseases, however, with a much more limited scope and the features such as data sharing and coordination of care between hospitals, specialists and General Practitioners (GPs) are still missing. Hence the opportunity to learn about these features and their potential transferability to Olomouc region needs to be further explored.

2. Integrated care solution to address the needs of the receiving region

2.1 Transferring region: Hospital@Home Good Practice

Hospital@Home Good Practice is designed as a technological support for already structured activities in home care. The main objective is to reduce hospitalisation and re-hospitalisation and to improve the quality of care for patients at home. In addition, the objective is to:

- Reduce the number of patients with heart disease, diabetes and other chronic diseases in the process of instability
- Activate protected de-hospitalisation
- Optimise the therapy and diagnosis according to international guidelines.

The Good Practice has also an ambition to validate new telemedicine models applied for diagnostic and therapeutic pathways for the management of chronicity. The aim is to implement a new type of telemonitoring, based on continuous collaboration and patient monitoring by different professionals and different users.

Patients, opportunely selected, are telemonitored by their General Practitioners by using the innovative home and health monitoring technological solution (H&H Hospital@Home). This solution is able to detect the main clinical and instrumental parameters in addition to the therapeutic administration, based on oxygen and bronco-aspiration. It is allocated at

the patients' home and it is permanently interconnected with the General Practitioner and/or Specialist, by computer, telephone, tablet and other devices.
At the same time, there is a central monitoring room at the hospital in Ceglie Messapica (Brindisi) for all patients and all devices located at their home. All clinical parameters of patients are stored on a dedicated server, respecting the rules for the respect of privacy. The system allows the healthcare professionals (neurologists, pulmonologist, cardiologists, diabetologists, etc) to monitor and speak with patients remotely. The patients can also activate the visit of the healthcare professionals in their homes. In addition to real-time monitoring of physiological parameters, the healthcare professionals can also monitor the physical and technical characteristics of home device. As a result, it is possible to deliver therapy to the patient remotely. In particular, it is possible to deliver oxygen therapy and endocavitary aspiration. Healthcare professional determines the limit of the range of physiological parameter values and when the parameter is beyond the limit, the system draws the operator's attention through the alert.

2.2 *Transferring region:* Current progress of the Hospital@Home Good Practice

Challenges/problems that the Good practice is supposed to solve:

The five challenges that Hospital@Home Good Practice address are:

- Reduction of the number of patients with chronic diseases in the process of instability
- Reduction of hospitalisation and re-hospitalisation
- Activation of protected resignation
- Optimisation of the therapy and diagnosis according to international guidelines
- Promotion of the integrated management of hospital and community.

Key innovative elements of the Good Practice

Hospital@Home Good Practice is based on increased collaboration and involvement of General practitioners, specialists, nurses, patients and their caregivers.

The analysis of data related to the monitoring of about 100 patients allows better understanding of the effectiveness of the remote monitoring system and to what extent it improves the quality of care for patients. Patients are directly supervised by their General Practitioners in a much faster way which in turn increases the performance. We notice a very facilitated dialogue between General Practitioners and Specialists in delivering the service. Finally, the General Practitioners feel more supported by the Specialists when there is a need for a quick consultation. 60% of patients are over 65 years old. 30% of the patients suffer from heart diseases, 40% patients of COPD and the remaining patients are diagnosed with diabetes. In all of the patients who presented the values of blood oxygen saturation beyond the threshold, oxygen administration by concentrator has allowed to re-establish the normal clinical condition. In approximately 30% of patients is the drug therapy that improved due to telemonitoring.

Costs/investments needed for the deployment of the Good Practice:

The total investment necessary for the adoption of Hospital@Home Good Practice is between €100.00 - €499,999. The main source of funding came from the European Union, specifically European Regional Development Fund (ERDF).

Impact/outcomes observed:

There is an evidence that the Good Practice is economically viable, and it brings benefits to the target group. Further research and development are needed in order to achieve market impact and for the Good Practice to become part of the routine care.

The advantages of the use of technology in the field of telemedicine and especially with the use of H@H hospital equipment at home are:

- Reduction of hospital stays
- Greater assistance for the patients delivered directly to their homes
- Improvement of the psychological and physical condition and improvement of the therapeutic plan
- Easier monitoring of physiological parameters
- Easy to use and flexible management system.

The Good Practice has been transferred within the same region. A similar initiative is launched in another area of Italy, based on a slightly different organisation of the care model.

For a full description of the Good Practice please see ***https://www.scirocco-project.eu/p6-puglia-italy-telehomecare-telemonitoring-teleconsultation-and-telecare-project-aimed-at-patients-with-heart-failure-chronic-obstructive-pulmonary-diseases-and-diabetes/***

Other useful links include:

http://www.hospitalathome.org/
http://www.hospitalathome.it/index.php?lang=it

3. Maturity Requirements of Hospital@Home Good Practice

3.1 *Transferring region:* Maturity requirements for the adoption and transferability of Hospital@Home Good Practice.

Figure 1: Maturity requirements of Hospital@Home Good Practice

Dimension	Score	Description	Justification and Reflection
Readiness to Change	4	Leadership, vision and plan clear to the general public; pressure for change	In order to succeed in the implementation of the Good practice it is important to have leadership. It also needs to be in line with the general vision of policy makers and professionals involved.
Structure & Governance	4	Roadmap for a change programme defined and accepted by stakeholders involved	It is necessary to have a clear roadmap for a change programme, including clear definition of regulation, supported by shared vison with stakeholder
eHealth Services	3	eHealth services to support integrated care are piloted but there is no yet region wide coverage.	Information sharing among professionals is needed as well as a central monitoring control room to coordinate the monitoring of patients.
Standardisation & Simplification	3	A recommended set of agreed technical standards at regional/national level; some shared procurements of new systems at regional/national level; some large-scale consolidations of ICT underway	The activation of the remote monitoring doesn't need specific ICT standards, but the solution needs to be interconnected with the Regional Platform. The adopted technology complies with the existing standards
Funding	4	Regional/national funding and/or reimbursement schemes for on-going operations is available	The implementation of the Good Practice requires an initial investment for the procurement of the bed side table. Nevertheless, the Good Practice can also be implemented by building an agreement with the IT provider and make the maintenance of the service and training of healthcare professionals part of the procurement.

Dimension	Score	Description	Justification and Reflection
Removal of inhibitors	2	Strategy for removing inhibitors agreed at a high level	The key to success is a minimum impact in the routine of healthcare professionals involved. Some in-depth information about the service shared among the stakeholders involved, including patients and care givers can help the removal of possible obstacles or diffidence.
Population Approach	3	Risk stratification used for specific groups i.e. those who are at risk of becoming frequent service users –	Population stratification is not needed. Shared healthcare pathways among the Care team is envisaged in order to guarantee the correct monitoring of the patients both clinically and psychologically.
Citizen Empowerment	3	Citizens are consulted on integrated care services and have access to health information and health data	Patients enrolled in this good practice are very frail. They need to be informed and trained for the use of the platform, but a big work needs to be done also on the side of care givers. Self-motivation of the patients is critical for the success.
Evaluation Methods	4	Most integrated care initiatives are subject to a systematic approach to evaluation; published results	It is important to have an evaluation habit. The possibility to have a systemic evaluation system helps. The data collection informs a continuous improvement of the ICT software/system used.
Breadth of Ambition	3	Integration between care levels (e.g., between primary and secondary care) is achieved	It is necessary to have integration between hospital care and primary care. The practice can easily take off wherever there is integration between care levels.
Innovation Management	3	Formalised innovation management process is planned and partially implemented	The implementation of the Good Practice is based on an important change of approach in managing frail chronic patients out of hospital. The principle of de-hospitalization must be embedded in the policy vision.
Capacity Building	3	Learning about integrated care and change management is in place but not widely implemented	It is necessary to train professional for the use of the devices and activate continuous learning and training processes.

4. Benefits and opportunities of the adoption of Hospital@Home Good Practice in Olomouc Region

The adoption of features of Hospital@Home Good Practice to Olomouc Region would contribute to the improvement of a number of outcomes:

- Decreased a need for hospital beds
- Improved care of chronically ill, including those discharged from hospital
- Reduced number of reduce the number of unstable patients with chronic diseases.

5. Conditions enabling the adoption of Hospital@Home Good Practice in Olomouc Region

5.1 Maturity of local health and social care system in Olomouc Region

Receiving region: Maturity of Olomouc Region's health and social care system, highlighting the strengths and weaknesses of the local system is captured in the spider diagram below:

Figure 2: Maturity of Olomouc Region's healthcare system

5.2 Conditions enabling the adoption of Hospital@Home Good Practice in Olomouc Region

Receiving region: Maturity of healthcare system in Olomouc and Puglia Region is captured in the spider diagram below:

Figure 3: Comparison of maturity requirements of Good Practice with maturity of Olomouc's healthcare system

5.3 Feasibility of transferring of learning about Hospital@Home Good Practice to Olomouc's local context

Dimension	Score Puglia	Feature(s) of the Good Practice	Score Olomouc Region	Feature(s) of Olomouc healthcare system	Feasibility of the transfer and rationale
Readiness to Change	4	Leadership Good Practice implemented in line with general vision of policy-makers	1	There is a leadership in place, however, the concept of integrated care is not reflected in legislation, hence the vision of policy makers is lacking as well.	Yes; the transferability of is feasible with lot of efforts. This is a very complex feature to be introduced as there has been lack of political willingness to address the need for integrated care for long time and co-operation of various healthcare providers was activated mostly by medical community. However, awareness raising activities may active a change and the need for change has already been recognised by many experts and managers actively participating in health and social care. New project related to the development of integrated care strategy has been designed in mid-2018 by the Ministry of Health of the Czech Republic and is going to be implemented through Structural Reform Support Programme 2017-2020.
Structure & Governance	4	Roadmap for change programme Shared vision of stakeholders Organisational structure	0	Roadmap for change programme is missing hence it is difficult to create a shared vision and organisational structure for integrated care; the structure is fragmented. Some rare integrated care initiatives are active at the level of municipalities but there is no national/regional structure in place.	Yes; the transferability is feasible with lot of efforts. The first step to be introduced can be around the awareness raising about the need and benefits of integrated care, similarly as in case of Domain 1. Developing the roadmap for change is a part of the project mentioned above.
eHealth Services	3	Connection to national/regional platforms to allow information sharing Healthcare/IT providers are central	0	There is a national eHealth strategy approved (in November 2016) and gradually being implemented, however electronic health records are not available. As such,	Yes; the transferability is feasible with lot of efforts. There are plans on the national level to develop solutions and platforms to allow information sharing. However, this is a very challenging issue due to fragmentation of care providers who own the

