European Innovation Partnership on Active and Healthy Ageing

ACTION PLAN

on

'Replicating and tutoring integrated care for chronic diseases, including remote monitoring at regional levels'

Date and place: 6 November 2012, Conference of Interested Partners, Brussels

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1. INTRODUCTION

1.1 Integrated Care Action Plan

This Action Plan is a result of work which started with adoption of the Strategic Implementation Plan (SIP) in November 2011. Integrated care was identified as one of the six specific priority actions of the European Innovation Partnership (EIP) planned for 2012-15 (see *Appendix B*). Please see *Appendix A* for a Glossary of Terms used in this Plan.

The B3 Integrated Care Action Plan is a product of intensive work by the B3 Action Group, focussed on the SIP specific action – "replicating and tutoring integrated care for chronic diseases, including remote monitoring at regional level". The Action Plan builds on the objectives, targets and deliverables, as suggested in the SIP for the area of Integrated Care (B3 Action Group).

Activities were selected for implementation because they were relevant and have potential for impact. B3 Action Group members have reaffirmed their original commitments by agreeing to contribute to the achievement of objectives that are relevant for their region / organisation, in light of the resources and capacities available to them. They also agreed to work collaboratively to implement related deliverables in their own region / organisation and to support others to do so. Activities will be implemented on planned basis from 2012 until 2015 and have been scheduled to impact on the European Integrated Care Agenda.

Today, the B3 Action Group is made up of 144 participants representing regions, delivery organisations, patient / user and carer organisations, academic institutions, industry and members organisations. The Group has delivered a realistic but challenging action plan designed to encourage, enthuse and inspire health and social care providers, along with industry and academia, to collaborate with patients, service users and carers to form partnerships to deliver innovative service redesign. This work will be underpinned by a commitment to patient / user empowerment, education and training for all stakeholders (workforce, patients and carers), supported by technology, where safe and effective to do so.

1.2 Development of the Action Plan

The Strategic Implementation Plan recognises that the increased complexity of health problems and the specific challenges posed by increased prevalence of chronic conditions within a growing population of people aged over 65 in Europe will require changes in professional activities, qualifications, care settings and processes as described in *Appendix B*.

There is a need to re-design health and social care systems and this will involve the development of integrated care models that are more closely oriented to the needs of patients / users, multidisciplinary, well co-ordinated and accessible, as well as anchored in community and home care settings.

Introduction of integrated care involves shifting from reactive service delivery to preventive, proactive and patient-specific care. It requires a move from institutional to community / home based care. In this way benefits can be realised through reductions in avoidable / unnecessary hospitalisation, patient / user empowerment, more sustainable and optimised use of resources and more efficient care throughout the whole care system. Ultimately, this brings benefits to end users and makes it possible for patients / users to play an active role as become co-producers of health and social care and to do this an integral part of the entire system.

1.3 Rationale for Action Group Area

The overall objective of the B3 Action on Integrated Care is stated in the European Innovation Partnership Active and Health Ageing Operational Plan of November 2011 as:

'*Reducing avoidable/unnecessary hospitalisation of older people with chronic conditions, through the effective implementation of integrated care programmes and chronic disease management models that should ultimately contribute to the improved efficiency of health systems*.'

The B3 Action Plan and Action Area will contribute to increasing the average number of healthy life years by two (2) years in the European Union by 2020, and by the associated triple win for Europe:

- Improving the health status and quality of life of European citizens, with a particular focus on older people;
- Supporting the long term sustainability and efficiency of health and social care systems;
- And enhancing the competitiveness of EU industry through an improved business environment providing the foundations for growth and expansions of new markets.

The SIP envisaged that B3 activities would result in the achievement of the following targets:

1. ***By 2015:*** *Availability of programmes for chronic conditions/case management (including remote management/monitoring) serving older people in at least 50 regions, available to at least 10% of the target population (patients affected by chronic diseases in the regions involved).*
2. ***By 2015-2020:*** *Based on validated, evidence-based cases, scale-up and replication of integrated care programmes serving older people, supported by innovative tools and services, in at least 20 regions in 15 Member States.*

1.4 Calls for Commitment

The European Commission launched a Call for Expressions of Commitment to Action Area B3 (Integrated Care), which closed on 31st May 2012. Sixty seven (67) submissions were received - an analysis of the commitments is provided in *Section 2* of this Plan and a list of organisations which made commitments is provided in *Appendix C*.

Of the 67 organisations which submitted commitments, 57 were invited to attend the first B3 Action Group Meeting held in Brussels on 19th and 20th June 2012.

1.5 Structure of the Action Group

At the first meeting of the B3 Action Group, it was agreed that a Co-ordination Group should be set up to oversee the development of the B3 Action Plan. Professor George Crooks for NHS 24 (Scotland) was appointed as Chair of the Co-ordination Group. It was also agreed to:

- develop the Action Plan via three Working Groups: Best Practice, Implementation and Scale-up (of Integrated Care Programmes).
- implement a governance structure to guide the implementation activities of the Action Plan (see *Section 5*).
- gain a clearer understanding of the priorities, challenges and gaps perceived by the Regions and delivery organisations which are implementing Integrated Care Programmes by means of a Delta Questionnaire (see *Section 2.2*).

Following the first meeting in Brussels, the Co-ordination Group has held regular (virtual) progress meetings and met face to face in Brussels on 20th September 2012.

The full B3 Action Group met in Brussels on 17th October 2012 to review and initially approve this Action Plan.

1.6 The Delta Questionnaire

The Co-ordination Group and the Commission agreed that the B3 targets will only be achieved if more regions and care delivery organisations decide to implement integrated care for wider populations. They, therefore, felt it was important to better understand the perspectives of regions and delivery organisations.

Regions and delivery organisations that had made commitments, and also a number of organisations applied to become candidate Reference Sites of the EIP, were invited to complete the B3 Delta Questionnaire.

27 regions / organisations out of 67 had completed the Questionnaire by the end of September 2012. The 15 responses received from Regions revealed that they were providing care to a total population of c. 54 million people, and that they are spending > €15 B per annum on the care of people with chronic conditions. The results and insights gained from the Delta Questionnaires are explained in further detail in *Section 2.2* and *Annex 1*.

A key test of the viability of the B3 Action Plan will be its potential to assist Regions and delivery organisations in addressing the challenges they described in their responses to the Delta questionnaire (see *Section 2.2)*. The Co-ordination Group applied this test to the actions proposed within the B3 Programme of Work (*Section 3*).

1.7 Programme of Work

The Co-ordination Group considered the results of the Delta Questionnaire Analysis (*Annex 1*) before developing a comprehensive 'B3 Programme of Work for Integrated Care' (*Section 3*). This was designed to address the priority issues identified by Regions upon which the Action Group might have an impact. In other words, the activities proposed should help Regions and delivery organisations to implement chronic care and integrated care programmes; make integrated care accessible to wider populations and maximise the use of innovative tools and services. This 'design challenge' was factored into the planning and prioritisation of B3 activities from the start.

In view of the potential resource implications of the suggested activities within the B3 Programme of Work, and the voluntary principle underpinning the proposed Collaborative which will co-ordinate its implementation (see *Appendix D*), the Action Group considered it essential to prioritise B3 activities.

Priority activities, deliverables and milestones were chosen on two main criteria:

- the Action Group considered the activities to be most likely to deliver the biggest impact on the targets;
- the members of emerging B3 Collaborative were committed to them and had resources which they could share to mutual benefit.

These criteria were applied to an initial list of B3 activities suggested at the first meeting of the B3 Action Group in June 2012 to produce the final B3 Programme of Work for Integrated Care (*Section 3*).

However, it is anticipated that additional activities may be implemented over time, as new members join the B3 Action Group and additional opportunities, resources and capacity become available.

On 17th October 2012, prior to publication of the Action Plan, B3 Action Group members re-affirmed their existing commitments by agreeing to contribute to the achievement of objectives and deliverables that are relevant for their region / organisation, to work collaboratively to implement deliverables for their own region / organisation and to support others to do so.

1.8 Delivering the Action Plan

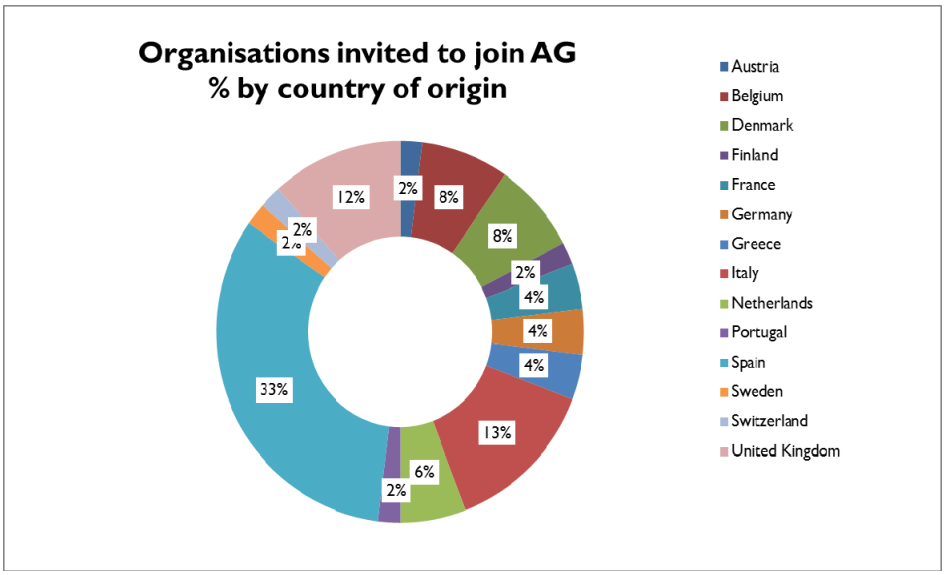
In parallel to the development of the B3 Programme of Work, the Action Group developed its approach to structuring its work and governance over the next 3 years -see *Section 5* on Governance and the B3 Memorandum of Understanding (*Appendix D*).

