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VIGOUR

Evidence-based Guidance to Scale-up Integrated Care in Europe

Lessons Learned from the Project Methodology for Care Planners and Practitioners

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Content

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1 Introduction

Integrated Care is a way of working collaboratively, between a range of health, social care and support organisations, to help improve people's health and wellbeing. The organisations involved work together in a partnership, sometimes sharing budgets, staff and other resources where appropriate, to best meet people's needs and preferences. The VIGOUR project, co-funded by the European Union's Health Programme, supported 15 care organisations in regions across Europe to take the next step on their path towards better integrated care delivery. A common methodology was developed and applied for better joining-up existing health care delivery processes. This document summarises key lessons learned from applying this methodology in 15 European regions.

This starts with a brief overview of the VIGOUR project's approach and outcomes presented in the following Chapter 2. Next, Chapter 3 provides guidance on how the VIGOUR methodology may be used by others, based on lessons learned by the project participants. This is followed by a concise set of recommendations, presented Chapter 4. Moreover, several instruments developed and applied in the VIGOUR project are annexed to the main document.

As the VIGOUR project has shown, the methodology presented here is in principle suitable for application in different health care ecosystems. It is hoped that this document will encourage readers to consider possible steps towards better integrated health care in their own settings, relying on the VIGOUR methodology where appropriate. For reasons of readability, the present document is limited to a condensed presentation of the experience gained within the project. Further details on the VIGOUR project and its outcomes can be found on the dedicated website (www.vigour-integratedcare.eu). This document is part of a series of 3 that VIGOUR project has created for future usage:

- Lessons learned for care planners and practitioners
- Decalogue for scaling up integrated care for decision makers
- Policy brief for policy makers

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2 The VIGOUR project in a nutshell

What VIGOUR means by integrated care

The debate about integrated care is anything else but new. The call for better joined-up service delivery, for example to older persons living with chronic conditions, traces back as far as into the 1950s.[1] Today, practitioners and researchers largely agree that integrated, patient-centred service delivery promises great benefits. Often referred to as "quadruple aim", integrated care aims at improving patient experience, outcomes of care, effectiveness of health systems and healthcare workforce experience. At least in theory, all this can be achieved through continuity and coordination of care services.

However, the practical implementation of integrated care seems to be far less widespread than one would expect given the benefits generally associated with it. Although examples of integrated care can be found in several countries, the reality for most patients is still care delivered through uncoordinated "islands of excellence".[2] There is much evidence to suggest that integrated care is unlikely to evolve as a natural response to emerging care needs in any system of care whether it is planned, or market driven. The reasons for this are complex and not easy to grasp. The absence of a unifying definition has for instance hampered the development of a common understanding of what integrated care is or should be about.[3] The World Health Organisation has for example concluded from a global review of integrated care schemes that, while it has been possible to identify general principles and core components, it cannot be stated that one model best supports all the integrated care efforts.[4]

Against this background, the VIGOUR project adopted a gradual concept of integrated care as graphically summarised by Figure 1 overleaf. In practice, different types of integration can help in better joining up hitherto disconnected care delivery processes around the needs of the patient. For example, systematically interlinking different services providers by the mere sharing of patient related information can help individual stakeholders make better decisions about the care to be provided, even if no common care pathway has been agreed. The latter typically requires a higher level of care coordination, e. g. in terms of multi-disciplinary protocols.

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[1] Burney, L. E. (1954). Community Organization - An Effective Tool. American Journal of Public Health, 44(1), 1–6. (p.6)

[2] Rigby, M., Koch, S., Keeling, D., Hill, P., Alonso, A., & Maeckelberghe, E. (2013). Developing a New Understanding of Enabling Health and Wellbeing in Europe - Harmonising Health and Social Care Delivery and Informatics Support to Ensure Holistic Care. Paper presented at the Standing Committee for the Social Sciences. London, UK. (p.42)

[3] A literature review conducted in 2009 uncovered for example some 175 overlapping definitions and concepts of integrated care, indicating the absence of consensus in its definition. See Armitage GD, Suter E, Oelke ND, Adair CE. Health systems integration: state of the evidence. Int J Integr Care. 2009;9(2).

[4] WHO Regional Office for Europe: Integrated care models: an overview. Health Services Delivery Programme, Division of Health Systems and Public Health, Working Document, 2016

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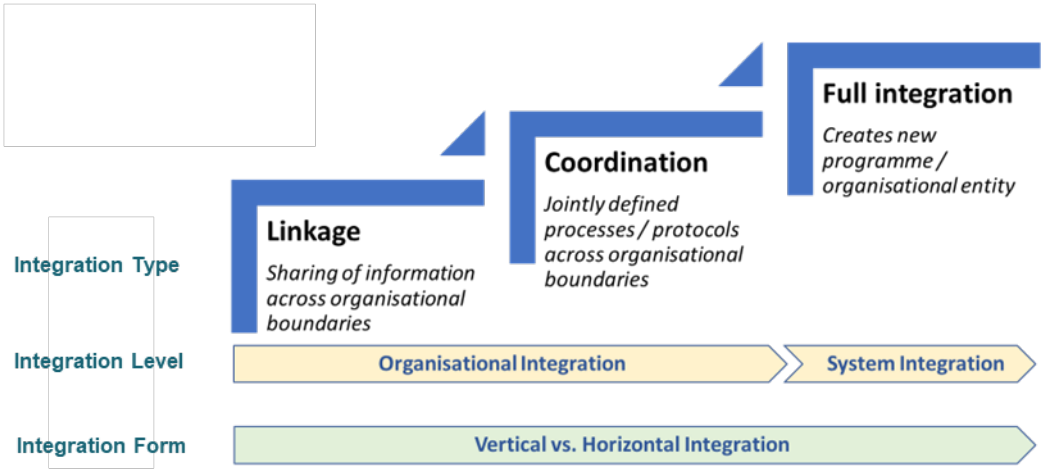
Figure 1 – Integrated care as a multi-layered concept



Source: VIGOUR adapted from McAdam 2008

In general, care integration efforts that are directed towards the mere informational linkage of existing services or towards interdisciplinary care coordination tend to aim at making existing organisational boundaries more permeable (organisational integration).[5] In contrast, fully integrated care schemes tend to aim at eliminating such boundaries entirely, for example by setting up new organisational entities or units (full integration). Independently of this, integrated care can either take place within the health care system, for example between general practitioners and specialists treating the same patient (vertical integration), or it can take place across the boundaries of the health care system, for example when social service providers are involved in addition to health care providers (horizontal integration).

How VIGOUR helped to put integrated care into practice

Earlier experiences made with the implementation of integrated care schemes under everyday conditions suggest that any integrated care model development is strongly context-bound and nearly impossible to replicate.[6] There is a strong process element to the implementation of integrated care, e. g. when it comes to enabling stakeholders in different care settings or sectors to work together. On a case-by-case basis, such processes can ultimately take very different forms depending on the given implementation conditions. Also, the care authorities participating in the VIGOUR project did not start from the scratch. Most were able to build on previous efforts to better align care delivery towards people with chronic or other conditions across the care chain, albeit in different ways and to different degrees.

[5] See MacAdam, M.. Frameworks of Integrated Care for the Elderly: A Systematic Review. CPRN, 2008.

[6] WHO Regional Office for Europe: Integrated care models: an overview. Health Services Delivery Programme, Division of Health Systems and Public Health, Working Document, 2016

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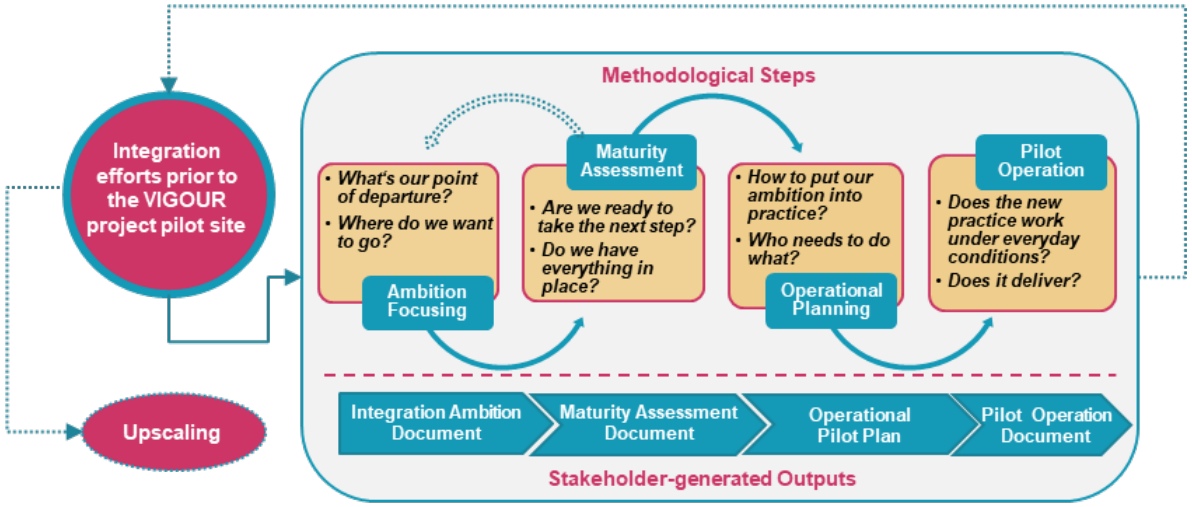
Against this background, the VIGOUR project was not designed to transfer certain models of integrated care that were successfully implemented elsewhere to the VIGOUR regions. Rather, the project was intended to support participating health authorities in initiating an incremental innovation process to take the next step on their own path towards integrated care. In this sense, these were picked up from where they were at the beginning of the project and supported in gradually improving the current level of health care interaction. To this end, they went through a multi-staged process of defining and piloting better integrated care practices within existing health care eco-systems (Figure 2). A common methodology was developed to support the care authorities in this process, considering a wide range of patient needs, legacy processes, and digital support infrastructures.

Figure 2 – The VIGOUR innovation process



Source: VIGOUR

Considering prevailing implementation conditions and existing care practices, each care authority first consolidated its initial view on how to better integrate existing care processes (Ambition Focusing). This was followed by a systematic self-assessment of the envisaged integration approach with respect to its appropriateness and feasibility under given framework conditions (Maturity Assessment). Often, the results required a critical review of the originally envisaged care integration approach, e. g. when serious implementation barriers not previously considered were identified at this stage. Next, an operational implementation plan (Operational Planning) was developed as basis for piloting the hitherto developed care integration approach under everyday conditions, with a view to preparing further upscaling. Existing knowledge available from published sources of information was consolidated and fed into the innovation process in terms of thematic workshops. Also, mutual learning and knowledge exchange was facilitated by means of structured twinning activities.

Integration strategies pursued by the VIGOUR participants

As a result of the context-driven methodological approach adopted for the purposes of the VIGOUR project, different integration strategies were pursued by the participating care authorities. All in all, four strategic approaches towards better integrating existing care delivery practices can be discerned (Figure 3). Some of the VIGOUR regions focused on better coordinating care delivery to certain patient groups through multi-disciplinary care teams. Others put the emphasis on the coordination of remote patient management with help of digital care platforms. Another integration strategy concerned the linkage of health care services with social services typically provided outside the health care system. Finally, some care authorities followed an integration strategy that aimed to link health care services with preventative wellbeing services available in the community, some of which are provided by voluntary organisations.

Figure 3 – Integration strategies supported by VIGOUR

Source: VIGOUR

In detail, however, the integration approaches pursued in each case differ considerably. This concerns, among other things, the patient groups addressed, the stakeholders involved, the workflows developed, and the digital infrastructures and tools used.