Dimension	Score Puglia	Feature(s) of the Good Practice	Score Olomouc Region	Feature(s) of Olomouc healthcare system	Feasibility of the transfer and rationale
		part of the service redesign and additional work such as maintenance of the service or training is part of the procurement.		electronic sharing of health information across the care providers is a challenge and not really happening between health providers of diverse ownerships be they general practitioners, hospitals, clinics or other providers.	ICT systems, lack of transport and data storage infrastructure, lack of national standards for communication between healthcare providers.
Standardisation & Simplification	3	Connection to national/regional platforms to allow information sharing; no need for specific standards	1	There is some initial work around the standards; the need for standards is recognised.	Yes; the transferability is feasible with lot of efforts. National consensus would need to be reached and supported by legislation in place. Effective health data sharing between providers is recognised as a strong element supporting integration; national standards will then have to be agreed as mentioned in the Czech national eHealth Strategy.
Funding	4	Maintenance of the services is part of the procurement to ensure sustainability	1	Lack of funding is the biggest barrier to implement any changes in the care models; sustainability remains an issue. Regardless of the funding some innovation is still happening at small scale.	Yes; the transferability is feasible with lot of efforts. Considering Czech national healthcare system, the implementation of Good Practice requires multisource funding than can be composed of: centrally supported investment, funding by healthcare providers involved reimbursements and funding from regional and municipal budgets. All these sources will have to be newly defined and agreed.
Removal of inhibitors	2	Readiness of healthcare professionals – GPs led clinics, minimal changes to their routine practice and familiarisation of professionals with ICS solutions	1	Culture plays a major role here; it is very difficult to change the day-to-day routine of healthcare professionals. In addition, sharing of information among the professionals is rather challenging.	Yes; the transferability is feasible with lot of efforts. There are essentially no recognised barriers on professionals' side (managers, medical) to introduce innovations such as this Good Practice but the healthcare system is strongly based on *fee-for-service* scheme. As a result, this payment scheme does not well motivate to do some changes in organisation of care as it can observed in other healthcare systems where these providers are

Dimension	Score Puglia	Feature(s) of the Good Practice	Score Olomouc Region	Feature(s) of Olomouc healthcare system	Feasibility of the transfer and rationale
					owned or managed by one authority with clear interest in effective use of common resources.
Population Approach	3	Existence of risk stratification tools/approaches	1	There are very limited risk stratification initiatives in place.	Yes; the transferability is feasible with some efforts. There is a considerable progress made with the development of Czech Central Health Statistic Institution (UZIS) with the objective to provide better, more accurate data to be used for the business intelligence. The date become available and they can be potentially well used also for risk stratification.
Citizen Empowerment	3	Citizens driven service, there is a demand for the service; tools/incentives to support citizen empowerment	0	Citizen empowerment is recognised in national strategy Health 2020 but its implementation remains a challenge. Healthcare by law still focuses on care and not on support of citizens in improving their health. There is a lack of capacity to support citizen empowerment initiatives.	Yes; the transferability is feasible with some efforts. There is some work under the preparation at the University Hospital Olomouc (UHO) around the development of ICT tools to support citizen empowerment. Some elements supporting patient empowerment, especially for better information about the health status and communication with care providers are subjects of several initiatives in wider Olomouc region.
Evaluation Methods	4	Systematic evaluation and data collection	0	There is no systematic evaluation in place; the health insurances pay usually for the cheapest or otherwise justified services. Olomouc already uses MAST (a model derived from HTA) for internal purposes of UHO – usually projects.	Yes; the transferability is feasible with some efforts. Some evaluation tools are already at the place; broad spectrum of data is collected and process by central institution UZIS as outlined above but the introduction of systematic evaluation would require further efforts at national level.
Breadth of Ambition	3	Integration across primary and hospital care	1	There is some level of interactions/coordination of care at the level of hospitals.	Yes; the transferability is feasible with lot of efforts. A new reform of primary care has been developed at the Ministry of Health and it is expected that it will include some important elements enabling

Dimension	Score Puglia	Feature(s) of the Good Practice	Score Olomouc Region	Feature(s) of Olomouc healthcare system	Feasibility of the transfer and rationale
					coordination of care, particularly of chronically ill patients.
Innovation Management	3	Change of approach embedded in policy	1	Municipality in Olomouc Region widely recognised the need and benefits of innovation. However, the implementation of concrete actions is very difficult.	Yes; the transferability is feasible with lot of efforts. As mentioned above, problems of the current healthcare system regarding the care of chronically ill are mapped by acting experts and politicians but many relevant amendments addressing the need for change and innovations in the current care models are politically sensitive and require broader consensus in the whole society.
Capacity Building	3	Training of healthcare professionals	1	Training of healthcare professionals is on-going; the training on integrated care is already included in the curricula at the Universities, particularly Palacky University Olomouc.	Yes; the transferability is feasible with some efforts. There is training of healthcare professionals in place, even though some Curricula should be upgrade. There is a lot of ad hoc education at the pilot phase which should be expanded to continuous learning and training.

5.4 Priority areas for the transferability of learning

Receiving region: List of the prioritised features Hospital@Home Good Practice to be considered for the transferability to the local settings in the Olomouc Region is outlined in the Table below:

List of the prioritised features of the Good Practice (maximum 3 features)
Readiness to change • Recognition of the need for change supported by shared vision of policy-makers • Legal conditions in place to facilitate a change Funding • Investment in the integrated care solutions and reimbursement model • Maintenance of the service is considered as part of the procurement to ensure the sustainability of the service

6. Adaptation of local environment to enable transferability of learning

Receiving region: List of the suggested changes to enable the creation of local conditions in the Olomouc Region for the transferability of learning about the features of Hospital@Home Good Practice is outlined in the Table below:

Features of Hospital@Home Good Practice	Adaptation of the features to Olomouc's local context
Readiness to change • Recognition of the need for change supported by shared vision of policy-makers • Legal conditions in place to facilitate a change	• Introduce new legislation related to digital healthcare and integrated care; development of strategy of integrated care is currently on-going. • Organise information campaigns to raise awareness about the benefits of the Good Practice for the stakeholders involved, policy-makers and healthcare professionals in particular. • Encourage new way of working; a need for improved collaboration and partnerships-building among stakeholders involved.
Funding • Investment in the integrated care solutions and reimbursement model • Maintenance of the service is considered as part of the procurement to ensure the sustainability of the service	• Promote multi-sourced and coordinated funding which would include investment in technologies, updates of the reimbursement schemes to reflect the costs that are relatively new in care process e.g. telecommunication charges and involvement of other parties such as municipalities. • This model of financing will require extensive negotiation with many stakeholders on several levels. • Demonstrate the economic benefits of the proposed solutions by piloting of the Good Practice in local conditions.

7. Priority actions to enable conditions for the transferability of learning

Receiving region: List of the proposed actions to enable conditions for the transferability of learning about the features of Hospital@Home Good Practice to the local context of Olomouc Region, improved including objectives, anticipated outcomes and policy implications, is provided in the Table below

Priority Action	Objective of the Action	Anticipated outcomes	Policy implications, including the responsible actor and anticipated duration.
Awareness raising campaigns	• Increase awareness about the need for integrated care and its benefits for stakeholders involved • Create conditions to support a change towards more connected and coordinated health and social care services • Influence the planning and design of integrated care concept	• Recognised urgency of the need to change the way the healthcare is delivered • Improved awareness about the benefits of integrated care • Improved conditions to enable the adoption of integrated care solutions such as Hospital@Home Good Practice.	There has been a new strategy developed for integrated care at national level in Czech Republic in August 2018. New models of care are introduced and piloted across the country. As such, there is an opportunity to feed the learning about Hospital@Home Good Practice rather than reinvent the wheel.
Create a shared vision for integrated care	• Raise awareness about a new way of working; partnership-building approach and its benefits • Use of European Regional Development Fund (ERDF) to develop and implement a complex strategy for integrated care and digital healthcare	• Improved collaborations of all stakeholders involved in the planning, design and implementation of health and social care services. • Increased resources to finance the service redesign in the Olomouc region and wider Czech Republic	

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Annex X Action Plan to create conditions for the adoption of integrated care in Basque Country - Improvement of engagement of third sector in the provision of integrated care in Scotland

Background: The objective of the Action Plan is to reflect on the possibility to transfer and adopt the learning about the role and involvement of third sector in the provision of integrated care in Scotland to local settings in the Basque Country, including the feasibility of the transfer and recommendations on policy priority actions that would enable the creation of local conditions for the adoption of integrated care.

The Action Plan builds on the outcomes of the study visit organised in Scotland on 4-5 September 2018. The study visit was an opportunity to learn about the role of the third sector in the provision of integrated care in Scotland and discuss a potential transferability of learning by comparing and contrasting the maturity of the healthcare system in Scotland with the maturity of local health and social care system in the Basque Country. As such, the Action Plan can inform the health and social care authorities about the future strategies and policies related to the role of third sector in the provision of integrated care in the Basque Country. This process was facilitated by SCIROCCO self-assessment tool which provided the basis for the twinning and coaching activities.

The Action Plan is co-designed jointly by Scotland as the transferring region and the Basque Country as the receiving region as follows:

- Section 1: Needs of the adopting region – **Receiving region**
- Section 2: Description of the integrated care solution – **Transferring region**
- Section 3: Maturity requirements of the integrated care solution **-** **Transferring region**
- Section 4: Benefits and opportunities of integrated care solution – **Receiving region**
- Section 5: Conditions for the adoption of integrated care solution – **Receiving region**
- Section 6: Adaptation of local environment to enable the adoption of integrated care solution – **Receiving region**
- Section 7: Priority actions to enable conditions for the adoption of integrated care solution: **Receiving region**

1. Needs of the receiving region – The Basque Country

In 2010, the Basque Country has started developing the Osakidetza's Care Integration Plan[16] with an objective to transform the healthcare system and respond to increased challenges of ageing, chronicity and dependency. The ambition of the Plan is to provide a coherence, promote changes in healthcare management and seek synergies between the different levels of care (primary and hospital) in order to ensure less fragmented, more efficient and higher quality care. On 3 July 2018, the Department of Health formalised the 100/2018 DECREE of the Osakidetza Integrated Care Organisation (ICO)[17]. As a result, a total of 13 Integrated Care Organisations (ICOs) have been established which bring together public primary and hospital care structures of a specific geographical area. The provision of social services is out of scope of the ICOs.