In summary, it was agreed that a Collaborative governance model would be most appropriate – a voluntary grouping of organisations who commit to and see advantage in pooling resources and collaborating for mutual benefit.

2. B3 COMMITMENTS AND DELTA QUESTIONNAIRE

2.1 Analysis of Commitments

A total of 67 commitments to B3 Action on Integrated Care were received in response to the call which closed on 31st May 2012.

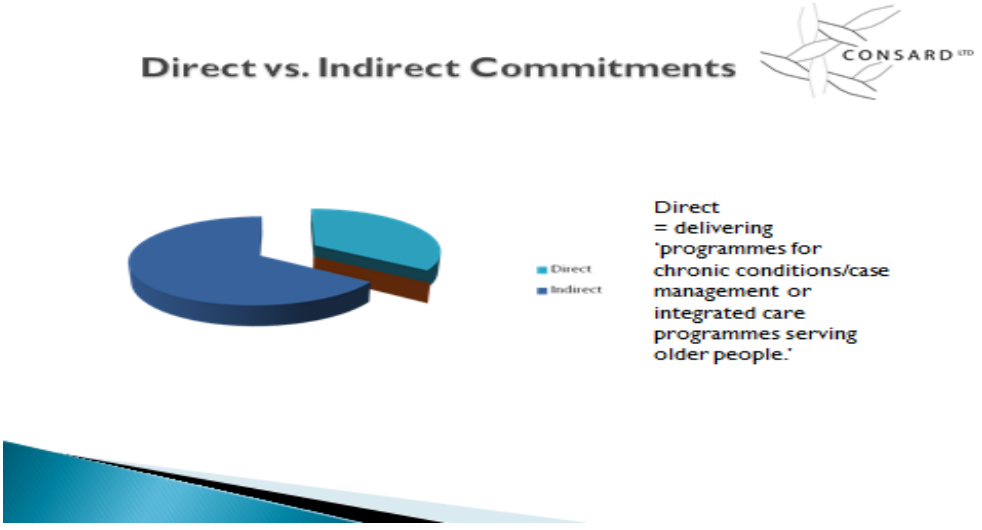


Organisation Committing	Investment committed	Population covered	Patients impacted
	€M.	M.	
Municipality of Palaio Faliro	1		800
Coöperatie Slimmer Leven 2020		1	
Department de Salut - Generalidad de Catalunya		8	760000
Agencia Valenciana de Salud			12000
Department of Health, Social Services and Public Safety	4	0	23000
Department of Health and Consumer Affairs of the Basque Government	750	2	160000
Region North Denmark	7		1400
Europäische Vereinigung für Vitalität und Aktives Altern eVAA e.V.	3	4	
Agenzia sanitaria e sociale regionale	50	5	500000
CSI-Piemonte (Consortium for Information Systems)	2		
University of Valencia (UVEG)			12000
Philips Healthcare	4		15000
NHSScotland, co-ordinated by NHS24	320	6	55000
Zealand Denmark	0		
Federico II University / Campania Region			15000
Institute of Health Carlos III	10		50000
Regional Healthcare Agency of Puglia		2	300000
Région Languedoc Roussillon	3		15000
	1154	***26***	***1919200***

From these commitments, it was noted that:

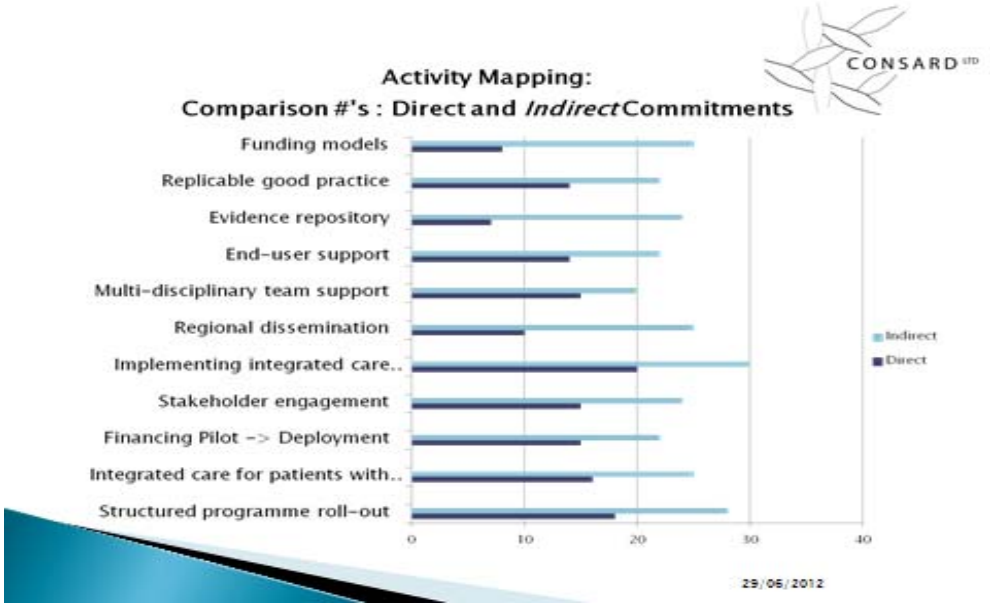
- integrated care activities already under way covered more than 20 regions in Europe;
- reach out to the new Member States is clearly envisaged by those organisations committing;
- close to1.9 million patients were receiving integrated care; and
- €1,150 million was already being invested.

The call attracted a high level of interest across Europe, especially from research / academia and 'other' organisations. There was a good geographical spread with a strong interest from Spain, but newer Member States were not represented.



35% of commitments were considered **"direct"** as they came from organisations delivering 'programmes for chronic conditions/case management or integrated care programmes serving older people.' The majority (65%) were considered "**indirect"**.

All 11 activity areas specified in the invitation to commitment were of interest to those making commitments and, as such, were considered viable for the development of the Action Plan.



2.2 The Delta Questionnaire Analysis

The B3 Co-ordination Group considered the results of the Delta Questionnaire Analysis before developing a comprehensive Programme of Work (*Section 3*). The full Delta Questionnaire Analysis Report is available as *Annex 1*.

Key findings are highlighted below:

Q3. Where is your care delivery organisation planning to be by 2015 and 2020?

Availability of Programmes for chronic conditions/case management	**By 2015**	**By 2020**
3.1. How many programmes for chronic conditions/case management will your organisation make available to patients affected by chronic diseases.	Regions: 171 Delivery Orgs: 107	Regions: 184 Delivery Orgs: 191
Integrated care programmes supported by innovative tools and services	**By 2015**	**By 2020**
3.2. How many programmes supported by innovative tools and services (including electronic patient records, telehealth, telecare and remote monitoring, etc.) will your organisation be offering?	Regions: 61 Delivery Orgs: 24	Regions: 108 Delivery Orgs: 28

Q4.1. The location of the care you deliver

For patients affected by chronic diseases, in what setting (by %) is their care delivered?

Location of healthcare	Now	2015	2020
Hospital (acute) based	*15-49%*	*15-49%*	*<15%*
Primary care based	*15-49%*	*15-49%*	*15-49%*
Community (home) based	*<15%*	*<15%*	*15-49%*

This response revealed an expectation from respondents that a significant shift in location of care provision to community (home) will not occur until 2020. It is hoped that the B3 Action Plan will help to bring this date forward.

In addition, it is important to recognise that the bulk of care for older people with long-term conditions is provided by informal carers (family, friends and neighbours). The B3 Action Group, therefore, acknowledged that this important resource needs to be integrated and sustained within programmes and initiatives, so that better coordination and integration of service delivery can be achieved.

Q7. Summary of responses by Regions on Top Challenges

Activity Area	Top challenges identified by Delta respondents
Organisational models / change management	Fear of change in professionals; staff attitudes and reluctance to change
	Introduction of comprehensive chronic integrated model
	Closure of small hospitals and bed reduction
	Dissemination of best practice
	Lack of support for the integrated care concept and availability of funding
	Public acceptance
	Alignment of health and social care strategic and operational objectives
	Benefits / profit realisation
	Patient Empowerment
	Co-ordination between systems and care levels
Workforce Development, Education and Training	New multidisciplinary teams for care of chronic patients
	Fostering a culture of shared responsibility and joint working
	Supporting improved collaboration
	Improve knowledge amongst formal and informal carers
	New management model for targeted health and quality of life outcomes
	Identification of patient clusters, identification of targeted care plans and engagement of professionals
	Develop understanding and agreement of what to measure and how to do it.
	Multi-morbidity
Care Pathways	Implementing integrated care frameworks to support patient centred care
	Avoidance of complication and readmission of chronic patients
	Chronic disease programme involving all stakeholders (integrated)
	Patient self-management
Electronic Care	Resistance to sharing data

Activity Area	Top challenges identified by Delta respondents
Records	ICT barriers
	Integrated ICT system
	Interoperability of regional ICT platform
Teleservices	Deployment of required technologies
	ICT tools capable of supporting innovative methodologies
	Telemedicine service implementation
	Robust technology infrastructure for cross organisational working
Finance / funding	Clinical and financial evidence to move from pilot to deployment
	New funding models
	Finances / organisations / coordination
	Willingness to invest of funding agencies
	Changes to insurance reimbursement schemes
	Financing for ICT solutions
	Regional funding for integrated chronic disease care extension

2.3 Informing the Action Plan

The Delta Questionnaire provided the basis for the development of a structured programme of activities. Nine action areas were defined in response to the top challenges identified by respondents. The resulting B3 Programme of Work is detailed and includes specific deliverables, milestones, timings and governance arrangements.