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3 Lessons learned - How you can use the VIGOUR methodology for own purposes

The deployment of integrated care practices represents a multi-dimensional challenge. It should be considered as a continuous process of change and adaptation that can take different forms. VIGOUR lessons derive from the experience of implementing scaling up of integrated care pilots in 16 different public health provider organizations. In view of the diverse framework conditions within which integrated care service delivery occurs in different countries and regions, the service integration strategy pursued needs to be flexible both in terms of service process and in terms of supportive technology. A non-contextual, normative approach would be extremely risky. Wholesale migration poses major budgetary problems for service providers and introduces risks in terms of system delivery and potential loss of service continuity. To avoid these risks, the VIGOUR methodology supports incremental, controlled migration from existing work practices and technologies (Figure 2). In particular, the controlled migration process towards newly integrated care practices should be prepared by means of four subsequent work steps as follows:

1. *Ambition focusing*: The first step puts the focus on making sure that all stakeholders share the same vision when it comes to migrating from current practices towards a better joined up care delivery model.
2. *Maturity assessment*:
   Once a joint vision for better integrating current practices has been agreed among all local stakeholders, the next step focuses on assessing the appropriateness and feasibility of this vision under day-to-day conditions.
3. *Operational implementation planning*: This work step aims at translating the outcomes of the previous work into an operational plan setting out how and when exactly the different steps of the envisaged integration are to be put into practice.
4. *Pilot operation*: Prior to a wider roll-out of the new care delivery approach, it should be piloted under every-day-conditions involving a confined set of participants and/or in a confined geographic area.

In the following subsections, further guidance is presented on how each of these preparatory steps may best be put into practice.

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3.1 Ambition Focusing

What this step generally should be about

What's our point of departure?

Where do we want to go?

The transformation of existing health care practices requires a joint effort by all stakeholders concerned. This effort should be guided by a joint vision to make sure that all stakeholders share the same understanding of the envisaged transformation process and what the goal of this process should ultimately be. In essence, the joint vision should include not only to express an initial idea on which existing care delivery processes should be better integrated, but also on how this might best be achieved, and any benefits envisaged to flow from better joined-up care delivery processes to the different stakeholders involved. It should not be assumed that a common understanding of this will emerge almost automatically. Of particular importance is a thorough understanding of the factors that have shaped and may continue to shape the initial status of the organization. Based on this, initial priorities for effective integration measures can be drawn up by care planners and practitioners for review before being proposed to relevant decision-makers. The need to prioritise at local level is clear. Health and social care systems across European regions are very diverse in organizational, financial, and legal terms. The integrated care configuration that would best suit a particular local situation differs in consequence.

What this step should include in particular

Alongside clinical, technical, and organisational issues, a set of factors continuing to shape the system is constituted by the particular interests of various stakeholders. Many groups have different stakes in the methods, process, organisation and financing of care delivery in each health care system. Differences of perspective and possibly of economic interest between stakeholder groups are particularly likely where joined up care delivery crosses traditional organisational process or system boundaries. If the perspective of one or more groups setting integration priorities may not fully align with the perspective of other stakeholders, the latter would then not share the necessary sense of urgency to change and potentially not carry out necessary actions in the expected time. This will particularly apply where stakeholders benefit from maintaining the status quo. A response can be to attempt to compensate them for losses faced in change.

It is important that the different stakeholders involved in this consensus building process share a "common language" on what they are generally striving for and – not less important – what their individual point of departure is when attempting to better align care delivery processes in concrete care settings. The taxonomy of different "types", "levels" and "forms" of integration presented earlier in Figure 1 can for instance be used in a pragmatic manner to facilitate a "common language". By providing a generic vocabulary at the conceptual level, in VIGOUR it proved useful across varying health care systems and care settings.

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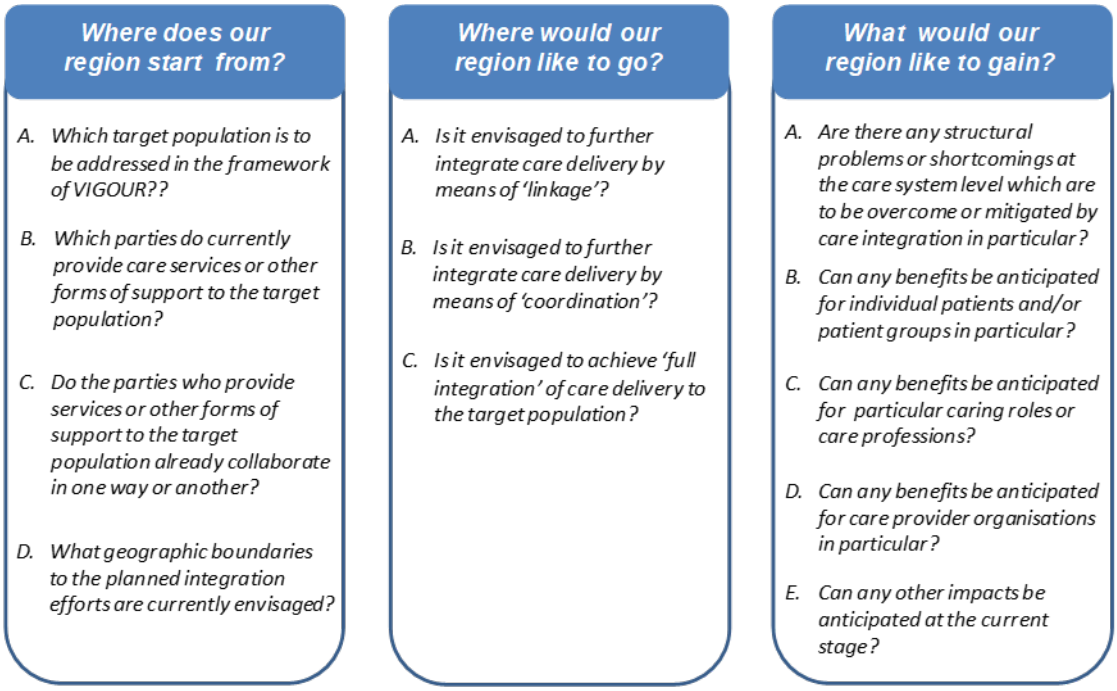
Also, digital technologies have frequently been ascribed the role of catalyst for change towards better joined-up care delivery. However, by simply adding ICT to current care practices one will most likely not end up with better care. Rather, a multi-pronged innovation approach needs to be pursued, one that simultaneously pays attention to the different stakeholders involved, to the working models and workflows of service providers affected and to the technologies to be deployed.

Figure 4 - Key questions to guide the joint development of an initial ambition statement by the stakeholders to be involved



Source: VIGOUR

Against this background, a set of key questions has proved useful in the VIGOUR project to guide the different concerned stakeholders in jointly reflecting on what they are striving for. As summarised by Figure 5, the first set of questions aims primarily at elaborating a common view among all stakeholders on what exactly are the main "pain points" that should be addressed by better integrating existing care delivery processes, and on which existing care delivery practices need to be changed in this context (Where does our region start?). The second set of guiding questions aims at arriving at a shared view on how progress might best be achievable under given framework conditioners (Where would our region like to go?). Here it has turned out as beneficial in VIGOUR to encourage the stakeholders participating in the joint reflection process to think about these questions with different time horizons in mind, e. g. from short-term and a long-term perspective. The final set of guiding questions aims to help arriving at a common view among the stakeholders concerned on what tangible benefits should be finally achievable by means of the envisaged care integration approach (What would our region like to gain?). The views on the goals that should be achieved and/or whether priority should be given to certain goals - and expected benefits potentially related to these goals - may well vary across the stakeholders involved.

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All stakeholders should eventually agree on a common position along the guiding questions which they can credibly represent to third parties, both inside and outside their own organisation or unit. Although this initial vision may undergo further detailing and/or revisions throughout the further planning process, it should be set out in writing to serve as a reference document to all stakeholders involved. For the purposes of the VIGOUR project, the participating care authorities were for example provided with a template to document the outcomes of the stakeholder discussions in a common format along the guiding questions presented in Figure 5 (see Annex I).

3.2 Maturity assessment

What this step generally should be about

Are we ready to take the next step?

Do we have everything in place ?

This preparatory work step focuses on a critical appraisal of the initially stated integration ambition as set out in a written ambition statement. Aspects that might make it difficult or perhaps even impossible to put the currently stated ambition into practice should receive particular attention in this context. Depending on existing framework conditions, a range of quite different factors may potentially impede the successful implementation of the jointly developed ambition. Equally, diverse supportive capacities may potentially be available for putting the currently envisaged care integration approach into practice, albeit these may not yet have been considered in a systematic way. Therefore, the stakeholders involved should “take a step back” and reflect in a systematic manner on whether the practical implementation of the initially envisaged integration approach seems indeed appropriate and feasible under existing framework conditions.

What this step should include in particular

It is worth noticing that the maturity assessment approach developed for the purposes of VIGOUR does not aim at assessing the level of integration achieved in relation to the health system in general. Also, it does not aim at enabling a comparison of the levels of integration different regions or countries may have reached according to a set of common indicators or quantitative scores. Rather, it is intended to support the stake holders involved jointly in preparing the hands-on implementation of specific activities for better joining up currently prevailing health care delivery processes around the patients' needs. To this end, VIGOUR developed a two-staged assessment approach as graphically summarised by Figure 6 overleaf. In a nutshell, the results of a SWOT analysis to be conducted in a first step are then to be assessed in a systematic manner with respect to possible implications for development of a fully operational pilot scheme to be implemented for testing the envisaged integration approach under day-to-day

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conditions. Both steps should be conducted by means of focus groups involving all stakeholders concerned.

A SWOT analysis is an analytical method suitable for evaluating strengths, weaknesses, opportunities, and threats of the envisaged care integration approach. This method considers so-called internal and external factors that can influence the planned implementation under day-to-day conditions. As summarized in Table 1, strengths and weaknesses are regarded as internal factors while opportunities and threats are regarded as external factors.

Table 1 – Overview of key elements of a SWOT analysis

1 INTERNAL FACTORS fall within the scope and control of the envisaged integrated care pilot scheme	1a	STRENGTHS are understood as characteristics of the envisaged integration approach that give it an advantage over other options potentially under consideration. Certain STRENGTHS can sometimes be used to address certain WEAKNESSES.
	1b	WEAKNESSES are understood as characteristics of the envisaged integration approach that place it at a disadvantage relative to other options potentially under consideration.
2 EXTERNAL FACTORS are conditions that are outside the direct control of the envisaged integrated care pilot scheme	2a	OPPORTUNITIES are understood as factors that may facilitate the implementation of the envisaged integration approach.
	2b	THREATS are understood as factors that may stand in the way of the practical implementation of the intended integration approach.

Source: VIGOUR

As can be seen from Figure 6 overleaf, the initial Ambition Statement should be assessed in relation to four core dimensions:[7]

1. the target population to be addressed by the envisaged integration approach.
2. the service intervention to be integrated,
3. the information system design to be utilized to support integrated service delivery,
4. and the funding and political support of the envisaged service integration.

[7] For the purposes of VIGOUR, these assessment dimensions were derived from an broader assessment framework developed by the SCIROCCO project. See: xxx ref

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Figure 5 – Summary of the VIGOUR maturity assessment approach

Source: VIGOUR

For each assessment dimension two analytical steps should be performed as follows:

a. **STEP I: Perform a SWOT analysis of the Initial Ambition Statement**

The integration ambition should be assessed in relation to both, internal and external factors. For each assessment dimension strengths and weaknesses of the envisaged care integration approach should be identified (internal factors). Moreover, conditions that are outside the direct control of the envisaged pilot scheme should be identified which potentially facilitate or hinder the implementation of the current integration ambition under day-to-day conditions (external factors).

b) **STEP II: Assess practically implications of SWOT results for the planned pilot scheme**

The results of the SWOT analysis should be assessed in relation to possible implications for operationally implementing a fully up-and-running pilot scheme to test the envisaged integration approach under day-to-day conditions. Here, different aspects deserve attention:

- Can any issues be identified that may make it difficult or even impossible to put the integration ambition into practice under day-to-day conditions?
- Should such "roadblocks" indeed be identifiable at the current stage, are there any options available for successfully addressing them?
- Equally to barriers, can any capacities be identified potentially supporting the implementation of the integration ambition under day-to-day conditions?
- If so, are there any options available for practically exploiting them under day-to-day condition?

- All in all, when could a pilot scheme be considered as a success within existing framework conditions?
- Are there any specific indicators that could be used to monitor the success of the envisaged integration efforts within existing framework conditions in qualitative and/or quantitative terms?

For the purposes of the VIGOUR project, a common reporting template was developed to document the outcomes of this assessment process. The template also provided some further explanations on each of the assessment dimensions and on how they should be assessed in the context of a SWOT analysis. A generalised version of the template can be found in Annex II

3.3 Operational pilot planning

What this step generally should be about

How to put our ambition into practice?