The health and social sectors are managed by two separate Ministries with different competences, budgets and government structures. In order to respond to social and healthcare needs, the Basque Government is committed to a model of social and health coordination which is essential to ensure that organisations work together to guarantee the continuum of care for citizens. The model promotes the coordination of professionals and different levels of care in order to provide an integrated response to the population needs.

Social initiative and social intervention organisations are a fundamental asset of the Basque's society. Their contribution is essential to build a society that is both fair and supportive, egalitarian and cohesive, democratic and participative. These organisations are also very well placed to respond to social needs in a more appropriate way by promoting integral, close and personalised collaborations between the sectors, people, families, collectives or communities.

Basque's society has an extensive and active social fabric made up of organisations that arise from citizens' initiatives and channels promoting solidarity and the social participation of citizens and communities affected by a particular situation, problem or need of a social nature. This is what is referred to as Third Social Sector (TSS) in the Basque Country. It is composed of entities of social initiatives, voluntary actions and non-profit organisations with the objective to promote and protect rights and social needs of the Basque population. It is estimated that the Basque's TSS is made up of 3,500 organisations in which 36,000 people work under contracts (4% of the population employed) and 125,000 are volunteers. There has been some progress with aligning TSS organisations which resulted in the development of TSS network called Sareen Sarea[18]. The budget managed by these organisations in 2013 was €1,451mil. which represents 2.2% of the Basque's GDP[19].

Regarding the relationship of the TSS with the Basque's public sector, these organisations have participated and continue to participate in a number of areas related to public responsibility initiatives, social services, employment, income guarantee, social inclusion and in the areas of where the systems are linked to social intervention e.g. education, health or house policies. The scope of these activities is around the consolidation and deployment of these services. As a result, the TSS and the public sector collaborate in the

[16] http://www.euskadi.eus/contenidos/informacion/buen_gob_planes/es_def/adjuntos/Plan_de_atencion_integrada_en_Euskadi.pdf
[17] http://www.euskadi.eus/gobierno-vasco/-/decreto/decreto-1002018-de-3-de-julio-de-las-organizaciones-sanitarias-integradas-del-ente-publico-osakidetza-servicio-vasco-de-salud
[18] https://www.sareensarea.eus/es/
[19] http://www.3sbizkaia.org/archivos/documentos/enlaces/1823_1_libroblancotsseuskadi2015.pdf

provision of social services of general interest, as defined in the European regulations of reference, as well as in other social activities of general interest other than the provision of services.

However, the public sector needs to contemplate new forms of relationship with civil society that allow progress in a model of open administration and participatory governance and society. In this sense, the organisations of the third social sector must collaborate with the public sector to a greater extent in the provision of integrated care to citizens, particularly at the meso and micro levels. It is necessary to act upon and address a lack of a culture of working together, a lack of shared objectives and a need for a common language. In conclusion, there is a need to involve the Third Social Sector in the provision of integrated care in order to tackle the challenge of ageing population and its consequences, in particular in relation to financial sustainability of the services and lack of resources.

2. *Aspect*[20] *of integrated care that addresses the needs of the Basque Country*

2.1 *Transferring region*: Role of the third sector in the provision of integrated care in Scotland

The "third sector" in Scotland is made up of non-governmental and non-profit organisations, from grassroot community groups and village hall committees to social enterprises and registered national charities. It is often also described as the voluntary sector, not-for-profit, charity sector, social economy, social enterprise sector, NGOs (non-government organisation) or civil society. It has an annual turnover of €5.96 billion. As of December 2017, Scotland's third sector was made up of over 40,000 organisations, including:

- 23, 300 registered charities;
- 20, 000 grassroot community groups, sports and art clubs
- 163 housing associations
- 5,2000 Social enterprises
- 432 community interest companies
- 107 credit unions.

The traditional idea of charities as benevolent organisations simply there to help the poor is being replaced by a modern, progressive, third sector which carries out an enormous range of activities to improve people's lives. It does it by:

- Supporting people through social care, health services and employability programmes;
- Empowering people by campaigning and advocating for minority and disadvantaged groups in our society;
- Bringing people together through social activities, local clubs and community centres;

[20] Please note that "aspect" in this case refers to a particular part/feature of the healthcare system.

- Enabling better health and wellbeing through medical research, addiction services, sport facilities and self-help groups;
- Improving our environment through conversation of our land and heritage, and regeneration of our communities.

There are 130,000 directly paid staff in the third sector – a figure comparable with NHS Scotland – collectively making it one of the Scotland's biggest employers. In relation to the health and social care agenda in Scotland, there are 5 main national membership organisations that represent third sector interests:

- Coalition of Care and Support Providers (CCPS) – to represent, promote and safeguard the interests of third sector and non-for-profit social care and support providers in Scotland.
- The Alliance – to support people of all ages who are disabled or living with long terms conditions to have a strong voice and enjoy their right to live well, as equal and active citizens.
- Voluntary Health Scotland – organisation working to improve health and address health inequalities
- Scottish Council for Voluntary Organisations (SCVO) – championing Scotland's vibrant charities, voluntary organisations and social enterprises.
- Scottish Federation of Housing Associations and Glasgow and West of Scotland Housing Forum
- Third Sector Interfaces (TSIs) – local voluntary sector umbrella organisations in each of the 32 local health and social care partnerships.

In Scotland, there is a legal framework in place for the engagement of third sector in the provision of integrated care. The Public Bodies (Joint Working) (Scotland) Act 2014 is the legislative framework for the integration of health and social care services which requires the integration of the governance, planning and resourcing of adult social care services, adult primary care and community health services and some hospital services. Other areas such as children's health and social care services, and criminal justice social work can also be integrated. As a result, the Act creates a number of new public organisations, known as integration authorities (31 integration authorities) and aims to break down the barriers to joint working between NHS boards and local authorities. Under this model an Integration Joint Board (IJB) is set up and the NHS boards and local authorities delegate the responsibility for planning and resourcing service provision for delegated adult health and social care services to the IJBs.

The IJB must include representatives of the local authority, NHS Board, a carer representative, a GP representative, a nurse representative, a secondary medical care practitioner, a service user representative, a staff-side representative, a third sector representative, an officer who is responsible for financial administration the Chief Officer and the Chief Social Worker. As such, a third sector organisation is directly involved in the strategic planning and locality planning of the integrated care provision, however, the

representatives of third sector do not have voting rights which often creates some uncertainty.

The third and independent sectors are contributing to the success of integration in range of ways:

- Delivering health and/or social care support
- Enabling access to people who use services and their communities, to support their engagement
- Providing access to data, and our ability to gather intelligence useful for monitoring and evaluation, and planning purposes
- Bringing expertise around barriers and needs from the wide diversity of groups of people who use services
- Facilitating communications and the gathering and collating of intelligence via umbrella groups and intermediaries.

In relation to service delivery, the third sector provide 69% of the total social services. The task is to harness this capacity, and to help the third sector grow in order to achieve the "radically reformed way of working and to make the most of the third sector contribution to the integration agenda.

2.2 *Transferring region:* Current progress in the involvement of third sector in the provision of integrated care in Scotland

Challenges/problems addressed by the involvement of third sector in the provision of integrated care:

A key driver towards integration and the engagement of third sector in the provision of integrated care has been the projected increase in demand for health and social care as a result of an increasingly ageing population, in particularly those who will be aged 75 and older. Older people make more use of hospital services than the rest of the population. An aim of the integration agenda is to help reduce unnecessary admissions to hospital, delayed discharges and shift the provision of care to local communities (Audit Scotland, 2016). Integration across the health, social, housing and third sector is seen as a way to make more efficient and effective use of limited resources and is believed to be central to the challenge of improving outcomes for patients and service users.

key innovative elements highlighting how the involvement of the voluntary sector in the provision of integrated care in Scotland improved the situation compared to previous status-quo

The introduction of legislation and legal framework for the integration of health and social care services has improved the engagement of the third sector in the provision of integrated services in a number of ways:

- It has enabled greater awareness and understanding of the role of the third sector in public service provision, particularly among integration authorities;
- It has improved the position of third sector as an equal partner in the planning and provision of integrated care services; there is a framework in place to build more

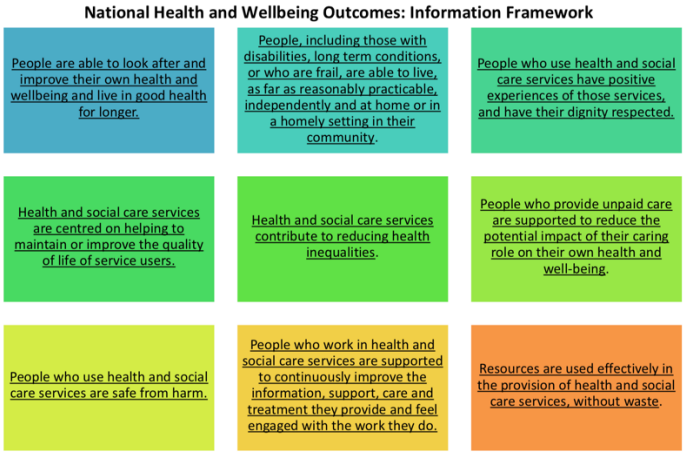
strategic relationships among the third sector and the statutory service providers built on trust, partnership and genuine understanding of the benefits of these relationships to both service delivery and community wellbeing.

- It has secured greater connectivity and collaboration around the delivery of community-based care; the services are perceived less fragment from the perspective of service users;
- It has promoted wider knowledge of how community assets can be better used to co-produce the national health and wellbeing outcomes, particularly in relation to integration outcomes;

impact/outcomes observed

The engagement of the third sector in the provision of integrated care in Scotland is showing a number of benefits such as better quality of life, less isolated people, better care integration and reduced admissions to hospitals.