Within the Programme of Work, nine Action Areas have been established. They each aim to produce tangible results with specific timed deliverables and milestones, so that it will be possible to track the overall progress of the Programme of Work. The Action Areas include: organisational models, change management, workforce development, risk stratification, care pathways, patient empowerment, with three cross-cutting Action Areas covering ICT / Teleservices, Finance / Funding and Communication / Dissemination.

3. ACTIONS

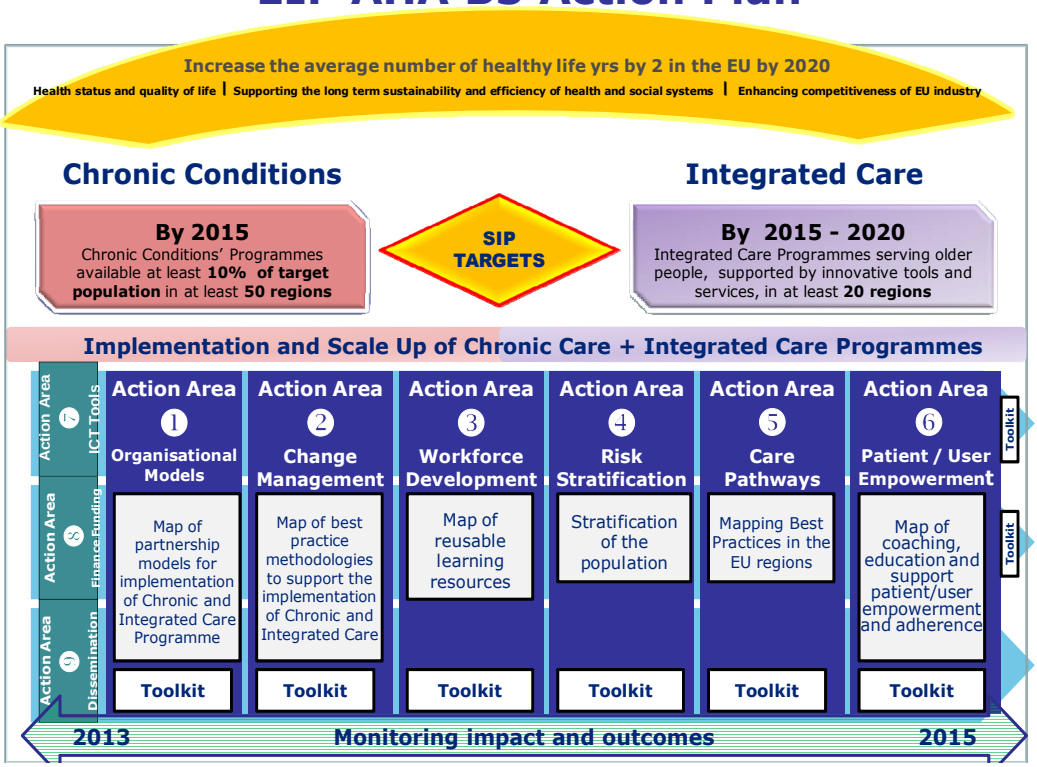
3.1 Overview of Programme of Work

The Strategic Implementation Plan proposed a list of activities and specific conditions applicable to the B3 Action Group's objectives and deliverables – for details see *pages 27 – 31 of the Operational Plan*[1]. The B3 Programme of Work takes account of these, the challenges identified in the Delta Questionnaire, and the feasibility of delivery within the 2012-15 timeframe.

In order to achieve the high level targets outlined in Section 1.3 above, the B3 Programme activities have been grouped into a series of Action Areas closely aligned to the priority areas for action identified through the Delta Questionnaire Analysis. For each Action Area, a sub objective has been proposed with associated high level deliverables, timing and milestones. Following approval of the B3 Action Plan, further work will be done to define specific Work Packages, to confirm co-ordinators and the specific contributions of members to each of the deliverables.

[1] Strategic Implementation Plan – Operational Part, p. 27-31 http://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/steering-group/operational_plan.pdf#view=fit&pagemode=none

EIP AHA B3 Action Plan



3.2 Activities, Deliverables, Milestones and Timing

B3 Action Area 1 – Organisational Models			
Sub-objective / activities	**Specific deliverables**	**Timing**	**Milestones / Outcome Indicators**
1-1 Regions are supported in expanding integrated health and social care programmes to a wider population by: • Securing the support of policy makers for integrated care; • Improving integration between systems and care levels – vertical and horizontal; • Implementing new models of integrated care.	**D1-1 Map of partnership models for implementation of chronic and integrated care programmes,** demonstrating how to develop: • vertical and horizontal public organisations integration; • public private partnerships (with risk sharing based on outcomes); • fully 'outsourced' delivery; • multi-organisational chronic disease management models; • collaborative models for health and social care; • care co-operatives; • community partnerships.	Dec 2013	M1-1 Agreement reached within the proposed B3 Collaborative on the optimal approach for organisational co-ordination, including the alignment of health and social care strategic and operational objectives. M1-2 Evaluated models of integrated care using mutually agreed indicators (structure, process, and outcomes) are implemented at scale. M1-3 New regions implementing integrated care programmes, or existing regions scaling up, take account of European best practice.
	D 1-2 Toolkit for organisational models to include: • literature review / peer reviewed published evidence on analysis of integrated care; • tools / practical tips for organisational development, implementation and scale up.	Dec 2014	

B3 Action Area 2 – Change Management – Incentivisation and Advocacy			
Sub-objective / activities	**Specific deliverables**	**Timing**	**Milestones / Outcome Indicators**
2-1 Regions are supported to orientate public policy and resource allocation decisions within political, health, economic	**D2-1 Map of best practice methodologies to implement chronic and integrated care,** including: • funding models - i.e. insurance based,	Dec 2013	M2-1 Regions use deliverables from this Action Area in design of incentive schemes or to help identify and overcome barriers.

and social systems, and to provide more responsive care delivery.	commissioning led incentives, etc; • effective use of incentives; • engagement with stakeholders; • implement decision support systems; • co-production.		M2-2 Regions seeking to introduce Integrated Care or expanding existing programmes to serve a wider population actively use deliverables from the Action Area to make the case / persuade stakeholders.
	D2-2 Toolkit for Change Management including: • analysis of barriers and successful approaches to implementation of chronic care programmes and integrated care models; • model business cases to support implementation and scale up.	Dec 2015	

B3 Action Area 3 – Workforce Development, Education and Training			
Sub-objective / activities	**Specific deliverables**	**Timing**	**Milestones / Outcome Indicators**
3-1 Regions are supported to: • Identify need for, and design new roles with associated competence development planning; • Improve competences (related to integrated care) in management and leadership , clinical roles, health and social care workforce (including third sector); • Foster a culture of shared responsibility and joint working; • Provide training, information and knowledge transfer for patients / users; • Improve knowledge of formal and informal carers.	**D3-1 Map of reusable learning resources** to support the delivery of awareness raising and education for all stakeholders, including the use of ICT education delivery methods and ICT decision support tools.	Dec 2013	M3-1 Improved access to education and training programmes to support improved functioning of multi-disciplinary teams: • Identification of new roles; • knowledge, skills and competences; • communication skills; • behavioural and attitudes changes; • culture of shared responsibility and team work; • co-operation with universities (teaching curricula). M3-2 Enhanced availability of education and training programmes for informal carers /volunteers/citizens to support their skills, motivation and willingness to use ICT and other innovative tools and solutions,
	D3-2 Toolkit for Workforce re-design, development, education and training to include: • workforce and training needs analysis; • workforce development plans; • system design to support best practice; • design and implementation of ICT decision support tools.	Dec 2015	

B3 Action Area 3 – Workforce Development, Education and Training			
Sub-objective / activities	**Specific deliverables**	**Timing**	**Milestones / Outcome Indicators**
			drawing on the repository for curricula and training materials.

B3 Action Area 4 – Risk Stratification - for optimised delivery of Integrated Care			
Sub-objective / activities	**Specific deliverables**	**Timing**	**Milestones / Outcome Indicators**
4-1 Analyse the needs of patients /users in the target groups for delivery of integrated care.	**D4-1 Map of existing patient stratification solutions** which: • identifies in which Regions risk-based stratification has been used; • documents the approaches developed and Delta challenges achieved as a result; • extrapolates the results of above to develop a European baseline, with associated potential benefits resulting from adoption of risk stratification-based change at a delivery organisation, regional and European level; • identifies best-in-class patient stratification tools (with focus on disease severity/activity, co-morbidities, frailty and technological skills of users).	Dec 2013	M4-1 More Regions use risk stratification in their plans for integrated care. M4-2 More Regions plan expansion of population coverage of existing integrated care programmes as a result. M4-3 Greater use of ICT and data mining to inform decisions about implementation and delivery of integrated care, with integration into devices to follow up patients as PDAs, phones and tablets.
4-2 Support partners to implement risk stratification methodologies.	**D4-2 Toolkit for Risk Stratification** which includes: • diagnostic activities; • success stories – *outputs from D4-1 above;* • tools / practical tips to help to: - identify patient clusters; - embed targeted care plans; - define a panel of indicators (outcome; clinical; organisational; epidemiological; lifestyle; quality of life, etc);	Dec 2015	

	- quality improvement models.		