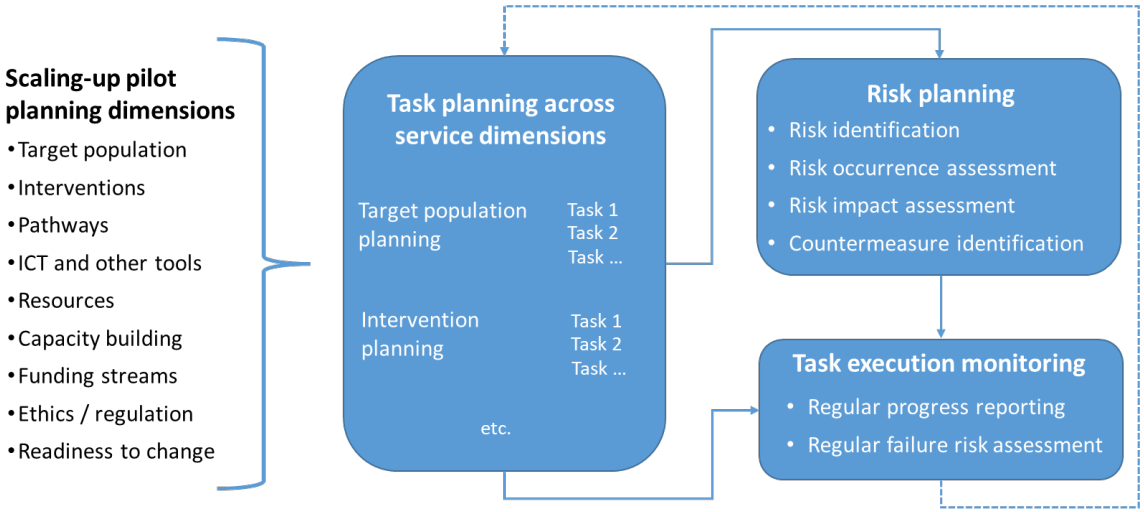
Who needs to do what?

The results of the maturity assessment should be used to critically appraise the initially stated integration priorities and the level of integration envisaged to be realised. In this context, a care authority can also rely on the solid understanding gained in the initial ambition focussing exercise of where it is coming from, and of the factors which have shaped developments so far and are expected to continue to shape the system. Taking all these aspects into account, a concrete plan should be established on how to put the envisaged integration approach into practice. This will typically concern elements such as target populations, organisations, pathways, ICT infrastructures / tools to be involved, resources to be allocated and other elements.

What this step should include in particular

A plan of change to integrated care, to be successful, must address the needs and wishes of all key stakeholder groups, obtain their buy-in, and instil in those who need to become active an appropriate sense of urgency. Consensus on urgency is particularly important to ensure that integration priority targets are met, and success is maintained in the long run. Once consensus has been achieved among all stakeholders concerned, they should agree an operational plan setting out how the planned integration approach is to be piloted under day-to-day conditions. In this context, different core planning dimensions should deserve attention, as graphically summarised by Figure 7. Each of these dimensions may again require careful planning of several operational tasks which may need to be accomplished if a given pilot scheme is to work within daily routine.

Figure 6 – Core elements integrated care pilot planning



Source: VIGOUR

In the VIGOUR project, for instance, the integration approaches envisaged at the individual pilot sites differed considerably. The detailed tasks that needed to be planned under each core planning dimension varied accordingly. The planning dimensions identified in Figure 7 should thus be considered as a list of generic "headings" under which specific tasks need to be identified on a case-by-case basis. For each individual task, it should be stated which party must do what and by when for the task to be completed successfully. In a next step, dedicated risk factors should be identified at this planning stage already which may potentially delay or even prevent the successful completion of the identified tasks. Counteracting measures potentially available under given circumstances should be anticipated respectively. The operational pilot plan should also enable a continuous monitoring of progress in the execution of the individual task identified. This is to enable swiftly putting remedial action in place, should any deviations from the planned task execution occur at some stage. Also, relevant lessons learned, and actions not foreseen at the planning stage should be documented.

In the VIGOUR project, a common template was used for operational pilot planning purposes. For illustrative purposes, a generalised version is provided in Annex III.

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3.4 Pilot operation

What this step should generally be about

Does the new practice work under everyday conditions?

Does it deliver?

Based on a carefully prepared operational implementation plan, the envisaged care integration approach should be piloted by involving a predefined number of individuals and/or within a confined geographical area. Depending on integration ambition jointly developed by the stakeholders throughout the previous work steps, the pilot activities may concern one or more integration types, levels, and forms (see Figure 1). Ultimately, the pilot phase should enable an assessment of whether the envisaged care integration approach works under everyday conditions as originally anticipated, and whether it delivers the expected outcomes. To this end, the pilot activities and its outcomes should be systematically documented with a view to informing decision making on wider upscaling.

What this step should include in particular

According to the evidence available from the literature[8], successful implementers of integrated care schemes tend to take an incremental approach towards changing existing service delivery models rather than a disruptive change model. In doing so, they typically strive for a balance between flexible decision making and formalised implementation structures. Different stakeholders affected by the envisaged care integration approach tend to be involved in collaborative governance models, and leadership is frequently distributed throughout different levels of the care eco-system. Also, successful implementers tend to build on a multidisciplinary team culture with mutual recognition of each other's roles. Moreover, the development of new roles and competencies for integrated care is often stimulated by dedicated measures. With respect to financing, secured long-term funding and innovative payments are often applied to overcome fragmented financing of health and social care. Apart from this, successful implementers often rely on digital solutions to support collaboration and communication, and on feedback loops and a continuous monitoring.

Against this background, the pilot operation of the envisaged integration approach should be documented in a way that is instructive for decision making concerning wider up-scaling after an initial pilot phase. In VIGOUR it has turned out as useful for

[8] See for example W. Looman et al.: Drivers of successful implementation of integrated care for multi-morbidity: mechanisms identified in 17 case studies from 8 European countries - Social Science and Medicine. 25 January 2021 (https://www.sciencedirect.com/science/article/pii/S0277953621000605), the website of the SELFIE project (https://www.selfie2020.eu/selfie-project/) and the

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documentation purposes to match key success factors with the task planning dimensions set out in the operational pilot plan as graphically summarised by Figure 8 overleaf. In the VIGOUR project, the participating care authorities used a common documentation template for summarising key aspects of the integration approach adopted and key lessons learned from the pilot phase. For illustrative purposes this is provided in Annex IV.

Figure 7 – VIGOUR documentation framework for pilot implementation

Operational pilot plan dimensions	Success factors derived from the literature		Description of contextualised task implementation activities	
			During pilot phase	After pilot phase
Target population Intervention Pathways Readiness to change	Service delivery (A)	Incremental grows model vs. disruptive innovation approach		
	Service delivery (A)	Balance between flexibility and formal structures of integration		
	Leadership (A)	Collaborative governance by stakeholders		
	Leadership (B)	Distributed leadership throughout different levels of the system		
Resources Capacity building	Workforce (A)	Team culture		
	Workforce (A)	New roles and competencies		
Funding streams	Financing	Funding typology / Innovative payments		
ICT & tools	ICT	Collaboration support / communication support		
Risk planning Execution monitoring & evaluation	Information	Feedback loops / continuous monitoring		

Source: VIGOUR

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4 Lessons learned – The VIGOUR decalogue for decision making to scale up integrated care

1. **Flexibility**. In view of the diverse framework conditions within which integrated care service delivery occurs the service integration strategy pursued needs to be flexible. Pursuing a "one-size-fits all" care integration approach across different care authorities would very likely fail to deliver the desired outcomes. The VIGOUR methodology can be used in a fast or slow track, e. g. depending on integration measures already implemented. Against this background, the VIGOUR methodology was designed to be applicable under varying framework conditions. Depending on the type and level of service integration already in place, it can for example be used in a "fast" or "slow" track when it comes to some or all of its sequential methodological work steps (see Figure 2). In this sense the VIGOUR methodology should be seen as a generic approach which, on a case-by-case basis, requires careful contextualisation and adaptation to prevailing framework conditions.
2. **Gradual service integration approach.** The VIGOUR methodology supports a gradual, controlled migration from existing work practices and technologies towards better joined-up care processes. This seems all the more necessary when integration efforts involve several existing services provided by different care organisations or managed under different regulatory and administrative systems, such as health care services and social care services.
3. **Stakeholder engagement & consensus.** The care authorities participating in the VIGOUR project were supported by means of a multi-staged process in defining and implementing better joined-up care practices. The effort and time required for acquiring knowledge concerning the joined-up care intervention envisaged needs to be taken into account. Additionally, time required for reaching consensus among all stakeholders involved on how to deliver it should not be underestimated. Taking this effort seems however advisable to address operational complexity, stakeholder inertia, and implementation dynamics. Only through a joint effort of all stakeholders concerned can the operational complexity and the associated implementation dynamics of integrated care models be successfully managed: Continuous information exchange is a key factor for successful and sustainable implementation. Improved communication between multidisciplinary professionals will pave the way for consensus and change.
4. **Interdisciplinary training**. A critical analysis of digital literacy in advance may help to prevent failure of ICT integration due to missing skills/interest to work with ICT solutions. Health and social care professionals need to be trained to use the ICT based solutions or any other that might be identified. Make sure that the people involved in the process have enough time for implementing their changes.
5. **Patient empowerment and literacy**. Training and development, educating patients is a must for a successful implementation of integrated care initiatives. Within the

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integration of ICT tools and solutions, awareness about a potential lack of digital literacy or digital skills in the target population is required.

6. **New roles.** New roles that were starting among health care professionals, mainly those favouring multidisciplinary work, are to be acknowledged and formalised to grant the future sustainability of the integration of care achieved. Clear distribution, responsibilities and competences on leadership and management level help to prevent/reduce lack of coordination and lack of shared visions across the regional health and social care context

7. **Digital solutions**. Digital technologies should be considered as enablers of change, as they hold great potentials for making information exchange processes and interpersonal communication more efficient. Although we have noted that technology in itself is usually not a limiting factor for the wider implementation of integrated care, there remains a continuing need for further technological innovation. Issues of relevance here vary from case to case, for example, when it comes to "ease of use" of existing digital solutions or lacking interoperability of new solutions with legacy infrastructures. Personalization of the digital solutions might be perceived beneficial by healthcare professionals and people receiving services. Involving future users of digital solutions will support proper adjustment.

8. **Pragmatic approach to piloting & evaluation**. The case for wider mainstreaming of a care integration approach successfully piloted in confined setting should be as robust as possible. However, a key challenge concerns the fact that there is a limit to how much one can prove things during the early implementation stage. Therefore, a pragmatic approach towards getting started needs to be adopted. The full impacts of changes, for example in relation to economic effects, can usually be expected to materialize only sometime after a 'proof of concept' was successfully achieved.

9. **Documenting pilot outcomes.** Before testing new care practices with a limited number of users, all stakeholders involved should agree on how such a test phase should be documented. Different stakeholders may have different information needs when it comes to deciding on the expansion of the new care model after a successful pilot phase. Make sure to report your results periodically to policy makers, decision makers, IC planners, and all the others involved, healthcare professionals, people receiving services.

10. **Context-sensitive pilot evaluation.** The diversity of possible care integration models and procedures that emerged in the framework of the VIGOUR project does not make it seem sensible to apply a uniform evaluation model. A general evaluation framework was therefore developed by the project. It was used by the individual pilot sites to develop their own, locally adapted pilot evaluation plans. In this context, it seems advisable to consider different phases of the implementation of a pilot project. In the first phase, the focus of the evaluation may be primarily on questions around the adoption and acceptance of the new procedures by relevant stakeholders, and on the practical feasibility of the new care model as such. In subsequent phases, the focus may change towards performance and sustainability related aspects. .

Throughout all phases, people participating in the new process should be involved in the evaluation and evaluation results should be shared with them.

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5 Policy recommendations for policy makers

VIGOUR project has been funded by the 3rd Health Programme. Since 2003, successive EU health programmes have contributed to knowledge and evidence as a basis for informed policymaking and further research. VIGOUR best practice, tools, and methodologies will hopefully benefit future policy and decision makers that are willing to support healthcare provision systems transformation towards people centred, integrated care.