In principle, the success of engagement of the third sector is measured by its contribution to National Health and Wellbeing Outcomes Framework:



To access full national data resources with data for partnership areas please see the following link: https://www.gov.scot/Resource/0047/00473499.pdf

For more information about the involvement of third sector in the provision of integrated care in Scotland please see the following links:

- https://scvo.org.uk
- Alliance - We need to talk about integration - a collection of sector perspectives on progress of integration and what difference it has made so far
- Scottish Parliament: Health and Sport Committee report on third sector engagement with integration after the first couple of years
- Audit Scotland - Integration inquiry - early review of progress from 2015 (a second report is expected in November 2018)
- CCPS/SCVO/Alliance MSG paper on third sector engagement (copy provided); CCPS digital event link - CCPS digital showcase event - demonstrating the range of digital technology care and support providers are using
- http://www.newcarestandards.scot/ - https://www.blackwoodgroup.org.uk/clevercogs - connecting service users with the internet, communications, and managing their care all from an iPad at home.
- https://irocwellbeing.com/ - online mental wellbeing recovery measurement tool
- http://www.ccpscotland.org/hseu/information/better-futures/
- http://www.parliament.scot/ResearchBriefingsAndFactsheets/S5/SB_16-70_Integration_of_Health_and_Social_Care

3. Maturity requirements of third sector involvement in Scotland

Transferring region: Maturity requirements of third sector involvement in the provision of integrated care in Scotland is captured in the spider diagram below and detailed justification is provided in the following Table.

Figure 1: Maturity requirements of third sector engagement in Scotland

Dimension	Score	Description	Justifications & Reflections
Readiness to Change	3	Vision or plan embedded in policy; leaders and champions emerging	There is a legislation in place to support integration of health and social care which sets a legal framework for the engagement of third sector in the provision of integrated care services. However, pace of change is a bit slower and the policy is not really fully implemented yet. There is a lot of dialogue and partnership building going on between the third sector and statutory care providers, there is also growing awareness and recognition of the expertise and experience of third sector, however the challenge remains how to make the real shift from the continued focus on health.
Structure & Governance	3	Governance established at a regional or national level	The legislation on health and social care integration provided the basis for better positioning and engagement of the third sector by making the representatives of the third sector part of the Integration Joint Boards (new integration authorities planning and delivering integrated care). However, there is a continuous uncertainty around the role of the third sector as the representatives do not have voting rights on the Board. The third sector is also well represented in the Ministerial Strategic Group for Health and Community Care to facilitate the contributions of third sector in improving people's well-being. There is also a number of umbrella third sector organisations representing the voice of local volunteers, charities, social enterprises etc. in the process of decision-making.
eHealth Services	2	There is mandate and plan(s) to deploy regional/national eHealth services across the healthcare system but not widely implemented	There is new Digital Health and Care Strategy to address the challenge of ICT solutions and infrastructure to support information sharing. The third sector is very well positioned in the Strategy, acting as one of the actors responsible for the design and delivery of these services. However, current experience shows that the integrated information systems are not fully developed or wooden spread across Scotland. Overall engagement is still lacking. There is an extensive data sets in the third sector which needs to be integrated to the statutory platforms such as SOURCE and SPIRE.
Standardisation & Simplification	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	Similarly, as it is in case of eHealth services, the systems and standards are in place but not joined up at the point of delivery. The third sector has not been very much engaged in the discussion around the standards until recently, so it is difficult to measure the progress.

Dimension	Score	Description	Justifications & Reflections
Funding	2	Consolidated innovation funding available through competitions/grants for individual care providers and small-scale implementation.	The funding of the third sector activities remain the challenge, in most cases it is very short-term funding and inconsistent. There is a continuous focus of funding on health rather than social care, shift of care to community and prevention initiatives needs to be followed by an appropriate budget. There is not much evidence of this happening except for demonstration work.
Removal of Inhibitors	1	Awareness of inhibitors but no systematic approach to their management is in place	There is a great awareness about the need to remove inhibitors and third sector plays a pivotal role in raising this awareness but there is still a big gap between the theory and [practice. From a voluntary sector perspective, there is a need to join up efforts to remove the inhibitors.
Population Approach	4	Population-wide risk stratification started but not fully acted on	There is a SPARRA in Scotland used in all GPs practices. The third sector also collects a vast majority of the data and there is a need to ensure better use of this data for sound decision-making and planning within health and social care integration. It is a shared responsibility of the third sector and statutory sector to gather analyse and report data and evidence on healthcare delivery. There is a group established “Third Sector Data in Health and Social Care Working Group” to support building the partnerships and increase the capacity of data collection and data analytics.
Citizen Empowerment	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.	The third sector facilitates a number of programme and initiatives related to the citizen empowerment; however, it still remains a challenge to involve citizen in co-design and co-production processes. For example, Self-directed support legislation and rights of the citizens exists but still not widely implemented across Scotland. Access to health data is a critical issue which as yet has not been systematically addressed. Examples of third sector initiatives to improve access to data is e.g. Our Voice Programme.
Evaluation Methods	4	Most integrated care initiatives are subject to a systematic approach to evaluation; published results	There is a Care Inspectorate in place which oversees the quality of the provided integrated care services, including the provision of third sector services.

Dimension	Score	Description	Justifications & Reflections
Breadth of Ambition	4	Integration includes both social care service and health care service needs	There is a strong ambition of the full integration of health, social, housing and third sector services, supported by legislation and dedicated funding however the Integration Act is not yet fully implemented.
Innovation Management	2	Innovations are captured and there are some mechanisms in place to encourage knowledge transfer	The third sector is very active in promoting the innovation agenda, in particularly the digital agenda, but the sector struggles to get proposed innovative approaches implanted. It is still more or less through the pilots and demonstration work that innovation in the third sector services is adopted.
Capacity Building	3	Systematic learning about integrated care and change management is in place but not widely implemented	There is a strong culture of the learning and sharing of experience. Third sector representatives play vital role in the knowledge transfer and embedding the learning about successful service provision. Capacity-Building is a key success factor of the third sector activities, but the investments are lacking e.g. for the capacity-building of data managers in the third sector.

4. Benefits and opportunities of improving involvement of third sector in the provision of integrated care in the Basque Country

There is a clear need to create a framework that defines the relationship between the health, social and third sectors in the Basque Country, including:

- Agreement on common objectives and creating a vision of "working together"
- Prioritisation of activities
- Involvement of sectors in the decision-making bodies related to integrated care
- Identification of added value of "working together" approach and breaking down the silos
- Promotion of intersectoral communication and collaborations
- Promotion of citizen participation in health matters.

Involving the third sector in the provision of integrated care would guarantee the most appropriate response to the needs of citizens at a right time; providing the citizens with resources and capacity to make and act upon their own decisions. In addition, involving the third sector in the provision of integrated care would also mean greater efficiency and use of resources and capacities in the Basque's society.

The Third Social Sector benefits from a better knowledge of people needs due to its proximity, empathy and active listening of citizens and promoting their active participation in the society. In turn, this would mean bringing citizens closer to the administration which would potentially lead to an improvement in the provision of coordinated and integrated care.

5. Conditions for involvement of third sector in the provision of integrated care in the Basque Country

5.1 Maturity of local health and social care system in the Basque Country

Receiving region: Maturity of the Basque Country's health and social care system, highlighting the strengths and weaknesses of the local system in integrated care:

Figure 2: Maturity of the Basque Country's healthcare system

5.2 Conditions enabling the improvement of involvement of third sector in the provision of integrated care in the Basque Country

Receiving region: Maturity of healthcare system in the Basque Country and maturity requirements of the involvement of third sector in Scotland is captured in the spider diagram below:

Figure 3: Comparison of maturity requirements with maturity of the Basque Country's healthcare system

5.3 Feasibility of transferring the learning from Scotland to Basque Country's local context

Dimension	Score Scotland	Features of Scotland's healthcare system for engagement of third sector	Score Basque Country	Features of the Basque Country's healthcare system	Feasibility of transfer and rationale
Readiness to Change	3	Legislation to support integration of health and social care; A legal framework for the engagement of third sector; Dialogue and partnership building; Growing and recognition of the expertise of third sector.	3	Integration policies are clearly defined; Integrated Care Management Plan is incorporated into the policies and structures, but change management is poorly implemented. The Third Social Sector (TSS) law 6/2016 of the 12 May[21] provides legal framework for the TSS, including its collaboration with the public sector and reinforces greater recognition of the TSS's social role.	Yes; the transferability is feasible with some efforts There is a legal framework in place recognising the need for coordination of health and social care. There is also an increased recognition of added value and contribution of TSS to the Basque's society, however the involvement of the TSS in the delivery of integrated care remains a challenge, in particular at the meso or micro level.
Structure & Governance	3	Third sector is represented in the planning, commission and delivery of integrated care services at different levels of governance; Existence of a number of umbrellas organisations representing the third sector in the process of decision-making.	3	There is a clear roadmap for change to an integrated system, but the progress is hampered, as the health and social Departments are managed separately. The inclusion of the third sector in the provision of integrated care is in progress, for example representatives from social, health and third sectors participate in the "Basque Volunteer Council" that meets at least once a year. There is also a Basque Volunteer Strategy 2017/2020[22] which aims to empower and increase social participation of all agents who have competences and obligations to carry out any type of social participation intervention.	Yes; the transferability is feasible with some efforts: There is a strategy and structure in place to facilitate the dialogue between health, social and third sectors, However, there is no umbrella organisation in place as in case of Scotland to promote and represent the third sector organisations. There are some networks/federations such as Sareen Sarea or subsidised entities which are contracted to provide services. Other entities compete for funding. In addition, the involvement of the TSS in the care delivery is not formally regulated and in principal their involvement at the meso or micro level does not exist.