B3 Action Area 5 – Care Pathway Implementation			
Sub-objective / activities	**Specific deliverables**	**Timing**	**Milestones / Outcome Indicators**
5-1 Align existing and new funded activities (EU, regional and local) and focus financial instruments to deliver chronic disease care pathways and integrated care programmes.	**D5-1 Map of best practice implementation in the EU regions** providing a repository of : • implemented chronic care pathways; • implemented integrated care; pathways for chronic conditions; • implemented pathways to managing multi or co-morbidity.	Dec 2013	M5-1 European, National and Regional stakeholders develop; deploying and replicate effective care pathway structures and care provider eco-systems. M5-2 A culture of shared responsibility and joint working is fostered through case management methodology identifying good practices to coordinate formal and informal care.
5-2 Develop the evidence base for integrated care pathways and associated guidelines and processes to speed their adoption within regions and care delivery organisations.	**D5-2 Toolkit for Integrated Care Pathways** to support: • care pathway redesign; • streamlining of diagnostic pathways; • the use of standardised protocols, procedures and activity workflows; • care pathway implementation plans using existing resources to enhance care pathway programmes; • European standardised methodologies and indicators to support the deployment and replication of care pathways and associated evaluation framework; • online specification for European initiative Service Specifications (if applicable).	Dec 2015	

B3 Action Area 6 – Patient / user empowerment, health education and health promotion			
Sub-objective / activities	**Specific deliverables**	**Timing**	**Milestones / Progress Indicators**

6-1 Support patients / users to actively participate and demand more responsive and integrated care programmes for chronic diseases.	**D6-1 Map of coaching, education or approaches** that support patient / user empowerment and improve patient adherence and compliance.	Dec 2013	M6-1 Increased availability of regional campaigns to improve patient / user / carer awareness about health education / promotion, care choices, opportunities, issues and services. M6-2 Tools for patient education and empowerment are based on advanced information and communication technologies (ICT) are more widely used.
	• **D6-2 Toolkit for patient empowerment and adherence** which covers: tools / practical tips for roll out and scale up of patient empowerment initiatives; • support for patient / user access to clinical / care records, and full participation in decision making relevant to their own health / care management; • patient / user advocacy in the form of training and facilitating patient / user representatives to participate in policy development / decision making bodies; • approaches to assessment and promotion of patients' ability to understand and adhere to self management plans, tailoring advice and support to the level of independence and health intelligence.	Dec 2015	

B3 Action Area 7 – Electronic Care Records / ICT / Teleservices			
Sub-objective / activities	**Specific deliverables**	**Timing**	**Milestones / Progress Indicators**
7.1 Highlight the potential of ICT / teleservices to underpin the delivery of integrated care and to realise service efficiencies / cost effectiveness.	**D7-1 Map of ICT solutions focusing on how services for chronic disease management or integrated care are being supported by eHealth infrastructure** including**:** • electronic care records; • electronic health records, personal health records;	Dec 2013	M7-1 Increased levels of integration of clinical and social data from multiple service providers and user-generated data. M7-2 Increased implementation of electronic consent and shared record capabilities.

B3 Action Area 7 – Electronic Care Records / ICT / Teleservices			
Sub-objective / activities	**Specific deliverables**	**Timing**	**Milestones / Progress Indicators**
	• electronic decision support templates which promote quality of referrals – supporting right patient, right place, right time; • outputs from European R & D (epSOS, Calliope); • common security processes, including identification, authentication, authorization and patient consent to deliver conformance to applicable legislation and guidelines; teleservices.		M7-3 Availability of functionality in Electronic Health / Care Record in order to: • enable citizens to interact with their health and social care professionals, record their own checks, receive health messages and access all health and social services; • support follow-up allowing communication and pro-active interventions. M7-4 Increased implementation of teleservices as part of Integrated Care Programmes.

7-2 Improve the effectiveness of health and social care ICT systems and data sharing by identifying solutions which improve interoperability between record systems and data sharing.	**D7-2 Toolkit for Electronic Care Records / ICT / Teleservices** to include**:**
	• approaches to managing:
	  • regulatory issues;
	  • security;
	  • privacy;
	  • liability;
	  • confidentiality;
	  • interoperability;
	• reductions of risk and time to market costs for industry;
	• model business cases to support implementation and scale up of teleservices;
	• European Initiative Service Specification for the development of personal digital health records for integrated care.
		Dec 2014	

B3 Action Area 8 – Finance, Funding, Value Creation and Procurement

Sub-objective / activities	Specific deliverables	Timing	Milestones / Progress Indicators
8-1 Align currently available and future finance and funding sources to facilitate shift towards integrated care.	**D8-1 Map of existing and future financial instruments** to include: • exploration of funding requirements and challenges for a Region / delivery organization implementing Integrated Care; • relevant sources of European / National / Regional / Private funding / Commercial funds; • description of what funds are for, how these align to integrated care programmes and decision making processes.	Dec 2013	M8-1 Increased funding sources and draw down by regions / delivery organisations of funds. M8-2 Innovative funding sources more accessible at local level for care services and industry to implement and develop innovative ICT solutions.

8-2 Identify approaches to procurement to support adoption of integrated care by more Regions.	**D8-2 Toolkit for Finances, Funding and Procurement Toolkit to include:**
	• diagnostic activities focusing on results of different approaches to funding and procurement / challenges identified from point of view of Regions and delivery organisations and also small and large business;
	• best practice;
	• tools / practical tips:
	  • how to define and access funds, covering European / National / Regional Funds / Private funding / Commercial;
	  • who to call for help;
	  • how to write successful funding applications.
		Dec 2018	

B3 Action Area 9 – Communication and Dissemination

Sub-objective / activities	Specific deliverables	Timing	Milestones / Progress Indicators
9-1 European Integrated Care Collaborative functions effectively and accountably for all members.	**D 9-1** An operational **Integrated Care Collaborative,** focused on promoting service improvement and the delivery of the B3 Action Plan.	February 2013	M9-1 Formal commitments to implement Action Plan activities received from existing and new members within the Collaborative to achieve B3 targets.
9-2 B3 activities are disseminated across EU regions and delivery organisations to: • encourage recruitment and retention of collaborative partners; • encourage regions and organisations in Europe to scale up the adoption of chronic care and integrated care programmes.	**D9-2 Mechanisms and tools to facilitate knowledge exchange** within and outwith the Integrated Care Collaborative e.g.- • website(s); webinars • seminars, conferences and workshops; • **co-ordinated campaigns** to disseminate the benefits of integrated care (via the success stories generated from other Action Areas); • publications**.** Dissemination activities to be linked with opportunities via existing organisations and networks.	Ongoing – 2013-2015	M9-2 Utilisation of networks and platforms for dissemination of best practice and knowledge.

4. MEASURING OUTCOMES AND PERFORMANCE

4.1 Monitoring and Evaluation Framework for the EIP on AHA

The measurement of the progress of the B3 Action Plan will be undertaken in line with the general monitoring and evaluation framework of the EIP. This is currently being developed by the European Commission and Joint Research Centre (JRC) in collaboration with experts and members of the six Action Groups. The monitoring process will be overseen by a group consisting of experts and two members of each Action Group.

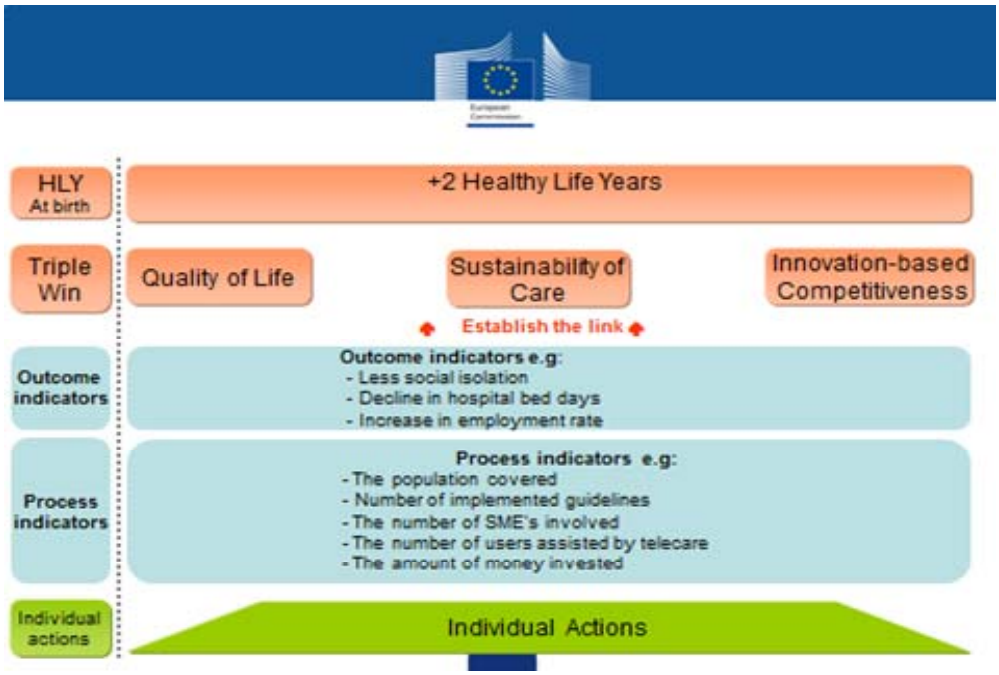
The monitoring process is divided into two steps. The first step will deal with the process of monitoring the EIP on AHA which will cover the following aspects:

- the involvement of stakeholders
- the creation of synergies
- knowledge transfer
- the adoption of innovation by health and care systems, and
- the added value for the participating organisations.