By the time VIGOUR project is over, June 2022, EU4Health programme (2021-2027) is in place, seeking to "bring a contribution to the long-term health challenges by building stronger, more resilient and more accessible health systems". Increasing coordination is to be promoted among EU member states, sharing the clear message the public health is a priority for the EU and will "pave the way to a European Health Union". [9] It has been seen in relation to COVID-19 management how the integration of healthcare services was key to managing successfully this global threat and thus strengthen the health systems.

VIGOUR project has made it possible that 15 public providers of healthcare services in Europe get together to scale up their integration of care of their respective healthcare systems. Some lessons were learnt, that can be valuable for future policy and decision makers wishing to scale up people centred integrated care systems. Is there anything that policy makers can support to foster the continuation of IC processes after VIGOUR?

EU AGREEMENT ON HOW TO MEASURE IC. Agreements at EU level on the key indicators to follow up and measure the people centredness and integration of care should be promoted.

SHARING KEY MESSAGE. Sharing with citizens and authorities the key message that increasing the resilience of HC systems can be achieved in post-COVID Europe using IC.

INFORMATION SHARING Setting an information sharing system including the integrated care initiatives, their results, methodologies, best practices. Any reliable information on successful integration could be valuable for regions or countries willing to start or continue their people centred integration of care.

BUDGETTING IN ADVANCE Pay attention to the budget planning in advance when regulating or implementing IC initiatives. Budget planning is not short term and not flexible. Evidence of effectiveness and convenience of IC will be interesting to be included. Cost-benefit analysis suggested.

PLAN IN ADVANCE Even if IC is included in the yearly budget, how is it going to be implemented, for instance in the first year? Is it going to be sustainable for the following years?

[9] https://health.ec.europa.eu/funding/eu4health-programme-2021-2027-vision-healthier-european-union_en#eu4health-and-the-european-health-union

SHARING VIGOUR GUIDANCE DOCUMENT for planners and practitioners will give them the tools to advance on the integration of care using reliable, tested tools for implementation once the framework for transformation has been stablished at policy level.

FLEXIBILITY. Pursuing a "one-size-fits all" care integration approach across different care authorities would very likely fail to deliver the desired outcomes. The VIGOUR methodology can be used in a fast or slow track, e. g. depending on integration measures already implemented.

INCREMENTAL APPROACH. VIGOUR supports incremental, controlled migration from existing work practices and technologies. This seems all the more necessary when integration efforts cut across several services located in different care organisations, e.g. in particular health services, social services and services supporting a healthy lifestyle.

STAKEHOLDERS ENGAGEMENT & CONSENSUS. The care authorities participating in the VIGOUR project were supported by means of a multi-staged process in defining and implementing better joined-up care practices. Additionally, time required for reaching consensus among all stakeholders involved on how to deliver it should not be underestimated. Taking this effort seems however advisable to address operational complexity, stakeholder inertia, and implementation dynamics.

DIGITAL SOLUTIONS. Digital technologies should be considered as enablers of change, as they hold great potentials for making information exchange processes and interpersonal communication more efficient.

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Annex I

Evidence-based Guidance to Scale-up Integrated Care in Europe

Task 4.1

Initial Ambition Statement Template

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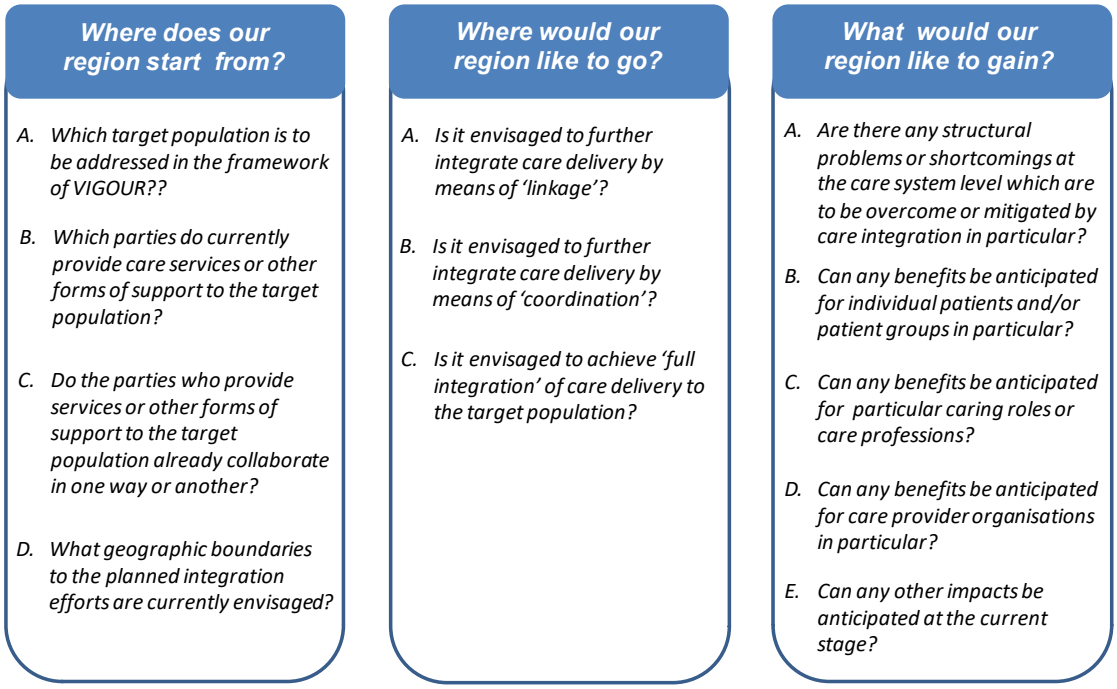
1 Introduction

The VIGOUR project intends to up-scale pilots for integrated care in 15 participating regions. During the proposal submission phase, each region briefly sketched the efforts which have been pursued to date to achieve more joined-up care delivery processes. Taking these initial descriptions as a point of departure, the current template is intended to help in consolidating the service integration work which is to be further pursued in the framework of the VIGOUR project. To this end, several service integration aspects are addressed throughout the remainder of this document. They are summarised by the schema below (Figure 1).

Figure 1 – Key questions to guide the joint development of an initial ambition statement by the stakeholders in the pilot region



As can be seen from Figure 1, at the current stage of the project a number of guiding questions have been formulated at a rather generic level. In this way, we hope to enable capturing the widest possible variety of maturity levels of integration considerations currently prevailing across the different pilot regions. In addition, we have tried to avoid the use of domain-specific terminology wherever possible. This way, we hope to encourage local stakeholders from different care domains such as health care, social care and/or family care to express their initial views on the envisaged service integration in a "common language".

Please try to describe the current service integration considerations in your region as precisely as possible with help of the current template, thereby reflecting on the following aspects:

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- What is it that could be 'integrated' in our region (the "what")?
- At what scale could it be 'integrated' in our region (the "how much")?
- How could it be 'integrated' in our region (the "how")?

Please note that, in accordance with the overall project's workplan, this initial 'ambition statement' will undergo further detailing and/or revisions throughout the project's life cycle in an iterative manner.

2 Where does our region start from?

2.1 Which target population is to be addressed in the framework of VIGOUR?

According to the input received during the proposal preparation stage, the target populations to be addressed in the framework of VIGOUR vary across the participating regions. Some regions have for instance put the focus on a further integration of service delivery to specific disease groups, while others have emphasised the need for further joining up service delivery across primary, secondary and tertiary care more generally. This subsection is intended to gain a better understanding of the target population(s) which is (are) currently envisaged to be addressed in your region.

As mentioned earlier, we have deliberately refrained from prescribing a specific terminology or a common set of descriptive dimensions to be used by all regions in the same way at the current stage of the project, e.g., clinical ones, socio-demographic ones or others. Please note that, as far as required, the next step in the project plan will offer an opportunity to further concretise and/or differentiate any initial considerations in this regard.

Using your own terminology, please try to describe as precisely as possible at the current stage which target population(s) is (are) expected to be addressed in your region. If possible, please support your description with available evidence, e.g. epidemiological and/or other data, you deem relevant at the current stage.

Please insert your text here

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2.2 Which parties do currently provide services or other forms of support to the target population?

Integrated care delivery typically requires the coordination of the efforts of different agencies and services such as clinical, public health and other services. In addition to formal services, be they health care services or social care services, individuals or groups who are not part of the formal care system tend to carry a considerable share of the caring burden in almost all countries today. These may include family carers, volunteer groups or third sector organisations.

Please try to describe as precisely as possible at the current stage each party providing formal services or other forms of support to the target population in your region. Here again, we have deliberately refrained from prescribing a particular terminology or specific descriptive dimensions.

Using your own terminology, please be as comprehensive as possible at the current stage. If ever possible describe the type(s) of service(s) or support provided by each party to the target population (the "what") and the scale at which these are currently provided to the target population (the "how much"). If possible, please also describe how each type of service/support is typically managed, funded and regulated today (the "how"). If possible, please also support your description with available evidence you deem relevant at the current stage.

Please insert your text here.

2.3 Do the parties who provide services or other forms of support to the target population already interact or collaborate in one way or another?

All participating regions have already pursued efforts to achieve better joined up care delivery, albeit in different regards and to varying extent. This subsection aims to better understand in what way and to what extent the different parities that provide services and/or other forms of support to the target population in your region do already collaborate or otherwise interact with each other.

Here again, we have deliberately refrained from prescribing a particular terminology or specific descriptive dimensions to be commonly used at this stage. Using your own terminology, please try to describe as precisely as possible in what way the different parties concerned do typically interact or collaborate (the "what"), and at which scale they interact/collaborate (the "how much"). If possible, please also describe whether they

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typically utilise any particular tools or technical infrastructures for their interaction/collaboration, be these ICT-based ones or others (the “how”).

Please insert your text here.

2.4 What geographic boundaries to the planned integration efforts are currently envisaged?

Please describe as precisely as possible at the current stage of the project which geographic area is envisaged to be covered by the service integration to be achieved in the framework of the VIGOUR project. It may for instance be intended to cover the whole region or just particular sub-areas or locations within a given region.

Please insert your text here.

3 Where does our region want to go?

3.1 Is it envisaged to further integrate care delivery by means of ‘linkage’?

For our purposes, the term ‘linkage’ refers to integration efforts directed towards better guiding the patient through the care system according to his/her needs without requiring any special arrangements. Implementing a smooth referral process may serve as an example here. Service integration in terms of ‘linkage’ is thus not directed towards creating new organisational structures or caring roles.

Please indicate whether your region is seeking any integration efforts that could be described as ‘linkage’. If so, please try to describe as precisely as possible at the current stage which parties could be linked and in what way they could be linked in the framework of VIGOUR (the “what”). If possible, please also describe the scale at which linkage could be achieved in your view (the “how much”). If possible, please also describe whether any existing or new tools could be utilised to achieve successful linkage of the different parties concerned, be it ICT-based ones or others (the “how”).

Please insert your text here

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3.2 Is it envisaged to further integrate care delivery by mans of 'coordination'?

For our purposes, the term 'coordination' refers to service integration efforts requiring that explicit structures and/or roles are put in place to coordinate service delivery to the target population(s). In this sense, coordination of service delivery may cut across one or more care domains such as health care, social care and informal/voluntary care. The implementation of joint case management structures may serve as an example here. While coordination is a more structured form of integration than linkage, it still operates through separate structures of current systems, e.g., when it comes to regulating, governing and/or funding the different services concerned.

Please indicate whether your region is seeking any integration efforts that could be described as 'coordination'. If so, please try to describe as precisely as possible at the current stage which parties could become involved in coordinated care delivery and in what way these could coordinate their activities (the "what"). If possible, please also describe the scale at which coordination could be achieved in your region (the "how much"). If possible, please also describe whether any existing or new tools could be utilised by the different parties to successfully coordinate their activities, be it ICT-based ones or others (the "how").

Please insert your text here

3.3 Is it envisaged to achieve 'full integration' of care delivery to the target population

For our purposes, the term 'full integration' refers to integration efforts directed towards creating entirely new programs or entities where resources from multiple systems are pooled.