[21] http://www.euskadi.eus/gobierno-vasco-/ley/ley-62016-de-12-de-mayo-del-tercer-sector-social-de-euskadi/
[22] http://www.euskadi.eus/contenidos/informacion/estrategia_voluntariado_2017/es_def/adjuntos/estrategiavascadelvoluntariado_es.pdf

Dimension	Score Scotland	Features of Scotland's healthcare system for engagement of third sector	Score Basque Country	Features of the Basque Country's healthcare system	Feasibility of transfer and rationale
Information & eHealth Services	2	Digital Health and Care Strategy addresses the need for ICT infrastructure to support information sharing; the third sector is recognised as an actor responsible for the data collection. Integration of third sector data with the statutory platforms remains a challenge.	3	There is a wide development of eHealth services for the healthcare professionals but not so much for citizens; Currently, the eHealth structure consists of Integrated Health Record, Health folder, eHealth Call Center and Betion[23]. Some work has been done to include social data in the eHealth structure.	Yes; the transferability is feasible with no need for major adaptation: There is eHealth infrastructure and services in place to support information sharing; the third sector is involved in the discussions and current work related to the inclusion of social data in the eHealth infrastructure.
Standardisation & Simplification	3	Engagement of the third sector in the discussion around the standards	3	Broad development of corporate platforms e.g. databases, platforms for clinical history, public procurement of Innovative solutions; ICT standardisation is still in process, lack of sufficient solutions and initiatives to integrate social and health sectors.	Yes; the transferability is feasible with some efforts: The TSS does not participate in the definition of indicators used in the Framework Programme or the Integrated Care Organisations (ICO)'s Preference Offer. However, professionals from the health, social, educational and the TSS sectors have worked together to set a minimum set of data for the future health and social data collection.
Funding	2	Dedicated funding for third sector, however mostly inconsistent and short-term funding.	3	Insufficient funding for integration agenda; Osakidetza's Framework Programme devotes only 5% of the budget to integrated care. The budget of the third sector is close to €5 mil. and it can be accessed in two ways: entities are subsidised and thus contracted to provide the services or they compete for funding (subsidies).	No, the transferability is not feasible: The healthcare sector has no funding for the activities of the TSS. It is also not planned in future to provide the funding as the TSS is the responsibility of the Department of Employment and Social Policies.
Removal of inhibitors		A great awareness about the need to remove inhibitors and	3	From a legal and structural point of view, the TSS role in removing	Yes; the transferability is feasible with no need for major adaptation:

[23] http://www.euskadi.eus/sociosanitario/-/equipamiento/teleasistencia-beti-on/

Dimension	Score Scotland	Features of Scotland's healthcare system for engagement of third sector	Score Basque Country	Features of the Basque Country's healthcare system	Feasibility of transfer and rationale
	1	third sector plays a pivotal role in raising this awareness, however implementation is still an issue.		inhibitors is already in place. However, from a cultural point of view, the implementation is a challenge.	Some improvements need to be done around the implementation and change of culture.
Population Approach	4	Existence of risk stratification tool; Existence of "Third Sector Data in Health and Social Care Working Group" to support building the partnerships and increase the capacity of data collection and data analytics.	4	The whole population has been stratified based on their morbidity risk. The socio-health stratification is not implemented. Frailty is not considered in the current risk stratification, but there is a deprivation index in place.	Yes, the transferability is feasible with lot of efforts: Risk stratification is in place, however, data collected by the TSS are not considered. There is no platform to facilitate the access to the TSS data. In general, the third sector is not involved in the stratification of population.
Citizen Empowerment	2	A number of programmes and initiatives related to the citizen empowerment facilitated by third sector, e.g. Self-directed support legislation.	3	It is Important to recognise the dichotomy between patient and citizen. Patients with high burden disease(s) are highly empowered which is not necessarily truth for the citizens. The citizens do not participate to the co-creation of care delivery.	Yes, the transferability is feasible with lot of efforts: The TSS does not participate in the design and implementation of citizens/patients' empowerment services. There are some empowerment initiatives in the social area e.g. empowerment of women who are victims of gender violence, empowerment of people who are at risk of social exclusion and others.
Evaluation Methods	4	A Care Inspectorate in place which oversees the quality of the provided care services, including the provision of third sector services.	3	The "Framework Programme" is the evaluation tool for integrated care, using the questionnaires such as D'amour[24] and IEMAC[25]. Some other initiatives have been considered but they are not in place. The Framework Programme includes social and health indicators, but	Yes, the transferability is feasible with lot of efforts: The activities of the TSS in the provision of integrated carte are not evaluated at all. There is some evaluation in place for the subsidised entities which need to report on their activities, both

[24] Nuño-Solinís R, Berraondo Zabalegui I, Sauto Arce R, San Martín Rodríguez L, Toro Polanco N (2013), "Development of a questionnaire to assess interprofessional collaboration between two different care levels", Int J Integr Care. 2013 Apr 12

[25] http://www.iemac.es/

Dimension	Score Scotland	Features of Scotland's healthcare system for engagement of third sector	Score Basque Country	Features of the Basque Country's healthcare system	Feasibility of transfer and rationale
				there are no indicators related to the third sector.	technically and financially to justify the future funding.
Breadth of Ambition	4	A strong ambition of the full integration of health, social, housing and third sector services, supported by legislation and dedicated funding.	4	Health and social services are the responsibility of different governance levels. Once a complete structural integration is accomplished, a functional integration, including health and social coordination is expected.	No, the transferability is not feasible: There is no formal joint structure for the delivery of health and social care services; the social services are the responsibility of provinces.
Innovation Management	2	Active role of the third sector in promoting the innovation agenda, however there is still existence of small pilots rather than systematic involvement.	2	There is a research and innovation strategy in place; bottom-up approach to promote innovation, in some of ICOs innovation units have been created. Innovation is supported directly by the Health Department, BIOEF and Kronikgune. However, the innovation management is not fully systematised.	Yes, the transferability is feasible with lot of efforts: The TSS does not appear in the innovation strategy of the Health Department but there are some initiatives such as Euskadi Lagunkoia"[26] or "Adinberri Gipuzkoa"[27]. However, there is a "Strategy for the Promotion of the Third Social Sector in the Basque Country" developed by the Department of Employment and Social Policies.
Capacity Building	3	A strong culture of learning and sharing of knowledge with a vital role of third sector; capacity-building is a key success factor of the third sector activities but remains a challenge.	3	Integrasarea[28] and the Framework Programme promote the change management and the learning on integration, but there is a need of a systematic method to standardise the capacity building within Osakidetza ICO.	Yes; the transferability is feasible with some efforts: Some improvements need to be done in making the capacity-building more systematic.

[26] http://www.euskadilagunkoia.net/es/
[27] https://www.gipuzkoa.eus/es/etorkizunaeraikiz/adinberri
[28] http://www.integrasarea.eus/index.php

5.4 Priority areas for the transferability of learning

Receiving region: List of the prioritised features to be considered for the transferability of learning in order to improve third sector's involvement in the provision of integrated care in the Basque Country are outlined in the Table below:

List of prioritised features
Structure & Governance • Involvement and representation of third sector at different governance levels responsible for the planning and commission of integrated care delivery. Evaluation Methods • Existence of Care Inspectorate which oversees the quality of the provided care services, including the services provided by third sector. Innovation Management • Active role of the third sector in promoting the innovation agenda.

6. Adaptation of local environment to enable transferability of learning

Receiving region: List of suggested changes to enable the creation of conditions for the involvement of third sector in the provision of integrated care services in the Basque Country, informed by the learning about the features of Scotland's healthcare system, is provided in the Table below:

Features of Scotland's healthcare system	Adaptation of features to the Basque Country's context
Structure and Governance Involvement and representation of third sector at different governance levels responsible for the planning and commission of integrated care delivery.	At the macro level, the third sector is represented in the Basque Volunteer Council, which includes representatives of the health and social sectors, including the Third Social Sector (TSS). At the meso and micro levels the situation is different. There are a series of Integrated Care Organisations' (ICOs) participation bodies, such as the Social Councils and the Social Health Commissions. The Social Council is the consultative body which provides an advice on social and community issues in each ICO. The Social Health Commission is the advisory body for the professionals responsible for the management of health and social issues in each ICO. They all include representatives of the ICOs, public health, town councils, provincial councils and representatives of the social health sector. The third sector is not represented. One of the main integrating initiatives of the Osakidetza is the creation of Integrated Care Directorates in the ICOs. The Directorate of Integrated Care is the body in charge of coordinating its activity with the community and social and health bodies, with the aim of promoting the link with each other through the health and social promotion and prevention activities. The objective of the Directorate is to:

Features of Scotland's healthcare system	Adaptation of features to the Basque Country's context
	• develop integrative mechanisms between professionals in order to direct and coordinate the commission of health and social care in each ICO. • direct, promote and coordinate social and citizen participation in health and social care and thus enhancing citizens' co-responsibility and self-management of their health.
Evaluation methods Existence of Care Inspectorate which oversees the quality of the provided care services, including the services provided by third sector.	There is a powerful evaluation tool for the health sector in place - the Framework contract. It includes health and social indicators but not necessarily indicators which would refer to the third sector. In principal, there is no tool to evaluate the involvement/provision of third sector services. Therefore, one option of how to improve evaluation of the third sector activities would be the creation of a working group, coordinated by the Integration and Chronicity service of the Osakidetza's General Directorate and the Basque Government. The Group would consist of representatives from public health, the Integration Directorates of the ICOs, socio-health coordination and the TSS. The objective of this group would be to identify a set of indicators to measure participation of the TSS in the provision of integrated care which could be then included in the Osakidetza's Framework Contract. Another aspect to consider would be the possibility to include these indicators in the Preferential Offer of primary care in each of the ICOs. The Offer is a simple and very useful operative tool that assesses the services offered by the ICOs in the primary care. These are the services which are prioritised by the Basque's Health Plan.
Innovation Management Active role of the third sector in promoting the innovation agenda.	Euskadi Lagunkoia is an initiative promoted by the Department of Employment and Social Policies of the Basque Government and launched by the Matia Foundation[29]. It aims to encourage the participation of older people and the general public to improve neighbourhoods and environments in the municipalities of Euskadi in order to continue living active life as we age. The initiative is based on the "Age-friendly Environments Programme" and the paradigm of Active Ageing promoted by WHO. An elderly-friendly environment reorganises and adapts its structures and services in order to be accessible and tailored to the needs and capacities of ageing population. The objective is to: • To take advantage of the potential of older population as generators of well-being in the Basque Country • To create and promote community participation processes • To create a network of friendly initiatives in the Basque Country • To facilitate the introduction of changes in the environments in order to improve the citizens' quality of life.