The second step is to monitor the outcome of the EIP on AHA. This will concern the activities and outcomes of the six Action Groups. It will address linkages to the overall target of the EIP on AHA:

- to add two healthy life years (HLY) to the average healthy life span of European citizens by 2020; and
- to ensure the triple win: improved Quality of Life, improved sustainability of care systems and improved innovation based competitiveness.

It is emphasised that this EIP on AHA Framework does not concern the evaluation of individual actions (i.e. B3 programme of work activities).



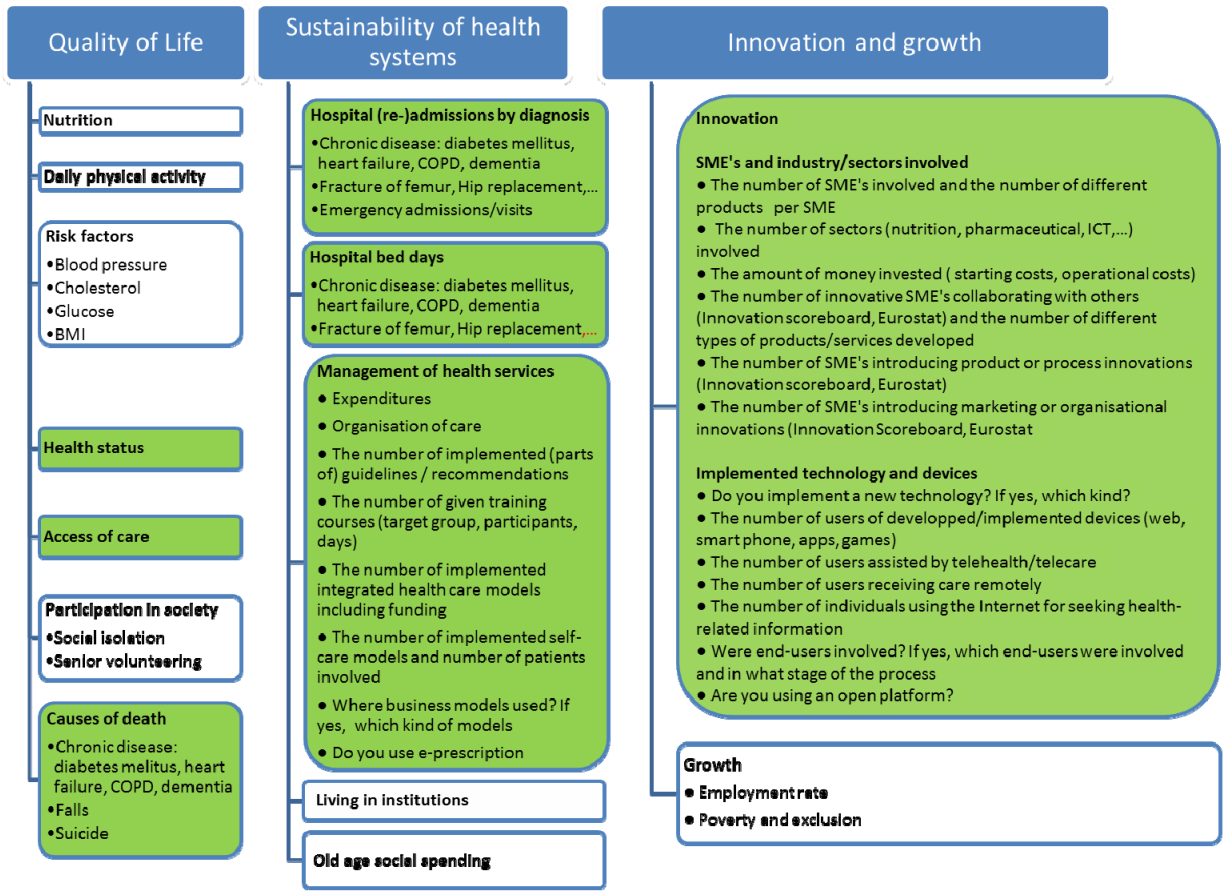
The monitoring framework consists of a set of outcome indicators for each of the six action groups based on the objectives of the Action Groups and on process indicators. The selection of

these indicators for the final draft of the monitoring framework has been an interactive process between the six Action Groups, the experts, EC and the JRC. More specific outcome indicators will be developed in close cooperation with the action group members.

The objective of the outcome indicators is to monitor the factors influencing the triple win, namely:

- the Quality of Life of patients/users , for instance, nutrition and physical activity;
- the sustainability of the health systems, for instance, are there less hospital admissions, is there a shift from cure to care;
- the innovation and growth possibilities, for instance, the employment rate.

Of course, not all Action Groups and all individual actions will contribute to all of the above mentioned factors. As such, the EIP on AHA Outcome Monitoring Framework consists of building blocks. For Action Group B3, the relevant building blocks are marked in green.



In addition to implementing the EIP on AHA Outcome Monitoring Framework, desk research will also be conducted.

4.2 Measurement Framework for the Action Plan

Measurement of the B3 Programme of Work will involve various levels of indicators:

- process indicators which will be used in the internal monitoring of the Programme of Work;

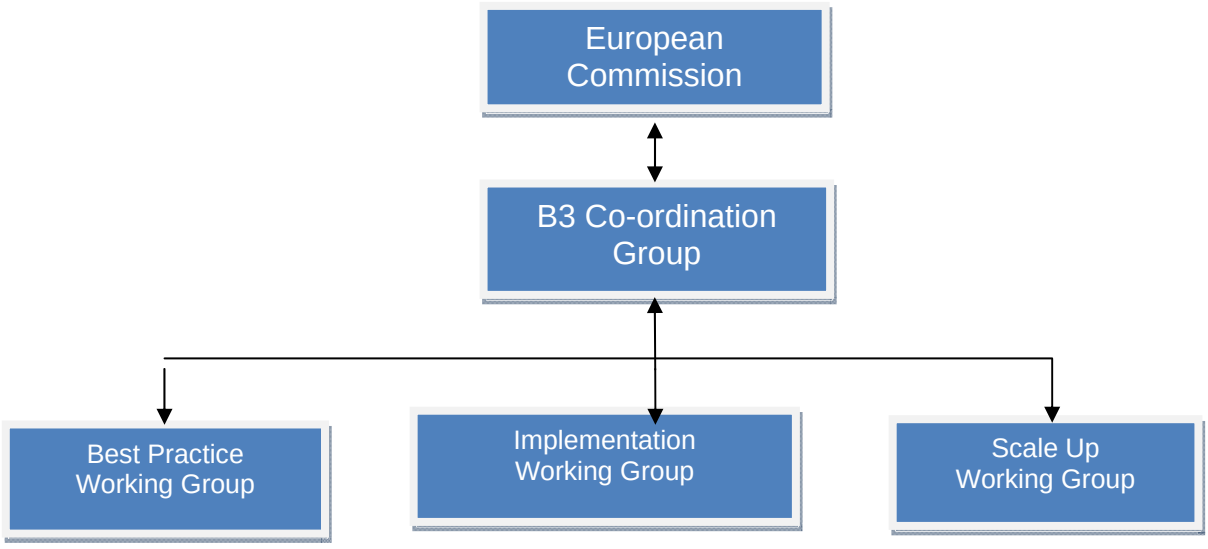
- indicators for the evaluation of effectiveness of the B3 Action Plan to the achievement SIP targets;
- the EIP on AHA Monitoring Framework.

The B3 Action Group proposes to set up a Working Group to agree on indicators that not only embrace health indicators, but also quality of life, sustainability of health and social care systems, carers burden, social inclusion, perceived quality of care, innovation and growth, etc.

5. GOVERNANCE

5.1 Structure prior to publication of Action Plan

The B3 Co-ordination Group adopted the following governance arrangements to ensure timely development of the B3 Action Plan by November 2012, in line with the expectations of the European Commission.



5.2 Roles and Responsibilities

B3 Co-ordination Group Chair

NHS 24 (The Scottish Centre for Telehealth and Telecare) agreed to lead, facilitate and co-ordinate the activities of the three B3 Working Groups by chairing the B3 Co-ordination Group from July 2012. NHS 24 committed dedicated support for Co-ordination Group activities.

B3 Co-ordination Group

The B3 Co-ordination Group agreed to be responsible for:

- the development of the B3 Action Plan, in consultation with the European Commission.
- ensuring that the views / input of all B3 Group members were reflected in the development and production of the Action Plan.
- leading, facilitating and co-ordinating the activities of the B3 Working Groups.

Co-ordination Group members

B3 Co-ordination Group members (co-ordinators) agreed to:

- support the development of the B3 Action Plan by delivering upon agreed individual actions.
- plan, direct and progress the activities of the B3 Working Groups, in accordance with Co-ordination Group decisions.
- actively contribute to the production of the draft and final B3 Action Plans.

5.3 Co-ordination Group Membership

Name	Organisation
George Crooks	NHS 24, **Scotland**, UK
Donna Henderson	NHS 24, **Scotland**, UK
Brian O'Connor	European Connected Health Alliance (ECHA)
Francesca Avolio	Regional Healthcare Agency of Puglia, **Italy**
Magdalene Rosenmoller	IESE Business School, Barcelona, **Spain**
Toni Dedeu	Ministry of Health of Catalonia, **Spain**
Jacqueline Bowman-Busato	European Platform for Patients' Organisations, Science and Industry (EPPOSI), **Belgium**
Christoph Westerteicher	Philips Healthcare, **Germany**
Esteban Keenoy	Basque Region, **Spain**
Jean Bousquet	Région Languedoc Roussillon, **France**

European Commission representatives (Loukianos Gatzoulis, Wojciech Dziworski and Andrew Ruck) also participated in Co-ordination Group.