Please indicate whether your region is seeking any integration efforts that could be described as 'full integration'. If so, please try to describe as precisely as possible at the current stage which hitherto separated entities could pool resources (staff, financial, other) and in what way these could deliver integrated services to the target population by pooling resources (the "what"). If possible, please also describe the scale at which joined-up service delivery could be achieved by means of full integration in your region (the "how much"). If possible, please also describe whether any existing or new tools could be utilised for the purpose of fully integrated service delivery to the target population, be it ICT-based ones or others (the "how").

Please insert your text here

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4 What would our region like to gain?

4.1 Are there any structural problems or shortcomings at the level of the care system which are to be overcome or mitigated by care integration in particular?

Depending on the local context, the 'value case' for integrated care delivery may vary across the participating regions. It has for instance been shown that joined up service delivery can provide an opportunity for addressing structural problems that may be particularly pressing at the level of the care system in each region, e.g., reducing the number of emergency admissions to mention just one example here.

Please indicate whether there are any structural problems or shortcomings in your region which are hoped to be mitigated in the framework of VIGOUR. If so, please try to describe as precisely as possible at the current stage which problems/shortcomings are expected to be mitigated and in what way service integration could make a positive contribution in this regard (the "what"). If possible, please also describe the scale of the problem/short coming to be mitigated (the "how much").

Please insert your text here.

4.2 Can any benefits be anticipated for individual patients and/or patient groups in particular?

Please indicate whether any benefits can be anticipated for individual patients and/or patient groups. If so, please try to describe as precisely as possible at the current stage which patient categories/groups may benefit from the service integration efforts to be pursued in the framework of VIGOUR, and in what way these are expected to benefit (the "what"). If possible, please also describe the scale at which patients are likely to benefit (the "how much").

Please insert your text here

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4.3 Can any benefits be anticipated for particular caring roles or professions?

Please indicate whether any benefits can be anticipated for different caring roles or care professions. If so, please try to describe as precisely as possible at the current stage which caring roles/professions may benefit from the service integration efforts to be pursued in the framework of VIGOUR, and in what way these are expected to benefit (the "what"). If possible, please also describe the scale at which particular caring roles or professions are likely to benefit (the "how much").

Please insert your text here

4.4 Can any benefits be anticipated for care provider organisations in particular?

Please indicate whether any benefits can be anticipated for care provider organisations. If so, please try to describe as precisely as possible at the current stage which provider organisations may benefit from the service integration efforts to be pursued in the framework of VIGOUR, and in what way these are expected to benefit (the "what"). If possible, please also describe the scale at which particular care provider organisations are likely to benefit (the "how much").

Please insert your text here

4.5 Can any other impacts be anticipated at the current stage?

Please indicate whether any other impacts can be anticipated at the current stage of the VIGOUR project. If so, please try to describe as precisely as possible in what way these impacts may ultimately materialise (the "what") and the scale at which they may materialise (the "how much")

Please insert your text here

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Annex II

Evidence-based Guidance to Scale-up Integrated Care in Europe

Task 4.2

Maturity Assessment Template

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1 Purpose of this document

VIGOUR has the aim to support the participating health care authorities in developing context-related models of integrate care delivers. During a preparatory phase, the so called 'Baseline Phase' described in the workplan, three subsequent work steps are to be concluded by each pilot region. These are graphically summarized by Figure 1. The overarching aim is to thoroughly prepare the implementation of local scaling-up pilots to be launched at a later stage in the overall project. The current document aims at supporting the VIGOUR regions in evaluating their local capacities and barriers for driving change management to implement their respective integrated care models, as outlined in their Initial Ambition Statement (Step I).

Figure 8 - The three tasks of the VIGOUR Baseline Phase

As can be seen from the above schema, the first two steps can be summarized as follows:

- The first step includes formulating a high-level vision for the further integration of current care practices. The outcomes of this process were already documented with help of a common 'Ambition Statement' template.
- The second step focuses on a critical appraisal of the initially stated ambition. Here, each region is requested to critically reflect on the strengths and weaknesses of the envisaged care integration approach described in its initial 'Ambition Statement'. When doing so, aspects that might make it difficult or perhaps even impossible to put the currently stated ambition into practice during the project should receive particular attention. Depending on the given framework conditions, a range of quite different factors may potentially impede the successful implementation of the initially stated ambition by means of a fully up- and running pilot scheme. Equally, diverse supportive capacities may be potentially available for putting the currently envisaged care integration approach

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into practice within the boundaries of the project, albeit these may not have been considered in a systematic way until now.

In this sense, this document is intended to serve as a tool to be utilized by each VIGOUR region for conducting a critical appraisal of its initial 'Ambition Statement' in a systematic manner. In methodological regard, the tool relies on self-assessment techniques known from the so-called SWOT (**S**TRENGTHS, **W**EAKNESSES, **O**PPORTUNITIES, **T**HREATS) analysis.[10] These should be applied along several assessment dimensions. These assessment dimensions were derived from existing models for assessing a region's level of maturity for implementing integrated care.[11] In the subsequent Chapter 2 it is described in more detail how this methodological approach should be applied in practical terms.

As a tangible output, this exercise is intended to help identifying:

a) potentials for further optimizing the envisaged approach towards care integration as it has been documented in the initial 'Ambition Statement' so far;

b) local circumstances that may make it difficult or even impossible to practically implement the initially stated ambition during the course of the VIGOUR project in terms of a fully operational pilot scheme;

c) options potentially available for addressing any identified "road blockers" for the implementation of a fully up-and-running pilot scheme;

d) meaningful criteria that could be applied for assessing whether or not the implementation of the envisaged care integration approach can be regarded as successful under the particular framework conditions prevailing in a given VIGOUR region.

In summary, the current work step is intended to yield a solid foundation for the subsequent development of a detailed operational implementation plan for a local pilot scheme.

It is worth being noted here that the methodological approach presented throughout this document does not aim at assessing a given region's maturity for integrated care in general terms, e.g. for comparing different regions according to a set of common indicators or quantitative scores. Rather, it is intended to help a given VIGOUR region in assessing - as far as this is possible at the current stage - whether there might be any aspects deserving particular attention when setting up its specific pilot scheme, as envisaged according to its initial 'Ambition Statement'.

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[10] A review of existing maturity assessment approaches and tools including the SCIROCCO model and others revealed, that none of these were suitable for the purposes of VIGOUR.

[11] These dimensions have been derived from the analysis of existing assessment approaches.

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2 How to perform the assessment

A two-staged methodological approach is proposed to be adopted for the purposes of the current task. It relies on established methods, in particular SWOT analysis and focus group sessions. The results of the SWOT analysis are then to be assessed in a systematic manner with respect to possible implication for development of a fully operational pilot scheme. Both analytical steps are to be conducted by means of a focus groups. This methodological approach and how it is to be practically applied is described in more detail in the following subsections.

What is a SWOT analysis about?

A SWOT analysis is an analytical method which is to be used in the context of VIGOUR for evaluating strengths, weaknesses, opportunities, and threats of the envisaged care integration approach. This method considers so-called "internal" and "external" factors that can influence the planned implementation under day-to-day conditions in terms of a fully up-and-running pilot scheme. As summarized in Table 1, strengths and weaknesses are regarded as internal factors while opportunities and threats are regarded as external factors.

Table 2 – Summary of key elements of SWOT analysis

1	INTERNAL FACTORS fall within the scope and control of the envisaged pilot scheme	1a	STRENGTHS are understood as characteristics of the envisaged integration approach that give it an advantage over other options potentially under consideration. Certain STRENGTHS can sometimes be used to address certain WEAKNESSES.
		1b	WEAKNESSES are understood as characteristics of the envisaged integration approach that place it at a disadvantage relative to other options potentially under consideration.
2	EXTERNAL FACTORS are conditions that are outside the direct control of the envisaged pilot scheme	2a	OPPORTUNITIES are understood as factors that may facilitate the implementation of the envisaged integration approach.
		2b	THREATS are understood as factors that may stand in the way of the practical implementation of the intended integration approach.

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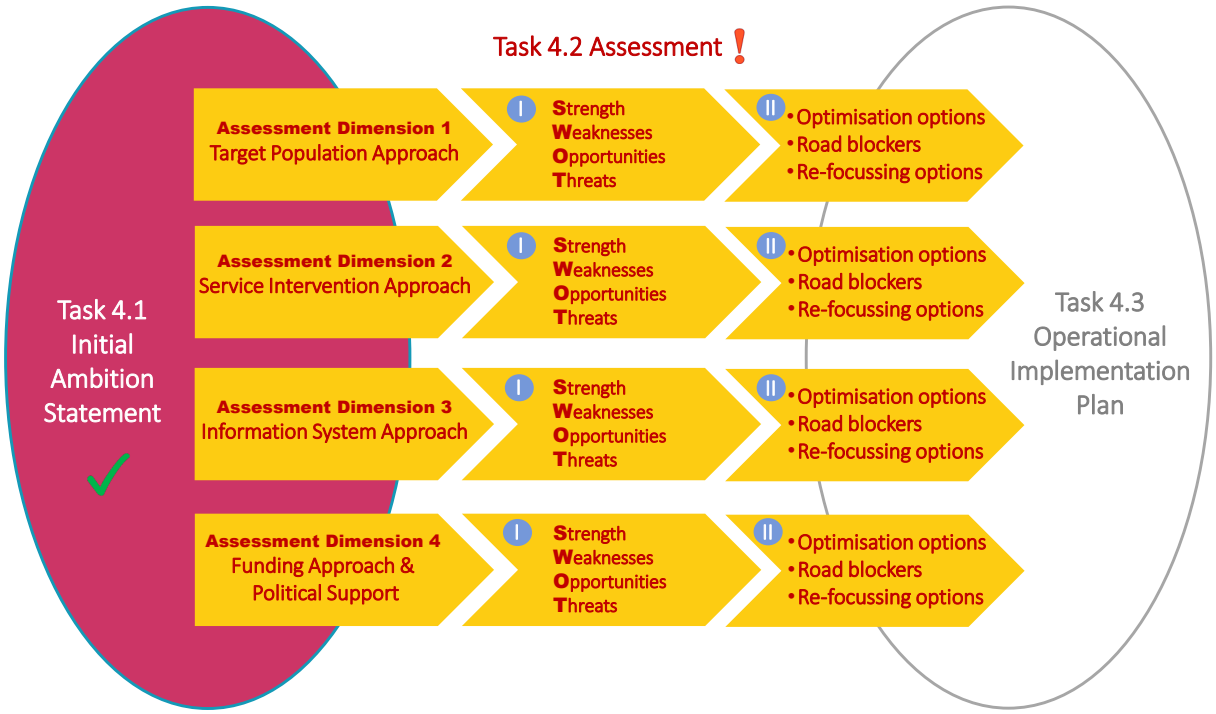
What should be analyzed?

As already mentioned, the initial 'Ambition Statement' as it currently stands should undergo a critical appraisal as graphically summarized by Figure 2.

Figure 9 – Summary of the overall assessment approach



As can be seen from the schema, the Initial Ambition Statement should be assessed in relation to four core dimensions[12]:

1. the target population to be addressed by the envisaged integration approach;
2. the service intervention to be integrated;
3. the information system design to be utilized to support integrated service delivery;
4. and the funding and political support of the envisaged service integration.

Each of these assessment dimensions is explained in some more detail in the following subsections. Generally speaking, for each dimension two analytical steps should be performed:

a) **STEP I: Perform a SWOT analysis of the Initial Ambition Statement**
The current care integration ambition should be assessed in relation to both, internal and external factors. For each assessment dimension, please identify potential strengths and weaknesses of the envisaged care integration approach (internal factors). Moreover, conditions that are outside the direct control of the envisaged pilot scheme should be identified which potentially facilitate or hinder

[12] For the purposes of VIGOUR, these dimensions were derived from the SCIROCCO maturity assessment model. See for example Grooten, L, et al. An Instrument to Measure Maturity of Integrated Care: A First Validation Study. International Journal of Integrated Care, 2018; 18(1): 10, 1–20. DOI: https://doi.org/10.5334/ijic.3063

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the implementation of the current integration ambition under day-to-day conditions (external factors).

b) **STEP II: Assess practically implications of SWOT results for the planned pilot scheme**

This analytical step focuses on assessing results of the SWOT analysis in relation to possible implications for operationally implementing a fully up-and-running pilot scheme at later stage of the overall project. Here, different key questions should deserve attention:

- Can any issues be identified that may make it difficult or even impossible to put the integration ambition into practice under day-to-day conditions?
- Should such "road blockers" indeed be identifiable at the current stage, are there any options available for successfully addressing them within the boundaries of the VIGOUR project?
- Equally to barriers, can any capacities be identified potentially supporting the implementation of the integration ambition under day-to-day conditions?
- If so, are there any options available for practically using these within the boundaries of the VIGOUR project?
- All in all, when could the VIGOUR pilot scheme be considered as a success within the given framework conditions? Are there any specific indicators that could be used to assess the success of the envisaged integration efforts under such conditions?