[29] http://www.matiafundazioa.net

Features of Scotland's healthcare system	Adaptation of features to the Basque Country's context
	In the Gipuzkoa province, the Adinberri initiative will work in collaboration with public administrations, universities, companies, the third sector, innovative agents and the bio sanitary sector. It will act as a rallying point for all the companies, organisations and institutions involved in the healthcare sector in order to generate the most innovative person-centred care solutions. Its objective is to support research, development and innovation activities with potential impact on the framework of healthy ageing, the excellence of the social-sanitary system and the competitiveness of the industry in this field. As a result, the province aims to identify, design and develop new fields of actions related to a promotion of new ways of working which improve the quality of life, quality and efficiency of healthcare systems and make a decisive contribution to the excellence and sustainability of the social and health care models for older people. A possible action is to rreinforce the Euskadi Lagunkoia initiative in the three Basque provinces and extend Adinberri Gipuzkoa to the whole Basque Country, involving the TSS's organisations in the process.

7. Priority actions to enable conditions for the transferability of learning

Receiving region: List of the proposed actions to enable conditions for improved involvement of third sector engagement in the provision of integrated care in the Basque Country, including objectives, anticipated outcomes and policy implications is outlined in the Table below:

Priority Action	Objective of the Action	Anticipated outcomes	Policy implications, including the responsible actor and anticipated duration.
Strengthen the representation of the third sector in various participation bodies at Integrated Care Organisations (ICOs)' level	Encourage the third sector to participate in decision making processes, regarding population's care in the area where the ICOs operate.	• Reduce the current healthcare fragmentation between the health and social sectors, especially in relation to the third sector. • Promote a common vision and objectives, detailing the activities to be carried out by each of the stakeholders involved in integrated care delivery.	It will be necessary to extend health strategic lines of both the Department of Health and Osakidetza's Health Plan[30], to involve third sector's representatives in the Osakidetza's ICOs. Responsible actors: • Department of Employment and Social Policies • Formal Deputations of the three provinces • Department of Health • Osakidetza's Executive. Anticipated duration - 2020.
Include indicators on participation of third sector in the provision of integrated care into the Osakidetza's Framework Contract and the Preferred Offer of ICOs	Promote communication between the ICOs and the third sector, agree common objectives and involve the third sector as an active agent in the provision of integrated care.	Analyse the extent to which the third and the health sectors work together in each ICO territory to allow the analysis of gaps and the definition of corrective measures and objectives needed.	It will be necessary to reinforce transversal evaluation to fortify horizontal integrated care and strengthen the coordination between stakeholders involved. Anticipated duration - during 2019.

[30] http://www.euskadi.eus/informacion/politicas-de-salud-para-euskadi-2013-2020/web01-s2osa/es/

Priority Action	Objective of the Action	Anticipated outcomes	Policy implications, including the responsible actor and anticipated duration.
Reinforce the Euskadi Lagunkoia initiative in the three Basque provinces and extend Adinberri Gipuzkoa to the whole Basque Country	To extend an innovative initiative that encourages the participation of all the actors involved in the care continuum of older people, promotes and environment of cooperation towards the common objectives.	Jointly develop new fields of action aimed at promoting innovative ways of care throughout the Basque Country, in an innovative and coordinated manner.	It will be necessary to extend innovation in the health sector to include the Third Social Sector (TSS) organisations. Responsible actors: • Department of Employment and Social Policies • Formal Deputations of the three provinces • Department of Health • Osakidetza's Executive. Anticipated duration - 2020.

8. *Contact details for the receiving region – the Basque Country*

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Annex XI Action Plan to create conditions for the adoption of integrated care in Puglia Region – Improvement of engagement of third sector in the provision of integrated care in Scotland

Background: The objective of the Action Plan is to reflect on the possibility to transfer and adopt the learning about the role and involvement of third sector in the provision of integrated care in Scotland to local settings in Puglia Region, including the feasibility of the transfer and recommendations on policy priority actions that would enable the creation of local conditions for the adoption of integrated care.

The Action Plan builds on the outcomes of the study visit organised in Scotland on 4-5 September 2018. The study visit was an opportunity to learn about the role of the third sector in the provision of integrated care in Scotland and discuss a potential transferability of learning by comparing and contrasting the maturity of the healthcare system in Scotland with the maturity of local health and social care system in Puglia Region. As such, the Action Plan can inform the health and social care authorities about the future strategies and policies related to the role of third sector in the provision of integrated care in the Puglia Region. This process was facilitated by SCIROCCO self-assessment tool which provided the basis for the twinning and coaching activities.

The Action Plan is co-designed jointly by Scotland as the transferring region and Puglia Region as the receiving region as follows:

- Section 1: Needs of the adopting region – **Receiving region**
- Section 2: Description of the integrated care solution – **Transferring region**
- Section 3: Maturity requirements of the integrated care solution – **Transferring region**
- Section 4: Benefits and opportunities of integrated care solution – **Receiving region**
- Section 5: Conditions for the adoption of integrated care solution – **Receiving region**
- Section 6: Adaptation of local environment to enable transferability of learning – **Receiving region**
- Section 7: Priority actions to enable conditions for the transferability of learning **- Receiving region**

1. *Needs of the receiving region – Puglia Region*

The Puglia Region is very active in implementation of integrated care and policies in favour of elderly and disabled people. Helping people with disabilities and their families can be addressed in several ways; e.g. by providing simple income support, direct support in the form of services such as community centres, school integration, transport, rehabilitation therapies or by adopting a more ambitious approach. This includes a provision of dedicated services, tools and opportunities for social inclusion and improvement of the autonomy and quality of everyday life. Although much has been done in this area in the past, there is still a number of challenges which need to be addressed in Puglia Region.

One of the upcoming challenges is to adopt a new working methodology that brings together social and health care system, both organisationally and financially, in order to create a welfare system that is increasingly integrated and able to better respond to the needs of the citizens.

Health and social care seem to be often fragmented, with services based on professional and institutional boundaries rather than being co-ordinated around the needs of citizens. A number of policy initiatives in Puglia have been designed to tackle this fragmentation, however integration of health and social care still remains a challenge.

The three main barriers to integration have been identified in Puglia:

- misaligned financial incentives; the incentives of those involved in integration are not aligned to outcomes;
- resistance of workforce to information sharing;
- lack of engagement of the "Third Sector" in participating in the delivery of integrated care services.

2. *Aspect*[31] *of integrated care that addresses the needs of Puglia Region*

2.1 *Transferring region*: Role of the third sector in the provision of integrated care in Scotland

The "third sector" in Scotland is made up of non-governmental and non-profit organisations, from grassroot community groups and village hall committees to social enterprises and registered national charities. It is often also described as the voluntary sector, not-for-profit, charity sector, social economy, social enterprise sector, NGOs (non-government organisation) or civil society. It has an annual turnover of €5.96 billion. As of December 2017, Scotland's third sector was made up of over 40,000 organisations, including:

- 23, 300 registered charities;
- 20, 000 grassroot community groups, sports and art clubs
- 163 housing associations
- 5,2000 Social enterprises
- 432 community interest companies
- 107 credit unions.

[31] Please note that "aspect" in this case refers to a particular part/feature of the healthcare system.

The traditional idea of charities as benevolent organisations simply there to help the poor is being replaced by a modern, progressive, third sector which carries out an enormous range of activities to improve people's lives. It does it by:

- Supporting people through social care, health services and employability programmes;
- Empowering people by campaigning and advocating for minority and disadvantaged groups in our society;
- Bringing people together through social activities, local clubs and community centres;
- Enabling better health and wellbeing through medical research, addiction services, sport facilities and self-help groups;
- Improving our environment through conversation of our land and heritage, and regeneration of our communities.

There are 130,000 directly paid staff in the third sector – a figure comparable with NHS Scotland – collectively making it one of the Scotland's biggest employers. In relation to the health and social care agenda in Scotland, there are 5 main national membership organisations that represent third sector interests:

- Coalition of Care and Support Providers (CCPS) – to represent, promote and safeguard the interests of third sector and non-for-profit social care and support providers in Scotland.
- The Alliance – to support people of all ages who are disabled or living with long terms conditions to have a strong voice and enjoy their right to live well, as equal and active citizens.
- Voluntary Health Scotland – organisation working to improve health and address health inequalities
- Scottish Council for Voluntary Organisations (SCVO) – championing Scotland's vibrant charities, voluntary organisations and social enterprises.
- Scottish Federation of Housing Associations and Glasgow and West of Scotland Housing Forum
- Third Sector Interfaces (TSIs) – local voluntary sector umbrella organisations in each of the 32 local health and social care partnerships.

In Scotland, there is a legal framework in place for the engagement of third sector in the provision of integrated care. The Public Bodies (Joint Working) (Scotland) Act 2014 is the legislative framework for the integration of health and social care services which requires the integration of the governance, planning and resourcing of adult social care services, adult primary care and community health services and some hospital services. Other areas such as children's health and social care services, and criminal justice social work can also be integrated. As a result, the Act creates a number of new public organisations, known as integration authorities (31 integration authorities) and aims to break down the barriers to joint working between NHS boards and local authorities. Under this model an Integration Joint Board (IJB) is set up and the NHS boards and local authorities delegate the

responsibility for planning and resourcing service provision for delegated adult health and social care services to the IJBs.

The IJB must include representatives of the local authority, NHS Board, a carer representative, a GP representative, a nurse representative, a secondary medical care practitioner, a service user representative, a staff-side representative, a third sector representative, an officer who is responsible for financial administration the Chief Officer and the Chief Social Worker. As such, a third sector organisation is directly involved in the strategic planning and locality planning of the integrated care provision, however, the representatives of third sector do not have voting rights which often creates some uncertainty.

The third and independent sectors are contributing to the success of integration in range of ways:

- Delivering health and/or social care support
- Enabling access to people who use services and their communities, to support their engagement
- Providing access to data, and our ability to gather intelligence useful for monitoring and evaluation, and planning purposes
- Bringing expertise around barriers and needs from the wide diversity of groups of people who use services
- Facilitating communications and the gathering and collating of intelligence via umbrella groups and intermediaries.