5.4 Governance Structure – post November 2012

The Action Plan was developed by the Co-ordination Group and was adopted by the full Action Group on 17th October. It will be further reviewed at a European level and an opinion on the approach proposed is expected towards the end of 2012.

From June to November 2012, the Co-ordination Group and full Action Group have been considering the model for future work and associated governance model. In summary, it has been agreed that the proposed Collaborative would be an essentially voluntary grouping of independent organisations who committed to and saw benefit in pooling resources and collaborating for mutual gain.

On the assumption that the Action Plan is fully endorsed by all stakeholders, the proposed European Collaborative on Integrated Care will then come into being – see the B3 Memorandum of Understanding in *Appendix D*.

5.5 Resourcing the Action Plan

In developing the B3 Action Plan, the Action Group also considered the resourcing implications and requirements and proposes that it be delivered on the following basis:

- The Collaborative will seek funding, or support in kind, from the European Commission to support the administration of the Collaborative.
- Some funding for core activities of the Collaborative may be provided by the European Commission. However it is expected that Collaborative members will commit to absorb the costs incurred by members participating in Action Area working groups, and other such activities. Favoured ways of working will seek to minimise these costs as much as is practical by using electronic communication routes wherever possible.
- Co-ordination of the resources committed by the members of the Collaborative will be a core function of the Collaborative Governance structure, and it may be held accountable to the full members of the Collaborative, in line with the proposed Charter.
- The approach to accumulating the necessary resources to carry out activities within the Action Plan will be fully addressed post-November 2012 when the final Action Plan is approved.
- It is expected, however, that the overwhelming majority of resources required will be identified through commitment of resources by members active within the Collaborative. Related to this, it is anticipated that members of the Consortium involved in the delivery of a number of key Action Plan activities will be using existing or future European funding (for example, Horizon 2020). A number of B3 deliverables also have the potential to be eligible for projects, for example in the INTERREG or CIP Programme.

6. GAPS

The development process of the B3 Action Plan highlighted the following potential gaps:

- Research and evidence to support whole system change. However the formulation of suggestions by the Action Group for research and innovation priorities in the domain of integrated care for Horizon 2020 may provide opportunities to address these.
- Activities not being addressed within other EIP AHA Action Groups. Further work is required to align the proposed activities of all of the Action Groups to avoid duplication and, importantly, to identify and agree how to address gaps.
- Approach to be taken to other Action areas considered by the SIP to be less mature:
  - B1: Protocols, education and training programmes for health workforce (comprehensive case management, multi-morbidity, poly-pharmacy, frailty and remote monitoring)
  - B2: Multi-morbidity and R&D

7. REFERENCES AND BIBLIOGRAPHY

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2 Chart book created by the staff of: Improving Chronic Illness Care, At Group Health's MacColl Institute Supported by The Robert Wood Johnson Foundation Grant # 48769.

3 http://www.kingsfund.org.uk/topics/integrated-care/our-integrated-care-programme-work (accessed 09/10/2012).

4 Strategic Implementation Plan – Operational Part, p. 27-31 http://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/steering-group/operational_plan.pdf#view=fit&pagemode=none

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2. Operational Plan relating to 1 above, go to http://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/steering-group/operational_plan.pdf
3. Deliverable 1: EIP AHA: B3 Integrated Care: Analysis of the Expressions of Commitment submitted, June 2012, Consard Limited
4. Review of B3 Action Group Delta Questionnaire Responses, prepared by Andrew Ruck, Consard Limited and Donna Henderson, NHS 24, September 2012

ANNEXES (NOT INCLUDED IN THIS DOCUMENT)

→ Delta Questionnaire Analysis Summary - filed in Dropbox, go to - **https://www.dropbox.com/sh/b9t4wp8d9xbgh5x/tMTG2bMU-9**

APPENDICES

Appendix A – Acronyms and Glossary of Terms

AAL	Ambient Assisted Living
CIP	Competitiveness and Innovation Programme
COPD	Chronic Obstructive Pulmonary Disease
CVD (CVS)	Cardiovascular Disease (Cardiovascular)
EC	European Commission
EEC	European Economic Community
EIP on AHA	European Innovation Partnership on Active and Healthy Ageing
EP	European Parliament
EU	European Union
FP7	Seventh Framework Programme
GDP	Gross Domestic Product
HLY (HLYs)	Healthy Life Years
HTA	Health Technology Assessment
ICT	Information and Communications Technology
MS/MSs	Member State(s)
MSD	Musculoskeletal Disease
PSP	Policy Support Programme
R&D	Research and Development
SG	Steering Group
SIP	Strategic Implementation Plan
SME	Small and Medium Enterprise
UN	United Nations
WHO	World Health Organisation
YLD	Years Lived with Disability

Additionally, the following definitions of terms will be used for the purposes of B3 Action Plan activities and for measurement of performance against SIP targets (see Section 2.2. below):

Case Management: For the purposes of the first SIP target, the features of case management[2] are taken to include:

- Regularly assess disease control, adherence, and self-management status;
- Either adjust treatment or communicate need to primary care immediately.
- Provide self-management support;
- Provide more intense follow-up.
- Provide navigation through the health care process.

Chronic Diseases and Conditions / Long Term Conditions: are defined by the World Health Organization (WHO 2008) as those conditions requiring *"continuous management over a period of years or decades"* and require co-ordinated input from a wide range of health professionals. They include some communicable diseases, such as the human immunodeficiency virus and the acquired immunodeficiency syndrome (HIV / AIDS) that have been transformed by advances in medical science from rapidly progressive fatal conditions into controllable health problems, allowing those affected to live with them for many years (Nolte E & McKee M, 2008).

[2] (Source: Chart book created by the staff of: Improving Chronic Illness Care At Group Health's MacColl Institute, Supported by The Robert Wood Johnson Foundation Grant # 48769).

The B3 Action Group understands Chronic Diseases to be *heart disease, diabetes and COPD and asthma* and Chronic Conditions / Long Term Conditions which comprise of the diseases listed above and a range of other chronic conditions such as hypertension and osteoporosis, which require *"ongoing management over a period of years or decades".*

Integrated Care: The B3 Action Group interprets this as follows, in line with the 2008 WHO Definition: *"The management and delivery of health services so that citizens receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system."*

This definition has been complemented by a range of authors, studies and practice initiatives that consider social care systems and in particular the huge contribution of informal carers as decisive elements in achieving integrated care. Users with chronic conditions and long-term care needs are experiencing shortcomings and gaps in particular at the interfaces within and between health and social care delivery.

Kodner & Spreeuwenberg: 2002: *[Integrated care] is a coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sectors.*

This is why linkage, networking, co-ordination and integration across professional, organisational and sectorial boundaries become decisive elements to realise seamless care pathways, preventive approaches within long-term care and a better quality of life for frail older people with long-term conditions and their carers. In order to prevent avoidable hospital admissions they require multi-professional support in different settings, ideally based on a mutually agreed (single) geriatric assessment and care planning supported by case managers who are able to facilitate communication and the information flow between various stakeholders including patients / users, carers and professionals to ensure that care is co-ordinated around their needs and aspirations.

The goal of these methods and models is to enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients / users with complex, long-term problems cutting across multiple services, providers and settings. The result of such multi-pronged efforts to promote integration for the benefit of these special groups is called 'integrated care'.

Region: The Action Group notes the definition of Region in the Assembly of European Regions (AER Statutes). In principle the term "region" refers to a territorial authority existing at the level immediately below that of the central government, with its own political representation in the form of an elected regional assembly. This term differs from country to country. Various synonyms exist in Europe, independently of the level of competencies or autonomy.

For the EIP AHA B3 objectives, the term "region" will be applied to the *landers*, states, non-sovereign countries, provinces, nations, counties, autonomous communities, among others, if they have a political electoral regional assembly or parliament.

Target population: Health and social care systems differ widely: while most health systems are largely built around an acute, episodic model of care and disease-specific programmes some systems have started to design more comprehensive approaches to chronic care and long-term care in general. The models to improve care for frail older people with long-term conditions are as diverse as health and social care systems are different.

However for the purposes of achievement of the SIP target, the B3 Action Group identifies the target population as: *at least 10% of the population over 65 years old within a region with a one or more long term conditions*.

Appendix B - Links to EIP AHA Strategic Framework

Integrated care: the Care and Cure Pillar within the EIP AHA

The European Innovation Partnership on Active and Healthy Ageing aims to increase by 2 the average number of healthy life years in the EU by 2020, by securing a triple win for Europe:

- improving the health status and quality of life of European citizens, with a particular focus on older people;
- supporting the long-term sustainability and efficiency of health and social care systems;
- and enhancing the competitiveness of EU industry through an improved business environment providing the foundations for growth and expansion of new markets.

This Integrated Care Action Plan will make a contribution to this triple win and addresses the Priority Action Area referred to as B3: Capacity building and replicability of successful integrated care systems based on innovative tools and services, under 'Pillar 2: Care and Cure' (see the Strategic Implementation and Operational Plans of European Innovation Partnership Active and Health Ageing Operational Plan of November 2011).

It relates to the specific action Replicating and tutoring integrated care for chronic diseases, including remote monitoring at regional level as further described in that document, and scheduled for launch in 2012.