What practical issues deserve attention?

A number of practical issues deserve attention when assessing the initial 'Ambition Statement' with help of the hitherto described methodological approach. From a methodological point of view, a key challenge is to cope with diversity across the participating regions, e.g. in relation to prevailing framework conditions within which current care delivery processes are to be better joined up. Also, the design of the overall VIGOUR project puts certain boundaries to the practical application of the proposed methodological approach, e.g. time wise and resource wise. The method proposed to be adopted for the purposes VIGOUR therefore enables a certain degree of flexibility when it comes to its application in different local contexts. This is described in the following subsections.

Who should do the assessment?

Typically, different stakeholders have a role to play when it comes to joining-up different care processes around the needs of the care service users, including the patients themselves. Ideally, all stake holder groups which can be envisaged to become involved in the pilot scheme should be involved in critically assessing the initial 'Ambition Statement' as it currently stands. When it comes to care provider organizations that may

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have a role to play in the envisaged pilot scheme, these should ideally be represented at the decision-making level and the service delivery level. However, for various practical reasons, it may happen that full coverage of all actors and organizational levels by the composition of the assessment group is not always possible, at least not at the current stage. As a rule, the widest possible range of stakeholders and decision levels should be involved in the assessment process. When documenting outcomes, type and number of participants should be indicated. The documentation format presented in the subsequent chapter caters for this requirement.

In what setting should the assessment be done?

The SWOT analysis (Step I) as well as the assessment of its results in relation to possible implications for the implementation of a fully operational pilot scheme (Step II) require a self-critical reflection process. Such a process can best be facilitated by an interactive and discursive research format, rather than e.g. by a survey. Both steps of the two-staged assessment method (Figure 2) should therefore be conducted in a focus group setting. There are no strict rules how to conduct a focus group. For the purposes of VIGOUR, a focus group session should be organized as a structured workshop. Experiences from earlier research and the literature suggest a number of aspects deserving attention:

- **How many people should take part in a focus group session?**
  Usually, having more than 20 people in a focus group will seriously hamper effectiveness. Within larger workshops, you can also choose to incorporate smaller sub-groups.
- **How many people should run a focus group session?**
  Conducting a focus group session requites a small team. At a minimum, the team should consist of a moderator and a note taker. Generally speaking, the role of the moderator is to share knowledge, lead the content of the discussion and to undergo passive, individual learning. The moderator should take a neutral position vis-à-vis to the other group members. The role of the note taker is to make notes and observations throughout the focus group session. The moderator should try to build trust amongst the group and secure their buy-in. At the same time the moderator should try to keep participants focused and attentive. The reporting sheets to be utilized for documenting the assessment of the initial 'Ambition Statement' should be completed on the basis of the notes taken.
- **How should a focus group be structured?**
  In comparable research settings it has turned out as useful to start preparing a focus group by writing up brief topic guide that can be used by the moderator. For the purposes of VIGOUR such a topic guide may best be structured along the line of the "research questions" emerging from the two staged method described earlier. It seems thus useful to split the focus group session in two parts, one for addressing the questions emerging from the SWOT analysis (Step I) and another one for addressing the questions emerging from the subsequent assessment

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implications of the SWOT outcomes for the pilot implementation (Step II). This may be illustrated as follows:

Assessment Dimension 1: The target population approach

Part I (SWOT):

- What are the strengths of the target population approach described in the Initial Ambition statement, if any?
- What are the weaknesses of the target population approach described in the Initial Ambition statement, if any?
- What factors outside the control of the envisaged pilot scheme may facilitate the practical implementation of the approach described in the Initial Ambition Statement, if any?
- What factors outside the control of the envisaged pilot scheme may hinder the practical implementation of the approach described in the Initial Ambition Statement, if any?

Part II (Implications Assessment):

- Can any issues be identified that may make it difficult or even impossible to put the envisaged target population approach into practice under day-to-day conditions?
- Should such “road blockers” indeed be identifiable at the current stage, are there any options available for successfully addressing them within the boundaries of the VIGOUR project?
- Equally to barriers, can any capacities be identified potentially supporting the implementation of the envisaged target population under day-to-day conditions?
- If so, are there any options available for practically using these within the boundaries of the VIGOUR project?
- All in all, when could the VIGOUR pilot scheme be considered as a success when it comes to the envisaged target population approach? Are there any specific indicators that could be used to assess the success of the envisaged target population approach under given framework conditions?

These topics would then be addressed in relation to the other three assessment dimensions as well. Before asking questions to the group the assessment dimension under discussion should be briefly introduced by the moderator.

- **How should a focus group session be started and ended?**
  The beginning of a focus group tends to be critical in putting all participants at ease and encouraging discussion. Before asking any questions, the group should be welcomed, and any housekeeping notes covered. It is also important that participant understand the confidentiality policy. Depending on the composition

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of the group, it may also be useful to begin with an 'icebreaker' tailored to the participant group. The icebreaker does not need to be related to the topic matter at all, but just needs to stimulate conversation and give everyone a chance to speak. The introduction part of the session is also critical in establishing the moderator as the leader of the group and it gives them the authority to manage the group. In terms of timing, it has turned out as useful to allow approximately 10 minutes for this introduction. When ending a focus group session, the important things that have been learned should be briefly summarized, and the next steps in utilizing the inputs of the group within the VIGOUR project.

- **How long should a focus group session last?**
  Typically, a focus group session tends to last between one to two hours. Extension beyond three hours should be avoided. A session of more than three hours of intense discussion is very likely to put a strain even on a well-trained professional. Ideally one short break should be foreseen.

- **How many focus group session should be organized?**
  The number of focus group sessions required for the purposes of VIGOUR depends on the number of individuals to be involved in a particular region. In case more than 20 people are to be involved, it is strongly recommended to split-up the group. Another factor determining the number of sessions that may be required concerns the scope and length of the discussion emerging in relation to a given assessment dimension. The group should have the opportunity to discuss the initial 'Ambition Statement' in relation to each of the four assessment dimensions at sufficient lengths. Should it turn out that not all dimensions can be sufficiently discussed within one single session one or more additional sessions should be organized. All in all, you should strive to reach an appropriate saturation level as far as the thoughts and ideas to be captured are concerned.

- **How should the outcomes of a focus group session be utilized for the purposes of VIGOUR?**
  As already mentioned, the focus group discussion should be documented in terms of notes. Based on a synthesis of the notes the reporting sheets presented in the subsequent chapters. It is strongly recommended to not utilize the focus group session for jointly completing the reporting sheets directly.

- **Are there any ethical aspects deserving attention?**
  There are key ethical principles that underpin all elements of running a focus group. This means that a focus group session should be designed to ensure integrity and quality. The following principles need to be respected:

    - Focus group participation is voluntary. When conducting a focus group session participants must understand that they are under no obligation to participate and that there will be no consequences for refusing or withdrawing, at any time. Recorded consent (preferably written) should be secured from all participants before undertaking any research. The team

conducting the focus group, e.g., the session moderator, should explain the purpose and objective of the research openly, honestly and clearly.

- Participant confidentiality. The team conducting the focus group need to agree to keep any identifiers or personal information confidential. It should be explained to the participant how their confidentiality will be protected and where their data is being stored. No information should be publicly reported unless you have obtained written consent from the participant to do so. Harm to the participants must be avoided.

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3 Assessment dimensions and reporting sheets

This chapter introduces each of the four assessment dimensions to be addressed by means of focus groups. Moreover, two reporting sheets to be utilize internal to the VIGOUR project are provided for each dimension.

3.1 Assessment Dimension 1 - Current target population approach

Care integration efforts can typically be driven by two different health perspectives, the "individual health perspective" and the "population health perspective".

Individual health perspective

Joined-up delivery of care has shown to benefit those individuals 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. In this sense, care integration efforts can be regarded as a practical response to meeting today's demands.

Population health perspective:

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. When adopting a health policy perspective in particular, a better integration of care delivery processes may by be seen as a means of

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

When adopting a population health perspective in particular, a systemic application of a population risk approach to the services envisaged to be integrated in the framework of VIGOUR can certainly be regarded as a strength. Independent whether an individual health perspective of a population health perspective is adopted for the purposes of VIGOUR, systematic consideration of health equity can certainly be regarded as strength as well, e. g. when it comes to socio-economic and minority groups but also in relation to gender. It has e.g. been highlighted that there is not enough attention on how diabetes specifically affects women when compared to men, independent of their socio-economic status.

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Table 3 - Reporting sheet

Assessment Dimension: Target population approach	
No. of focus group sessions conducted:	*Please insert here*
No. of participants involved:	*Please insert here*
Stakeholder groups represented:	*Please insert here*
SWOT	
Identified Strengths	Please insert here
Identified Weaknesses	Please insert here
Identified Opportunities	Please insert here
Identified Threats	Please insert here
Implications for pilot scheme implementation	
Road Blockers to the envisaged target population approach	Please insert here
Options for addressing these for the purposes of running a pilot scheme under day-to-day conditions	Please insert here
Supporting capacities to be used for a target population	Please insert here
Options for making use of supportive capacities for the purposes of optimizing a pilot scheme under day-to-day conditions	Please insert here
Options for optimizing other aspects of the envisaged target population approach for the purposes of running a pilot scheme under day-to-day conditions	Please insert here
Identified criteria for the successful implementation of the target population approach in the framework of a pilot scheme	Please insert here

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3.2 Assessment Dimension 2 - Current service intervention approach

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 (vertical integration) or it may include social workers, the voluntary sector, and informal care (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, aiming for:

- Integration supported at all levels within the healthcare system – at the macro (policy, structure), meso (organizational, 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 service

Concrete questions may help triggering a discussion during a SWOT session when it comes to the assessment of the service intervention approach adopted. Who can take the leadership for the new pilot? Do you have trained stuff to deliver the new pilot as a part of the overall service? Are you able to deliver a structured process management pathway for the pilot (sub-tasks, check availability of staff, milestones, and timing)? The questions listed here are only meant to be indicative examples. Depending on the breath of the integration ambition to be pursued in the framework of the VIGOUR project and the specific service intervention(s) to be integrated, you may want to develop a more tailored set of triggering questions in advance.

A theme that deserves sufficient attention in any case concerns capacity building to support the envisaged integration of interventional services. 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, new roles may need to be created and new skills developed. These may range from technological expertise and project management to successful change management. Ideally, the systems of care should become 'learning systems' that are constantly striving to improve quality, cost and access. They should develop their capacity so as to become more adaptable and resilient. As demands continue to change, skills, talent and experience should be retained. Depending on the service integration approach pursued in an individual case, a suitable capacity building approach may include diverse measures such as:

- Increasing skills; continuous improvement.
- Building a skill base that can bridge the gap and ensure that the capacity needs are understood and addressed by digital solutions where appropriate

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- Providing tools, processes and platforms to allow organizations 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.
- Human resources and capacities to be involved is an important aspect to be addressed, please consider identifying specific strengths and weaknesses in this regard as well.

Table 3 - Reporting sheet

Assessment Dimension: Current service intervention approach	
No. of focus group sessions conducted:	*Please insert here*
No. of participants involved:	*Please insert here*
Stakeholder groups represented:	*Please insert here*
SWOT	
Identified Strengths	Please insert here
Identified Weaknesses	Please insert here
Identified Opportunities	Please insert here
Identified Threats	Please insert here
Implications for pilot scheme implementation	
Road Blockers to the envisaged service intervention approach	Please insert here
Options for addressing these for the purposes of running a pilot scheme under day-to-day conditions	Please insert here
Supporting capacities to be used for the integration of the service integration(s)	Please insert here
Options for making use of supportive capacities for the purposes of optimizing a pilot scheme under day-to-day conditions	Please insert here
Options for optimizing other aspects of the envisaged service intervention approach for the purposes of	Please insert here

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running a pilot scheme under day-to-day conditions	
Identified criteria for the successful implementation of the service interventions approach in the framework of a pilot scheme	Please insert here

3.3 Assessment Dimension 3 - Current information system design approach

Integrated care requires, as a foundational capability, sharing of health information and possibly 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. Depending on the integration ambition to be pursued within the boundaries of the VIGOUR project, diverse aspects may deserve attention in a given local context such as:

- 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.