In relation to service delivery, the third sector provide 69% of the total social services. The task is to harness this capacity, and to help the third sector grow in order to achieve the "radically reformed way of working and to make the most of the third sector contribution to the integration agenda.

2.2 *Transferring region:* Current progress in the involvement of third sector in the provision of integrated care in Scotland

Challenges/problems addressed by the involvement of third sector in the provision of integrated care:

A key driver towards integration and the engagement of third sector in the provision of integrated care has been the projected increase in demand for health and social care as a result of an increasingly ageing population, in particularly those who will be aged 75 and older. Older people make more use of hospital services than the rest of the population. An aim of the integration agenda is to help reduce unnecessary admissions to hospital, delayed discharges and shift the provision of care to local communities (Audit Scotland, 2016). Integration across the health, social, housing and third sector is seen as a way to make more efficient and effective use of limited resources and is believed to be central to the challenge of improving outcomes for patients and service users.

key innovative elements highlighting how the involvement of the voluntary sector in the provision of integrated care in Scotland improved the situation compared to previous status-quo

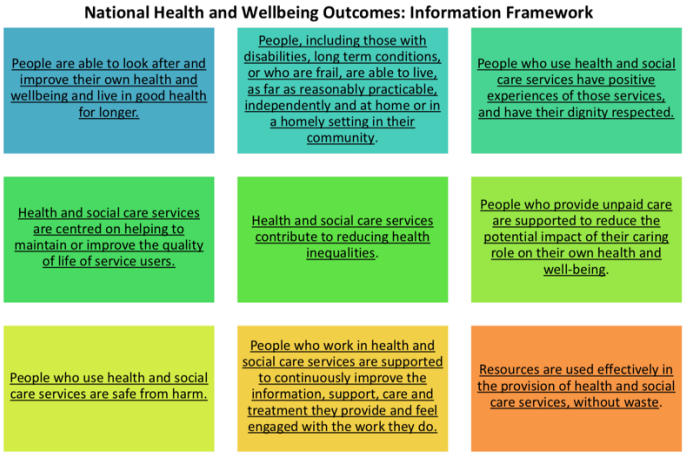
The introduction of legislation and legal framework for the integration of health and social care services has improved the engagement of the third sector in the provision of integrated services in a number of ways:

- It has enabled greater awareness and understanding of the role of the third sector in public service provision, particularly among integration authorities;
- It has improved the position of third sector as an equal partner in the planning and provision of integrated care services; there is a framework in place to build more strategic relationships among the third sector and the statutory service providers built on trust, partnership and genuine understanding of the benefits of these relationships to both service delivery and community wellbeing.
- It has secured greater connectivity and collaboration around the delivery of community-based care; the services are perceived less fragment from the perspective of service users;
- It has promoted wider knowledge of how community assets can be better used to co-produce the national health and wellbeing outcomes, particularly in relation to integration outcomes;

impact/outcomes observed

The engagement of the third sector in the provision of integrated care in Scotland is showing a number of benefits such as better quality of life, less isolated people, better care integration and reduced admissions to hospitals.

In principle, the success of engagement of the third sector is measured by its contribution to National Health and Wellbeing Outcomes Framework:



To access full national data resources with data for partnership areas please see the following link: https://www.gov.scot/Resource/0047/00473499.pdf

For more information about the involvement of third sector in the provision of integrated care in Scotland please see the following links:

- https://scvo.org.uk
- Alliance – We need to talk about integration – a collection of sector perspectives on progress of integration and what difference it has made so far
- Scottish Parliament: Health and Sport Committee report on third sector engagement with integration after the first couple of years
- Audit Scotland - Integration inquiry – early review of progress from 2015 (a second report is expected in November 2018)
- CCPS/SCVO/Alliance MSG paper on third sector engagement (copy provided); CCPS digital event link – CCPS digital showcase event – demonstrating the range of digital technology care and support providers are using
- http://www.newcarestandards.scot/ - https://www.blackwoodgroup.org.uk/clevercogs - connecting service users with the internet, communications, and managing their care all from an iPad at home.
- https://irocwellbeing.com/ - online mental wellbeing recovery measurement tool
- http://www.ccpscotland.org/hseu/information/better-futures/
- http://www.parliament.scot/ResearchBriefingsAndFactsheets/S5/SB_16-70_Integration_of_Health_and_Social_Care.pdf

3. *Maturity requirements of third sector involvement in Scotland*

Transferring region: Maturity requirements of third sector involvement in the provision of integrated care in Scotland is captured in the spider diagram below and detailed justification is provided in the following Table.

Figure 1: Maturity requirements of third sector engagement in Scotland

Dimension	Score	Description	Justifications & Reflections
Readiness to Change	3	Vision or plan embedded in policy; leaders and champions emerging	There is a legislation in place to support integration of health and social care which sets a legal framework for the engagement of third sector in the provision of integrated care services. However, pace of change is a bit slower and the policy is not really fully implemented yet. There is a lot of dialogue and partnership building going on between the third sector and statutory care providers, there is also growing awareness and recognition of the expertise and experience of third sector, however the challenge remains how to make the real shift from the continued focus on health.
Structure & Governance	3	Governance established at a regional or national level	The legislation on health and social care integration provided the basis for better positioning and engagement of the third sector by making the representatives of the third sector part of the Integration Joint Boards (new integration authorities planning and delivering integrated care). However, there is a continuous uncertainty around the role of the third sector as the representatives do not have voting rights on the Board. The third sector is also well represented in the Ministerial Strategic Group for Health and Community Care to facilitate the contributions of third sector in improving people's well-being. There is also a number of umbrella third sector organisations representing the voice of local volunteers, charities, social enterprises etc. in the process of decision-making.
eHealth Services	2	There is mandate and plan(s) to deploy regional/national eHealth services across the healthcare system but not widely implemented	There is new Digital Health and Care Strategy to address the challenge of ICT solutions and infrastructure to support information sharing. The third sector is very well positioned in the Strategy, acting as one of the actors responsible for the design and delivery of these services. However, current experience shows that the integrated information systems are not fully developed or wooden spread across Scotland. Overall engagement is still lacking. There is an extensive data sets in the third sector which needs to be integrated to the statutory platforms such as SOURCE and SPIRE.
Standardisation & Simplification	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	Similarly, as it is in case of eHealth services, the systems and standards are in place but not joined up at the point of delivery. The third sector has not been very much engaged in the discussion around the standards until recently, so it is difficult to measure the progress.

Dimension	Score	Description	Justifications & Reflections
Funding	2	Consolidated innovation funding available through competitions/grants for individual care providers and small-scale implementation.	The funding of the third sector activities remain the challenge, in most cases it is very short-term funding and inconsistent. There is a continuous focus of funding on health rather than social care, shift of care to community and prevention initiatives needs to be followed by an appropriate budget. There is not much evidence of this happening except for demonstration work.
Removal of Inhibitors	1	Awareness of inhibitors but no systematic approach to their management is in place	There is a great awareness about the need to remove inhibitors and third sector plays a pivotal role in raising this awareness but there is still a big gap between the theory and [practice. From a voluntary sector perspective, there is a need to join up efforts to remove the inhibitors.
Population Approach	4	Population-wide risk stratification started but not fully acted on	There is a SPARRA in Scotland used in all GPs practices. The third sector also collects a vast majority of the data and there is a need to ensure better use of this data for sound decision-making and planning within health and social care integration. It is a shared responsibility of the third sector and statutory sector to gather analyse and report data and evidence on healthcare delivery. There is a group established "Third Sector Data in Health and Social Care Working Group" to support building the partnerships and increase the capacity of data collection and data analytics.
Citizen Empowerment	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.	The third sector facilitates a number of programme and initiatives related to the citizen empowerment; however, it still remains a challenge to involve citizen in co-design and co-production processes. For example, Self-directed support legislation and rights of the citizens exists but still not widely implemented across Scotland. Access to health data is a critical issue which as yet has not been systematically addressed. Examples of third sector initiatives to improve access to data is e.g. Our Voice Programme.
Evaluation Methods	4	Most integrated care initiatives are subject to a systematic approach to evaluation; published results	There is a Care Inspectorate in place which oversees the quality of the provided integrated care services, including the provision of third sector services.
Breadth of Ambition	4	Integration includes both social care service and health care service needs	There is a strong ambition of the full integration of health, social, housing and third sector services, supported by legislation and dedicated funding however the Integration Act is not yet fully implemented.

Dimension	Score	Description	Justifications & Reflections
Innovation Management	2	Innovations are captured and there are some mechanisms in place to encourage knowledge transfer	The third sector is very active in promoting the innovation agenda, in particularly the digital agenda, but the sector struggles to get proposed innovative approaches implanted. It is still more or less through the pilots and demonstration work that innovation in the third sector services is adopted.
Capacity Building	3	Systematic learning about integrated care and change management is in place but not widely implemented	There is a strong culture of the learning and sharing of experience. Third sector representatives play vital role in the knowledge transfer and embedding the learning about successful service provision. Capacity-Building is a key success factor of the third sector activities, but the investments are lacking e.g. for the capacity-building of data managers in the third sector.

4. Benefits and opportunities of improving involvement of third sector in the provision of integrated care in Puglia Region

In Puglia, there are several third sector organisations (TSOs), however, their activities seem to be rather fragmented and not strongly aligned with a common integrated care vision. Scotland' s experience can help the Puglia Region to systematise the activities of the third sector by creating a more homogeneous regulatory and organisational framework in order to improve the involvement of TSOs.

In Scotland there are many TSOs working in social care, providing support for vulnerable and marginalised groups who frequently face poverty, social care needs and poor health. There are also organisations working in prevention, particularly in the area of food and healthy eating initiatives. Working closely with communities is a key remit of the third sector approach. In many case, organisational structure and aims are defined by the needs of a particular community in order to fill the gaps in the service provision. Third sector initiatives are very often are based on the development of social networks which are very powerful tool to improve social capital and reduce isolation. This in turn results in the improvement of health outcomes.

There is now a consensus that health and social care services in Puglia Region need urgent attention. Knowledge and ability to respond to this need is often hampered due to complicated communication channels. As organisations embedded in service users' communities, TSOs are often able to overcome these communication barriers. This Action Plan will aim to demonstrate that TSOs have the potential to meet the growing needs and positively contribute to the improvement of integrated care services in Puglia region.