The other Priority Action Areas also mentioned under Pillar 2:

Protocols, education and training programmes for health workforce and carers (e.g. comprehensive case management, multi-morbidity, polypharmacy, frailty and remote monitoring). Multi-morbidity and R&D have not yet been addressed in the same way, but this could be a logical next step. In any event, this decision is not for this Action Group to take and is not explicitly addressed in this Action Plan.

Activities envisaged by the EIP AHA B3 Strategic Implementation Plan

The achievement of this objective was considered (as stated in the EIP AHA B3 Strategic Implementation Plan (SIP)) to be likely to involve:

- Rolling out structured programmes for chronic conditions/case management including remote management
- Piloting and establishment of integrated care models for multi-morbidities
- Financing the move from pilots into full deployment
- Compiling a map of stakeholders involved in operational and piloted services and building a stakeholder network
- Setting up multidisciplinary teams and developing comprehensive curricula for the care workforce
- Developing training/coaching programmes for end-users (care professionals, informal carers, patients) in the use of innovative solutions and raising awareness of their availability and benefits
- Mapping and collecting evidence on health and economic outcomes of integrated care models, in one repository
- Setting up an assessment mechanism - with accepted and validated indicators – for evaluation and analysis of good operational practices, including business models
- Identifying successful organisational models for integrated care, scalable and reproducible, and supporting their implementation in regions across the EU
- Defining and promoting new care pathways for patients as they migrate between social and health care providers

- Exploring the effectiveness of existing funding models and developing, where appropriate, alternative funding models
- Coaching of regions: between "pioneering regions" with successful operational models and "follower regions"

As will be seen elsewhere in this document, the activities considered and proposed by the B3 Action Group on Integrated Care do indeed address these and other activities.

Specific Conditions envisaged by the EIP AHA B3 Strategic Implementation Plan

The challenges to be addressed or 'specific conditions' were described as follows:

- Defragmentation of social and healthcare strategies and linking of social care and healthcare budgets, and financial transparency with (cost-sharing) models
- Joint definition of standards and guidelines for take up of standards, for interoperable systems and services in support of integrated care
- Co-financing of deployment of evidence-based integrated care implementing organisational changes and development of new business models and innovative incentive mechanisms.
- Clear organisational rules and responsibilities in relation to integrated care models, including remote management of chronic conditions.
- Clear legal framework to implement integrated care, including data protection and liability.
- Clear rules for procurement (including pre-commercial procurement and innovative approaches to procurement).
- Incentives' mechanisms, as an important prerequisite for payers or service providers to invest in integrated care/ chronic disease management.

The activities and deliverables proposed in this Action Plan are designed to deliver practical and effective approaches for the Regions and care delivery organisations, which are tackling these critical issues.

Appendix C - List of organisations committing to B3 Action Plan

Organisation	**Region**
Agencia Valenciana de Salud	**Spain**
Agenzia Socio Sanitaria Regionale, Emilia Romagna	**Italy**
Andalusian School of Public Health	**Spain**
ARESS, Piemonte	**Italy**
Assembly of European Regions (AER)	**France**
Católica Porto	**Portugal**
Centre for Health and Technology, University of Oulu	**Finland**
Centre for Health Informatics and Multiprofessional Education, University College London	**UK**
COCIR	**Belgium**
Cooperatie Slimmer Leven 2020	**Netherlands**
CORAL Network	**Belgium**
CSI-Piemonte (Consortium for Information Systems)	**Italy**
DEPARTAMENT DE SALUT – GENERALITAT DE CATALUNYA	**Spain**

Organisation	Region
Departamento de Salud Valencia-La Fe	**Spain**
Department of Health and Consumer Affairs of the Basque Government	**Spain**
Department of Health, Social Services and Public Safety, Northern Ireland	**UK**
Dipartimento Lavoro e Welfare Trento, Provinci Autonoma di Trento	**Italy**
Directorate of Integrated Care, Health and Social Care Board	**UK**
Dresden Technical University	**Germany**
Dutch Associated Health Insurance Companies	**Netherlands**
eHealth Unit, Sotiria Hospital, 1st RHA of Attica	**Greece**
EHTEL	**Belgium**
European Association on Vitality and Active Aging eVAA in GerontoLab Europe	**Germany**
European Centre for Social Welfare Policy and Research	**Austria**
European Connected Health Alliance (ECHAlliance)	**Ireland**
European Federation of IASP® Chapters (EFIC®)	**Belgium**
European Federation of Nurses Associations	**Belgium**
European Platform for Patients' Organisations, Science and Industry	**Belgium**
European Regional and Local Health Authorities (EUREGHA)	**Belgium**
European Wound Management Association (EWMA)	**Denmark**
Fondazione Bruno Kessler (FBK)	**Italy**
Fondazione Democenter-Sipe	**Italy**
Grunenthal Europe and Australia	**Germany**
Hôpital Charles-Foix AP-HP	**France**
Hospital Clinic - IDIBAPS	**Spain**
IESE Business School	**Spain**
IK4 Research Alliance	**Spain**
Institute of Health Carlos III	**Spain**
IRCCS, Salvatore Maugeri Foundation	**Italy**
Landstinget Sörmland	**Sweden**
Life Supporting Technologies – Universidad Politecnica de Madrid	**Spain**
Medical Delta	**Netherlands**
Municipality of Palaio Faliro	**Greece**
Mútua Terrassa	**Spain**
New Tools for Health	**Sweden**
NHS Confederation	**UK**
NHS Yorkshire and the Humber	**England**
Novartis	**Switzerland**
Operational Research Centre – Universidad Miguel Hernández de Elche	**Spain**

Organisation	Region
ParkinsonNet, Radboud University Nijmegen Medical Centre	**Netherlands**
Pain Alliance Europe	**Belgium**
Philips Healthcare	**Germany**
Polibienestar Research Institute. University of Valencia. (UVEG)	**Spain**
Région Languedoc Roussillon	**France**
Region North Denmark	**Denmark**
Region Saxony	**Germany**
Region Skåne	**Sweden**
Region Syddanmark (Region of Southern Denmark)	**Denmark**
Regional Healthcare Agency of Puglia	**Italy**
Regione Campania- Progetto Mattone Internazionale- Ufficio Commissariale Sanitario	**Italy**
Regione Campania, Ufficio di Coordinamento Commissariale; University of Salerno	**Italy**
Regione Liguria	**Italy**
Research Institute Incliva, University of Valencia. (UVEG)	**Spain**
Scottish Centre for Telehealth and Telecare, NHS 24, Scotland	**UK**
SERMAS-HOSPITAL UNIVERSITARIO DE GETAFE	**Spain**
Servicios de Teleasistencia S.A. (ST)	**Spain**
South Karelia Social and Health Care District	**Finland**
Spanish Collaborating Centre of the Joanna Briggs Institute - Institut et Haute Ecole de la Sante La Source - Lausanne	**Switzerland**
Spanish Collaborating Centre of the Joanna Briggs Institute (Nursing and Healthcare Research Unit)	**Spain**
The Public Health Authority in Galicia (Consellería de Sanidade)	**Spain**
TicSalut Foundation	**Spain**
University Hospital Olomouc	**Czech Republic**
University of Alicante	**Spain**
University of Valencia. (UVEG)	**Spain**
Welsh Local Government Association, Wales	**UK**
Zealand Denmark	**Denmark**

Appendix D – Memorandum of Understanding

European Integrated Care Collaborative

Memorandum of Understanding

EIP AHA: B3 Integrated Care

Preface

The B3 Action Group was established along with five similar groups to develop a response for Integrated Care to the challenges set by the Strategic Implementation Plan of the European Innovation Partnership for Healthy and Active Ageing.

With over 144 participants, today, it has been engaged over the summer and autumn of 2012 in developing an Action Plan to promote the integration of care as a key way of delivering the EIP objectives. This work has involved regions, delivery organisations, patient / user / carer organisations, academic institutions, industry and members organisations.

The Group has now delivered a realistic but challenging Action Plan designed to encourage, enthuse and inspire health and social care providers along with industry and academia to work with patients, service users and carers and collaborate to form partnerships to deliver innovative service redesign. This is based on a firm foundation of education and training, supported where safe and effective to do so by technology, but keeping the patient / user at the centre of all that we do.

Together these organisations now intend to take this initial collaboration further and thereby:

- encourage many more Regions to introduce Chronic Care Programmes;
- spread the availability of Integrated Care to significantly larger patient populations;
- make sure that the full potential of innovative technologies, tools and services is harnessed in these programmes.

This Memorandum of Understanding sets out the way in which those organisations with have already made commitments to delivering Integrated Care (as defined by the EIP on AHA) as well as new member organisations will organise themselves into a European Collaborative on Integrated Care to deliver the results described in the B3 Action Plan.

1. Introduction

Purpose of MOU

This Memorandum of Understanding sets out the way in which those organisations with have already made commitments to delivering Integrated Care (as defined by the EIP on AHA) as well as the new organisations the B3 Action Group hopes and expects to attract, will organise themselves into a proposed European Collaborative on Integrated Care so as to deliver the results described in the Action Plan.

The overall objective of this Action is stated in the European Innovation Partnership Active and Health Ageing Operational Plan of November 2011 as:

'Reducing avoidable/unnecessary hospitalisation of older people with chronic conditions, through the effective implementation of integrated care programmes and chronic disease management models that should ultimately contribute to the improved efficiency of health systems.'

The targets addressed by the Action Plan address the achievement of the following deliverables / targets:

By 2015: Availability of programmes for chronic conditions/case management (including remote management/monitoring) serving older people in at least 50 regions, available to at least 10% of the target population (patients affected by chronic diseases in the regions involved).