Again, it may be helpful to develop a set of contextualized questions in advance to trigger a lively discussion during a SWOT session. Some generic examples are provided in the following for indicative purposes. Do you have a data sharing plan for the pilot available, based on secure and trusted services? Do you have fundamental building blocks to enable eHealth and e-services (e.g. infrastructures)? Do you have fundamental blocks available to support the new pilot to exchange medical data from different systems across care settings (at least the settings addressed in the pilot)?

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Table 4 - Reporting sheet

Assessment Dimension: Current information system approach	
No. of focus group sessions conducted:	*Please insert here*
No. of participants involved:	*Please insert here*
Stakeholder groups represented:	*Please insert here*
SWOT	
Identified Strengths	Please insert here
Identified Weaknesses	Please insert here
Identified Opportunities	Please insert here
Identified Threats	Please insert here
Implications for pilot scheme implementation	
Road Blockers to the envisaged information system approach	Please insert here
Options for addressing these for the purposes of running a pilot scheme under day-to-day conditions	Please insert here
Supporting capacities to be used for the implementation of the information system approach	Please insert here
Options for making use of supportive capacities for the purposes of optimizing a pilot scheme under day-to-day conditions	Please insert here
Options for optimizing other aspects of the envisaged information systems approach for the purposes of running a pilot scheme under day-to-day conditions	Please insert here
Identified criteria for the successful implementation of the information system approach in the framework of a pilot scheme	Please insert here

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3.4 Assessment Dimension 4 - Current funding approach and political support

The broad set of changes typically required to deliver integrated care at a regional or national level presents a significant challenge. Frequently, multi-year programmes are required to be set up 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. Here again, diverse aspects may deserve attention in a given implementation context such as:

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

Funding has frequently turned to be a key issue. 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).

Again, it may be helpful to develop a set of contextualized questions in advance to trigger a lively discussion during a SWOT session. Some generic examples are provided in the following for indicative purposes. Which domains are included for political support of the current pilot? Do you need any changes of the law (medical acts, information governance, data sharing)? Are you supposed to create new organisations to encourage boundary working? Do you need to change reimbursement to support behavioural change and process change? Is there funding available to support the pilot?

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Table 5 - Reporting sheet

Assessment Dimension: Current information system approach	
No. of focus group sessions conducted:	*Please insert here*
No. of participants involved:	*Please insert here*
Stakeholder groups represented:	*Please insert here*
SWOT	
Identified Strengths	Please insert here
Identified Weaknesses	Please insert here
Identified Opportunities	Please insert here
Identified Threats	Please insert here
Implications for pilot scheme implementation	
Road Blockers to the envisaged information system approach	Please insert here
Options for addressing these for the purposes of running a pilot scheme under day-to-day conditions	Please insert here
Supporting capacities to be used for the implementation of the information system approach	Please insert here
Options for making use of supportive capacities for the purposes of optimizing a pilot scheme under day-to-day conditions	Please insert here
Options for optimizing other aspects of the envisaged information systems approach for the purposes of running a pilot scheme under day-to-day conditions	Please insert here
Identified criteria for the successful implementation of the information system approach in the framework of a pilot scheme	Please insert here

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Annex III

VIGOUR
Evidence-based Guidance to Scale-up Integrated Care in Europe

Task 4.3
Initial Operational Scaling-Up Plan
Guidance Document

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TABLE OF CONTENTS

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1. Background

The overall aim of the VIGOUR project is to support regional care authorities in implementing a local pilot scheme for integrated care in different European regions. This document concerns the final output to be generated towards the end of the first project phase (Pilot Baseline Phase), namely a first version of an operational plan for practically implementing the envisaged pilot scheme under day-to-day conditions (Pilot Plan). The remainder of this document provides guidance on how to generate such a pilot implementation plan. The initial pilot plan that is now to be elaborated by each pilot site team should consider all lessons learned throughout the previous work steps.

2. Overview of the scaling-up pilot planning template and how it should be applied

The template of the initial pilot implementation plan is structured to allow preparing and managing the local upscaling pilots in a circular manner. This is graphically summarised by Figure 2. To this end, the outputs of the previous work steps (Initial Ambition Statement, SWOT report) were taken as a starting point. From this work, several core dimensions (scaling-up pilot planning dimensions) could be identified which deserve attention when practically implementing the overall pilot scheme under day-to-day conditions. These core planning dimensions are "labelled" in a generic manner. Each of these core dimensions may again require careful planning of several operational tasks which may need to be accomplished if a given pilot scheme is to work within daily routine.

However, the pilot schemes envisaged at the individual pilot sites differ quite a lot across the core planning dimensions identified from the previous work steps. It is therefore difficult to provide a definite list of tasks that need to be planned in any case under each core planning dimension. Taking the dimension labelled "target population" as an example (Figure 2), it may be the case that the population group(s) targeted by a given pilot scheme may be difficult to reach, so that particular measures may need to be planned for successfully enrolling users in the pilot service. In another pilot scheme, this may be a straightforward task requiring much less complex planning.

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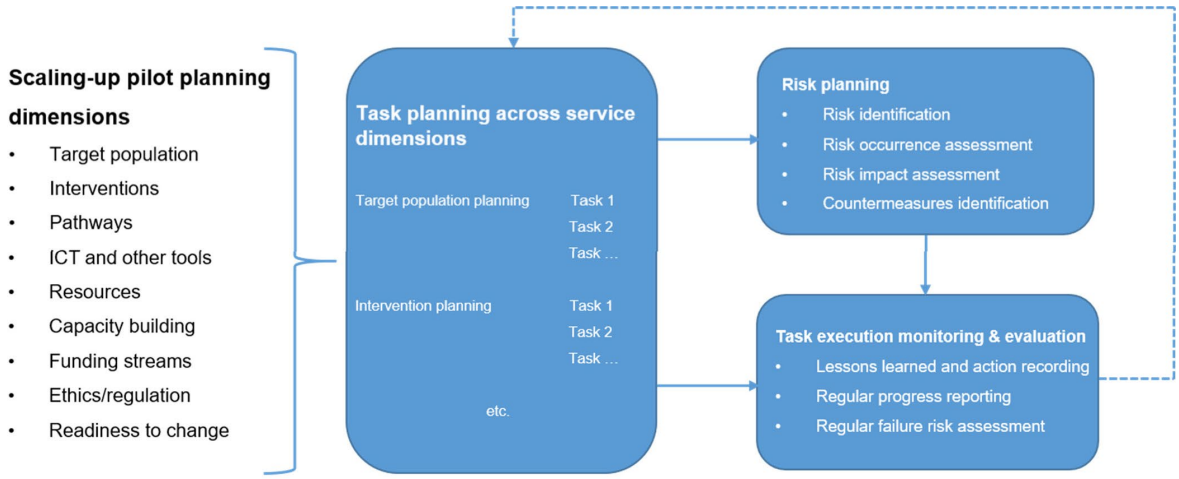
Figure 2 - Core elements of VIGOUR up-scaling pilot planning



Source: VIGOUR ©

Therefore, the core planning dimensions identified in Figure 2 should be considered as a list of generic "headings" under which specific tasks should be identified by each individual pilot site which may require practical implementation planning. When doing so, please try to be as comprehensive as possible at the current stage. With regard to each of the identified tasks, please consider who has to do what by when in order for the task to be completed successfully.

In a next step, the pilot planning template focuses on identifying risk factors potentially delaying or even preventing the successful completion of the identified tasks, and of counteracting measures potentially available under given circumstances (risk planning). Also, relevant lessons learned and actions not foreseen at the planning stage can be noted down and may be of help for the project success.

Finally, the pilot planning template focuses on monitoring of progress in the execution of the task identified earlier. This is to enable putting remedial action in place, should any deviations from the planned task execution occur at some stage (task execution monitoring and evaluation).

Beyond this, the current pilot planning template includes a section intended to help in developing initial considerations for the further upscaling of care integration approach to be piloted beyond the immediate duration of the VIGOUR project.

2.1. Pilot scheme summary

In the pilot scheme summary, the main features of your regional pilot project should be outlined briefly, as well as the aims and expected objectives of the pilot scheme.

2.2. Task planning across pilot planning domains

It is clear from the work conducted so far within VIGOUR that the great diversity of integration approaches and implementation circumstances prevailing across the VIGOUR regions require the elaboration of customised pilot plans. The following subsections provide further guidance on how customised task planning should be achieved with help of the current

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template:

a) Please start with describing each planning dimension of your scaling-up pilot as detailed as possible at the current stage. To support this work step, a set of illustrative indicators is provided in relation to each dimension in the following subsections. The individual indicators have been derived from the previous work conducted within the VIGOUR project, in particular initial ambition statements (Task 4.1) as well as from the evaluation framework (Task 3.1).
Please feel free to select or add descriptive indicators which you deem most appropriate to describe a given pilot planning dimension in your region.

b) In a second step, please identify all tasks in relation to a given planning dimensions which need to be completed in order to successfully prepare, launch and conduct the VIGOUR scaling-up pilot in your region. It is advisable to keep in mind the formulation of "SMART" measures (Specific, Measurable, Attainable, Realistic, Time-bound). To support this work, some exemplary tasks are provided for each planning dimension in a tabular format. Here again, these are intended to serve illustrative purpose only.
Please feel free to select and extend the task list as you deem appropriate in your pilot context.

c) As a third step, risk management and monitoring measures should be taken. This document provides a comprehensive step-based approach to keep an overview of the project progress, to identify and address risks, to record lessons learned and unplanned actions and to capture and evaluate progress during implementation. In the follow-up section, further scaling-up methods to ensure sustainability can be specified.

2.2.1. Pilot planning dimension #1: Target population

The Initial Ambition Statement document you have completed during the first stage of the VIGOUR project includes an outline of the population group(s) to be addressed within the upscaling pilot in your region. The current planning document aims at identifying concrete tasks required to be completed for practically involving individuals into the pilot. This starts with describing as precisely as possible the target population along a set of indicators suitable to serve as a starting point for specifying unambiguous inclusion/exclusion criteria for your pilot scheme. It emerges from the Initial Ambition Statements that the target populations identified so far vary a lot across the VIGOUR regions, and that suitable inclusion/exclusion criteria are strongly context dependent. It is therefore neither meaningful nor possible to define a common set of criteria that are equally applicable across all regions. Figure 3 below provides a collection of possible indicators derived from the available Ambition Statements. Together, they are reflecting the different target populations mentioned so far. With a view to deriving meaningful excursion/inclusion criteria for your pilot scheme, you may pick individual indicators or use additional ones as deemed meaningful in your region.