5. Conditions for involvement of third sector in the provision of integrated care in Puglia Region

5.1 Maturity of local health and social care system in Puglia Region

Receiving region: Maturity of Puglia's health and social care system, highlighting the strengths and weaknesses of the local system in integrated care:

Figure 2: Maturity of Puglia's healthcare system

5.2 Conditions enabling the improvement of involvement of third sector in the provision of integrated care in Puglia Region

Receiving region: Maturity of healthcare system in Puglia Region and maturity requirements of the involvement of third sector in Scotland is captured in the spider diagram below:

Figure 3: Comparison of maturity requirements with maturity of Puglia's healthcare System

5.3 Feasibility of transferring the learning from Scotland to Puglia's local context

Dimension	Score Scotland	Features of Scotland's healthcare system for engagement of third sector	Score Puglia	Features of Puglia's healthcare system	Feasibility of transfer and rationale
Readiness to Change	3	Legislation to support integration of health and social care; A legal framework for the engagement of third sector; Dialogue and partnership building; Growing and recognition of the expertise of third sector.	2	The regional system is ready for change, but there are still some critical issues: training, technical, generational gap and cultural gap	Yes; the transferability is feasible with lot of efforts. There is a need to embed reorganisation of third sector in Puglia' regional policies and planning. Involvement of voluntary networks in decision-making process need to be fostered in order to facilitate a change of culture.
Structure and Governance	3	Third sector is represented in the planning, commission and delivery of integrated care services at different levels of governance; Existence of a number of umbrellas organisations representing the third sector. in the process of decision-making.	3	Governance is mature for the integrated chronicity system. There is a structure and governance in place but the integration among Social and Health care system is still a challenge.	Yes; the transferability is feasible with lot of efforts. A roadmap for a change programme that would integrate funding for health and social care needs is needed in order to deliver tailored solutions for chronic complex citizens, including the solutions provided by voluntary sector.
Information & eHealth Services	2	Digital Health and Care Strategy in place to address the challenge of ICT solutions and infrastructure to support information sharing; the third sector is recognised as one of the actors responsible for the data collection. Integration of third sector data with the statutory platforms remains a challenge.	2	There are problems with the infrastructure. There are some local solutions but there is not a fully integrated Information System.	Yes; the transferability is feasible with lot of efforts. There would need to be a change in current legislation regarding the integration of ICT platform in order to achieve interoperability between health and social care systems platforms.
Standardisation & Simplification	3	Engagement of the third sector in the discussion around the standards	2	There is still not full integration between hospital and community settings. However, the situation is not	Yes; the transferability is feasible with lot of efforts.

Dimension	Score Scotland	Features of Scotland's healthcare system for engagement of third sector	Score Puglia	Features of Puglia's healthcare system	Feasibility of transfer and rationale
				homogeneous in the entire region. Some areas are more developed than others.	The requirements for the transferability of these features are directly linked to the domains 1, 2 and 3.
Funding	2	Dedicated funding for third sector, however mostly inconsistent and short-term funding.	3	In the recent years, there has been considerable investments at regional level in this subject.	Yes; the transferability is feasible with no need for major adaptation. Funds are available to support the engagement of third sector in the provision of care.
Removal of inhibitors	1	A great awareness about the need to remove inhibitors and third sector plays a pivotal role in raising this awareness, however implementation is still an issue.	2	It is necessary to increase information technology, and organise training courses for the staff (rise awareness) to support the removal of inhibitors	Yes; the transferability is feasible with some efforts. There is a need for continuous training sessions for the stakeholders involved in the third sector. Information campaigns about the role and benefits of involving third sector in the care provision should be promoted.
Population Approach	4	Existence of risk stratification tool; "Third Sector Data in Health and Social Care Working Group" to support building the partnerships and increase the capacity of data collection and data analytics.	2	There is a stratification of the population, but it is necessary to integrate data with environmental factors.	Yes; the transferability is feasible with some efforts. The algorithm used for population stratification will be in future integrated with social data which would facilitate the data analytics.
Citizen Empowerment	2	A number of programme and initiatives related to the citizen empowerment facilitated by third sector, e.g. Self-directed support legislation.	1	There is a need to invest more in communication/structured involvement of citizen/third sector in order to improve the knowledge about the availability of services (both social and health services). At the moment there is little awareness about this.	Yes; the transferability is feasible with some efforts. There is a need to invest more resources in communication and social media in order to support citizens' access to information about the availability of health and social care services and thus overcoming the issues of inequalities.
Evaluation Methods	4	A Care Inspectorate in place which oversees the quality of the provided care services,	2	The region has an active monitoring and evaluation service.	Yes; the transferability is feasible with some efforts.

Dimension	Score Scotland	Features of Scotland's healthcare system for engagement of third sector	Score Puglia	Features of Puglia's healthcare system	Feasibility of transfer and rationale
		including the provision of third sector services.			The focus of the evaluation methods would need to shift to better focus on chronicity.
Breadth of Ambition	4	A strong ambition of the full integration of health, social, housing and third sector services, supported by legislation and dedicated funding.	2	Services are not yet fully integrated into the territory. There is a need for greater linkage between hospital and territorial care	Yes; the transferability is feasible with some efforts. There is a need to define integrated health and social care pathways.
Innovation Management	2	Active role of the third sector in promoting the innovation agenda, however there is still existence of small pilots rather than systematic involvement.	2	The region is mature about innovation, now it needs to spread more information on the territory and train the staff involved.	Yes; the transferability is feasible with some efforts. Continue with the training programmes for all stakeholders involved in the delivery of health and social care, including third sector. Twinning and coaching mechanisms can help to facilitate the access to and implementation of innovative ideas.
Capacity Building	3	A strong culture of earning and sharing of experience; Third sector representatives play vital role in the knowledge transfer; Capacity-Building is a key success factor of the third sector activities but remains a continuous challenge.	3	The regional programming capacity for chronicity is adequate, future public policies should be geared towards greater involvement of the population and greater spread of eHealth in the region.	Yes; the transferability is feasible with no need for major adaptation. There is already an organisational structure in place to facilitate the training.

5.4 Priority areas for the transferability of learning

Receiving region: List of the prioritised features to be considered for the transferability of learning in order to improve third sector's involvement in the provision of integrated care in Puglia is outlined in the Table below:

List of prioritised features of Scotland's healthcare system for engagement of third sector
Readiness to Change • Importance of culture; third sector activities need to be embedded in the society • Need of the regulatory framework, policies and vision to better organise and align the activities of third sector organisations • Partnership approach Structure and Governance • Existence of legislation to support the involvement and the equal role of third sector • Equal distribution of resources across the sectors to coordinate the services around the needs of citizens Breath of Ambition • Full integration of health and social care services with a recognised role of third sector • Self-Directed Support service • Existence of shared protocols to facilitate the funding around the needs of citizens

6. Adaptation of local environment to enable transferability of learning

Receiving region: List of suggested changes to enable the creation of conditions for the involvement of third sector in the provision of integrated care services in Puglia, informed by the learning about the features of Scotland's healthcare system is outlined in the Table below:

Features of Scotland's healthcare system for engagement of third sector	Adaptation of features to Puglia's context
Readiness to Change • Importance of culture • Regulatory framework, policies and vision to better align the activities of third sector organisations • Partnership approach	• Embed Third Sector reorganisation in the regional policies and planning. • Foster voluntary workers involvement in institutional initiatives and in decision making in order to facilitate and favour cultural change.
Structure and Governance • Existence of legislation to support the involvement and equal role of third sector • Equal distribution of resources across the sectors to coordinate the services around the needs of citizens	• Develop a roadmap for a change programme to unify social and health funding in order to deliver tailored solutions for chronic complex citizens.
Breadth of Ambition • Full integration of health and social care services with a recognised role of third sector • Existence of shared protocols to facilitate the funding around the needs of citizens	• Need to adapt and reform third sector legislation in order to remove an organisational and financial fragmentation and deliver full integrated services.

7. Priority actions to enable conditions for the transferability of learning

Receiving region: List of the proposed actions to enable conditions for improved involvement of third sector engagement in the provision of integrated care in Puglia, including objectives, anticipated outcomes and policy implications is outlined in the Table below:

Priority Action	Objective of the Action	Anticipated outcomes	Policy implications, including the responsible actor and anticipated duration.
Reform of the third sector at a regional level	1. Embed third sector collaboration in the regulation and policies related to health and social care service delivery. 2. Map and coordinate third sector initiatives including at a regional level and thus facilitate the partnership building in order to systematically share strategies and co-design the Action Plans.	Extension of the existing pilots at a regional level and embracement of innovation; e.g. improvement of the "*Buoni Servizio*" experience carried out in Puglia with a similar methodology for Self-Directed Support as applied in Scotland, including testing of the digital platform in use (Car Gomm).	The regional Agency for Health and Social Service (ARESS) provides the technical support for Department for Health Promotion, Social Affair and Sports for all. The Agency main role is to foster health and social Innovation processes in the region. As such, the Agency will be involved in developing these priority actions further, e.g. by forecasting the skills, competences and knowledge needed for their implementation, including the development of feasibility study and SWOT analysis As a result, the Agency might consider useful to propose to the Department for Health Promotion, Social Affair and Sports for all to develop a Memorandum of Understanding with Scotland as a coaching region in order to support the transferability, adaptation and embedment of this successful experience
Integration of funding system	1. Overcome the fragmentation of funding for integrated care service 2. Promote the scaling up of existing pilots (e.g. *Buoni Servizio*) carried out in Puglia on the definition of "Health and Social Care Pathways" (PDTA) and related co-payment system "concept" to be shared between health and social sector (integration of funds)	More effective distribution of resources	
Improved data collection and information sharing	1. Make possible the full implementation of the concept of personalise medicine and "big data" in order to inform the definition of the Health and Social Care Pathways and protocols (PDTA).	Better management of citizens needs and reduction of inappropriate use of health and social care services	

Priority Action	Objective of the Action	Anticipated outcomes	Policy implications, including the responsible actor and anticipated duration.
	2. Accelerate the integration of ICT platform in order to share data (across health and social care settings)		of Scotland in engaging the third sector in the provision of integrated care.

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