By 2015-2020: Based on validated, evidence-based cases, scale-up and replication of integrated care programmes serving older people, supported by innovative tools and services, in at least 20 regions in 15 Member States.

The Collaborative will do this by ensuring that care is safe, effective and places the patient and service users at the centre of all that we do.

The B3 Action Plan

Starting work in June 2012, the B3 Action Group has been working to identify key deliverables based on not simply existing knowledge and expertise available through the membership, but from insights gleaned from a 'Delta Questionnaire' completed by 27 delivery organisations, covering over 54 million European citizens with a budget of over 15 billion euros committed to managing the challenges of long term care.

The Co-ordination Group considered the results of the Delta Questionnaire and then developed a 'Comprehensive Programme of Work' (as further described in the Action Plan). This Plan has been designed to be capable of addressing all the issues faced by Regions and on which the Action Group might in principle have an impact. It would thus help Regions and delivery organisations decide to implement Integrated Care, make it accessible to wider populations and to use innovative tools and services. Priority activities, deliverables and milestones were selected on two main criteria:

- the biggest potential impact on the targets
- the level of commitment of members of the emerging Collaborative to the activity proposed, the level of resources available and a willingness to share to mutual benefit.

It is anticipated that additional activities will be implemented over time, as new opportunities, resources and capacity arises.

Calls for Commitment

The European Commission launched a Call for Expressions of Commitment to Action Area B3 (Integrated Care), which closed on 31st May 2012. A total of seventy (70) submissions were received.

Of the organisations submitting commitments, 67 organisations were invited to attend the first Action Group Meeting held in Brussels on 19th and 20th June 2012.

From June until November 2012, the Action Group adopted the governance approach described in *Section 2.1*.

2. Governance

Governance Structure – post November 2012

The Action Plan was developed by the Co-ordination Group and was subject to review by the full Action Group on 17th October 2012. It will be further reviewed at a European level and an opinion on the approach proposed is expected towards the end of 2012.

From June to November 2012, the Co-ordination Group and full Action Group have been considering the model for future work and associated governance model. In summary, it has been agreed that the proposed Collaborative would be an essentially voluntary grouping of independent organisations who committed to and saw benefit in pooling resources and collaborating for mutual benefit.

On the assumption that the Action Plan is fully endorsed by all stakeholders, the proposed European Collaborative on Integrated Care will then come into being.

Principles and approach of the Collaborative

In proposing to form a European Collaborative for Integrated Care, the Action Group took into account the evidence base (see *References*) for the success of this sort of collaborative approach.

At the meeting of the Co-ordinating Group for the B3 Action on Integrated Care held in Brussels on 20th September and subsequently supported the full Action Group meeting held in Brussels on 17th October, the following principles and approach to underpin this Memorandum of Understanding were met with support.

The current B3 Action Group will evolve into the **European Collaborative for Integrated Care**, and on the following basis:

- The Collaborative aspires to be key to delivery of the Strategic Implementation Plan (SIP) of the European innovation Partnership on Healthy and Active Ageing;
- It adopts the targets of the Action Group (see *Section 1.1* above);
- The leadership of the Collaborative aspires to be fully accountable to the Membership;
- It will secure further commitments from Regions, delivery organisations and other stakeholders and encourage new participants to join the Collaborative.

The Collaborative expects the following principles to underpin its work:

- This will be a new way of doing business at a European level to achieve significant results locally: the focus will be on delivery and outcomes;
- It will involve ‘co-production’ with other committed partners: legal and organisational complexities will be minimised;
- Champions will be identified and supported and we expect to celebrate differences, not aim for a ‘one size fits all’ approach;

- The work agenda will be handled flexibly since evolution and changing priorities are to be expected – activities undertaken will need to add value for the EIP on AHA, and also the members of the Collaborative;
- The business of the Collaborative will be handled in an inclusive and transparent manner. All information will be in the public domain.

Why participate in the Collaborative?

This is not primarily a marketing document designed to attract new members (this will follow), however the Action Group has considered the potential reasons for joining from the perspective of Regions and care delivery organisations as well as other organisations involved in the Integrated Care agenda.

What's in it for delivery organisations?

- → Maximising on lessons learned from real deployment experiences and emerging from funded European projects;
- → Networking and peer collaboration;
- → Practical support with problem areas;
- → Raised awareness about how to access new funding streams and partners.

What's in it for supporting organisations?

- → Opportunity to influence European agenda – e.g. Horizon 2020 specification;
- → Direct contact with leading delivery organisations;
- → Opportunities for true collaboration;
- → Establish a critical mass for implementation and scale up of integrated care;
- → Industry: potential to input to regulatory discussions and guidelines, and to shape the evolving approach to releasing new investments to support EIP on AHA aspirations.

Working within the Collaborative

A small central Co-ordination Group is envisaged which will apply key tests to all proposals for collaborative activities:

- Is this a talking shop? (if yes, rethink)
- Is there a robust proposition for action?
- Is there a worked through rationale for delivery?

Action Area activities will be progressed within working parties set up on a time limited basis and tasked with delivering on agreed collaborative priorities.

The Collaborative expects to make full use of virtual collaborations tools, but an annual get together / network development event is also envisaged.

Links to existing related networks, including the International Foundation for Integrated Care (IFIC), will be established and fully utilised to facilitate Collaborative communication, dissemination and networking activities.

Resourcing Collaborative Activities

In developing its approach to the planned European Collaborative for Integrated Care, the Action Group also considered the resourcing implications and requirements and proposes that the Collaborative be established on the following basis:

- → The Collaborative will seek funding, or support in kind, to support the administration of the Collaborative from the European Commission.
- → Some funding opportunities for core activities of the Collaborative can be provided by the European Commission in the framework of its financial existing instruments: FP7/Horizon 2020, Public Health Programme, Competitiveness and Innovation Programme (CIP), Structural Funds/Common Cohesion Framework 2014-2020 allocating funding for priorities of the EIP on AHA. However it is expected that Collaborative members will commit to absorb the costs incurred by members participating in working groups, and other such activities. Favoured ways of working will seek to minimise these costs as much as is practical by using electronic communication routes wherever possible.
- → Co-ordination of the resources committed by the members of the Collaborative will be a core function of the Collaborative Governance structure, and it should be accountable for doing this in line with the Charter, to the full members of the Collaborative.

3. Charter

3.1 Developing a Charter

The Charter is currently conceived as a document which will guide the activities of the members of the Consortium and to which they will explicitly agree.

Until the Action Plan of the B3 Action Group has been endorsed by the competent European Authorities and other stakeholders within the Action Group and outside, it does not make sense to finalise the Charter.

Since the Collaborative will be an essentially voluntary activity for those involved, the Charter will not be a legal document. It will, however, set the terms of engagement between the organisations which become members of the Collaborative, its governance structures and other external organisations and interested parties. It will be designed to set out what expectations the Collaborative will have of its members and what members will expect of the Collaborative.

The intention is to finalise the Charter following the endorsement of the Action Plan of the B3 Action Group and also this Memorandum of Understanding.

3.2 Purposes of the Charter

- To outline the key objectives of the Collaborative, which may be expressed in relation to:
  - Improving patient / user experience;
  - Supporting informal carers;
  - Delivering safe, effective and person centred services;
  - Delivering sustainability;
  - Producing economic benefit;
  - Supporting local service change and innovation;
  - Releasing new resources and up-scaling capabilities.
- To establish the terms of engagement between members of the Collaborative and Collaborative Governance structures, especially with the principles guiding and approach to working within the Collaborative and especially with respect to resourcing;
- To outline the governance arrangements for the Collaborative which members are asked to work within;
- To make the link between the overall objective of the EIP on AHA for integrated care and the targets adopted within the B3 Action Plan and the activities of the Collaborative;
- To make the link between activities to be carried out within the Collaborative and the activities, deliverables, milestones and outcomes as outlined in the B3 Action Plan;

- To establish the working methods of the Collaborative and behaviours expected of members of the collaborative.

4. Membership Responsibilities

When the Collaborative is launched, existing members of the B3 Action Group and new members of the Collaborative would be asked to commit as follows:

Collaborative members will:

- Commit to help deliver the Integrated Care Action Plan.
- Have completed and agreed to share their responses to the Delta questionnaire.
- Have committed named resources to function within the Collaborative and agree to support relevant named activities (i.e. within the B3 Action Plan).
- Agree to be work within and provide feed-back on Collaborative activity undertaken, in line with Action Plan.
- Confirm that they will observe the terms of the Charter.
- Agree to be bound by the Governance approach set out in the Charter.
- Agree to contribute to the development of a Communications Strategy to share the workings of the Collaborative with a wider audience, with the intention of sharing knowledge and practice on integrated care and by so doing attract new members and contribute to the achievement of the B3 Action Plan targets.

Process for Committing to the Collaborative

Once more the approach is to be finalised following endorsement of the Action Plan, however it is currently expected that membership will be open to any organisation based in an EU Member States, and also within countries which have collaborations in place with the European Union.

A web presence with downloadable joining instructions will be established. Interested organisations / regions will decide if they wish to be to become a member of the Collaborative.

The organisation / region will have to complete required documentation and their completed documentation will then be considered by the Governance structure of European Integrated Care Collaborative. The Secretary of the European Integrated Care Collaborative will confirm membership, if the organisation / region is considered eligible to join.

The organisation / region can then start working within the Collaborative.

References

Evidence base for Collaborative Model

1. Long Term Conditions Collaborative Programme Handbook, NHS Scotland
2. Collaborative "Must Haves": What It Takes to Run a Great Breakthrough Series Style Collaborative, Institute for Healthcare Improvement: Sandy Murray, MA, Marie W. Schall, MA.