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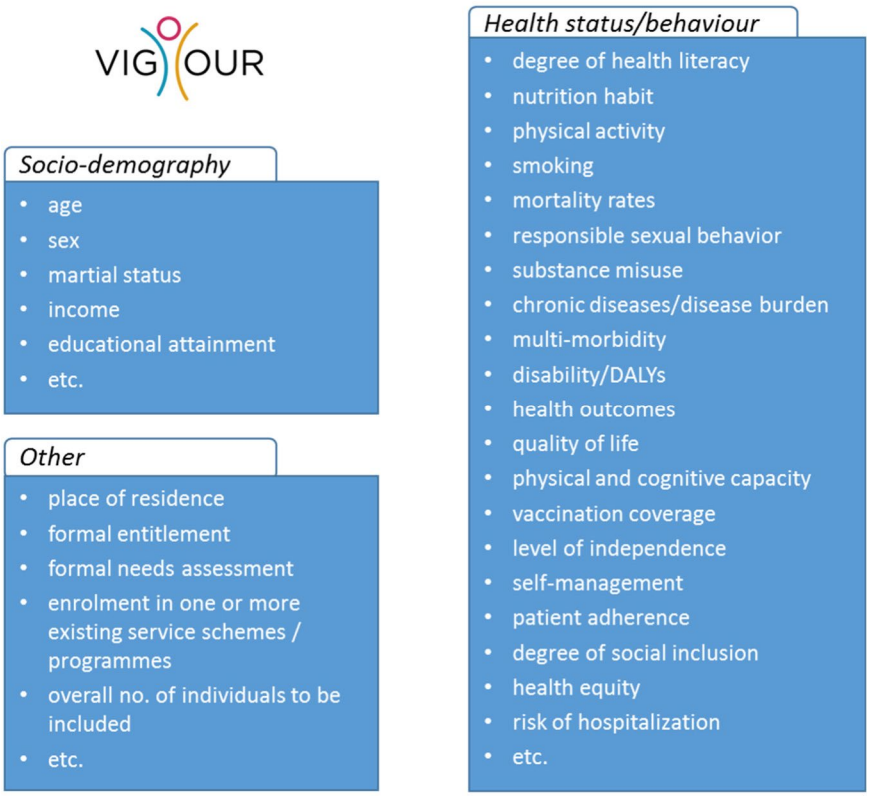
Figure 3 – Possible indicators for defining the pilot population



Source: VIGOUR ©

Some of these indicators may immediately be applicable as inclusion/exclusion criteria. Others may however require careful transposition into criteria that can be unambiguously applied in practice, e.g., with reference to existing guidelines, standards or measurement scales. In certain cases, it may also be required to agree upon exclusion/inclusion criteria among different stakeholders that have a role to play in successfully piloting the envisaged care integration approach within a given regional setting. Under certain circumstances, it may also be necessary to agree upon a specific enrolment process for the purposes of the VIGOUR pilot in your region.

For all activities to be implemented successfully, careful planning is required. Such a planning should include a clear description of the task(s) to be achieved together with clearly assigned responsibilities, timelines and required resources. Table 1 overleaf provides an indicative example of how such a task planning should be conducted in a tabular format.

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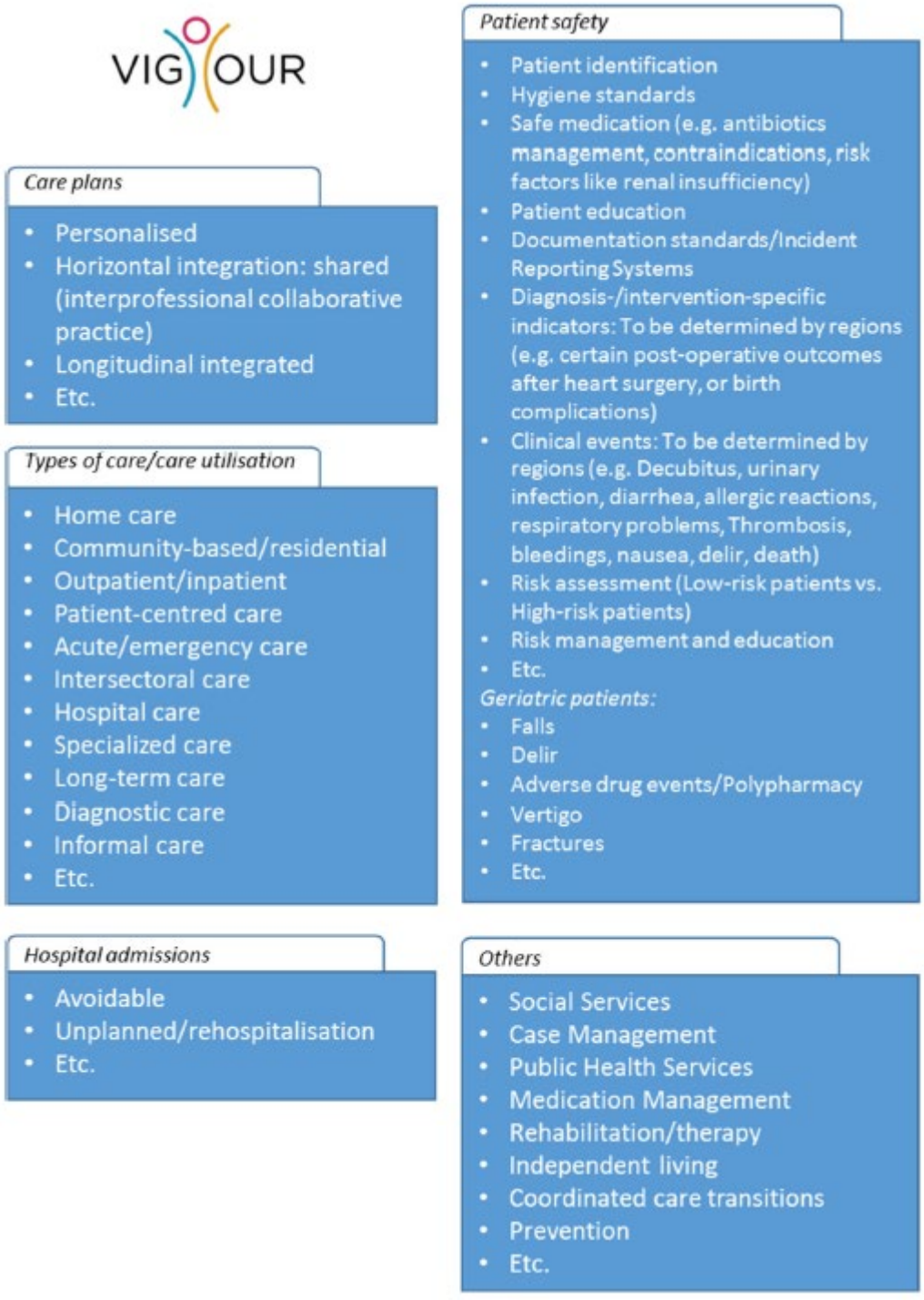
Table 1 –Example of documenting planned tasks in tabular format
(not exhaustive)

No.	Description	Start Date	End Date	Responsible	Contributors	Tangible Outputs
1	Clear definition of the project target group → inclusion and exclusion criteria with the help of indicators	01/01/20	15/01/20	Name of project team member	Stakeholder name	Target group identified
2	Analysis of setting of the target group (meso- & macro-level) and alignment with target group (micro-level)	15/01/20	31/01/20	Name of project team member	Stakeholder name	Setting of target group identified
3	Develop strategies for contacting and inclusion of target group in pilot project (plan: how to contact etc.)	31/01/20	15/02/20	Name of project team member	Stakeholder name	Strategies for target group inclusion developed (plan)
4	Approach and inform the target group about pilot-project (eventually provision of information material)	15/02/20	28/02/20	Name of project team member	Stakeholder name	Target group informed and included in project
...n	...?.	...?	...?	...?	...?	...?

2.2.2. Pilot planning dimension #2: Interventions

This section focuses on planning which intervention(s) is (are) to be delivered in a better joined up manner as part of the VIGOUR scaling-up pilot in your region. Diverse aspects may deserve attention when planning the interventions to be better integrated in one way or another, e.g., whether the VIGOUR scaling-up pilot is expected to concern any interventions that do already exist, so transferring an existing intervention to another context, or whether it is planned to develop new interventions. Which settings and core services do they address? Do they comprise different settings of care and core services? Do they contain any horizontal integration of interventions (multi-professional interventions for example) or on longitudinal level? If the pilot scheme refers to already existing interventions, that should be transferred to another context, transferability constitutes an important issue. Further information on assessing transferability of interventions can be found in the publication of Schloemer and Schröder-Bäck (2018). For illustrative purposes, Figure 4 indicates several other aspects that may be relevant in the context of the scaling-up pilot in your region.

Figure 4 - Possible aspects of interventions
(not exhaustive)



Source: VIGOUR ©

The table below illustrates an exemplary work-plan with concrete tasks (the current list is not exhaustive) for the implementation and pilot testing of a safe medication approach in a clinical setting (department of internal medicine) to increase patient safety as an overall goal.

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Table 2 Examples of documenting planned tasks in a tabular format
(not exhaustive)

No.	Description	Start Date	End Date	Responsible	Contributors	Tangible Outputs
1	Implementation of a departmental contact point for informal carers (family, relatives, ...)	01/01/20	31/01/20	Internal Medicine administration	Project team	Contact Point established
2	Development of information documents about safe medication for patients and informal carers	15/01/20	31/01/20	Clinicians	Internal Medicine administration, project team	Information documents developed
3	Process implementation: Information talk about safe medication with patient and informal carers before discharge and offer of contact point in case of questions/problems	01/02/20	30/05/20	Departmental workforce (physicians, nurse, ...)	Internal medicine administration	Milestone: 50 patients better informed about safe medication & improved handling with drugs
4	Evaluation of pilot phase	01/06/20	15/06/20	Internal Medicine administration	Departmental workforce, Project team	Evaluation report

2.2.3. Pilot planning dimension #3: Pathways

This section focuses on planning any care pathways, which may need to be developed and/or adapted for the purposes of the VIGOUR scaling-up pilot in your region. Again, diverse aspects may deserve attention in this regard. For instance, are there any guiding pathways or other structured care plans available? Are there any other national protocols or guidance documents that help you to put change into practice?

Figure 5 provides illustrative examples of further aspects potentially worth being considered for the purposes of planning the scaling-up pilot in your region.

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Figure 5 - Possible aspects of pathways

Source: VIGOUR ©

The table below illustrates an exemplary work-plan with concrete tasks (list not exhaustive) for the implementation and pilot testing of a new discharge management process in a hospital setting.

Table 3 Examples of documenting planned tasks in a tabular format (not exhaustive)

No.	Description	Start Date	End Date	Responsible	Contributors	Tangible Outputs
1	Development of a coordination structure for discharge management	01/01/20	31/01/20	Project team, hospital workforce	Hospital administration	Coordination structure for discharge management developed
2	Process management: development of a clear discharge management process & process description	01/02/20	28/02/20	Project team, hospital workforce	Hospital administration	Process for discharge management developed
3	Information, education and training of workforce on behalf of the discharge management process	01/03/20	30/04/20	Project team, hospital workforce	Hospital administration	Workforce is educated in discharge management
4	Development and provision of documentation files	01/03/20	30/04/20	Project team	Hospital administration	Documentation files for discharge management developed

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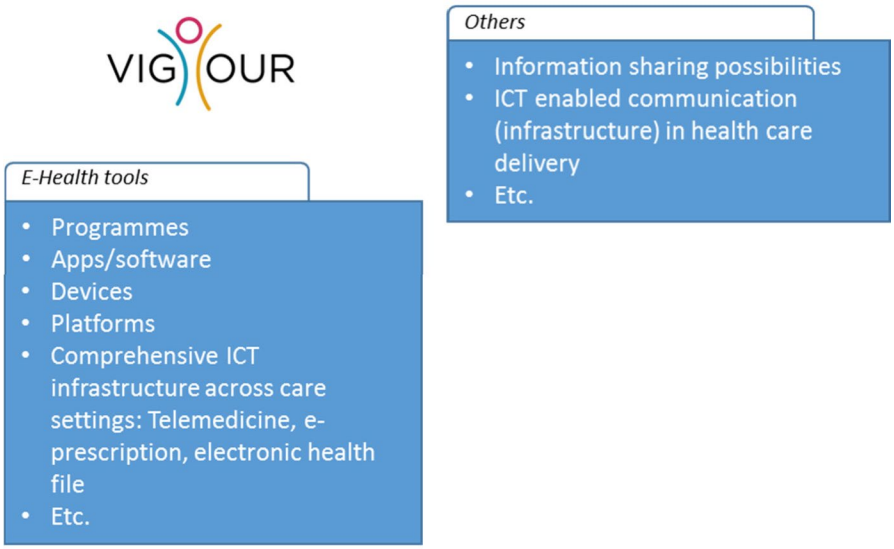
5	Application of new discharge management process in pilot phase	01/05/20	31/08/20	Project team, hospital workforce	Hospital administration	Pilot project completed
6	Evaluation of new discharge management process	01/09/20	30/09/20	Project team, hospital workforce	Hospital administration	Evaluation report

2.2.4. Pilot planning dimension #4: ICT and other tools

This subsection focuses on any ICT and other tools expected to be utilised for the purposes of care integration in the framework of the VIGOUR scaling-up pilots. Amongst other aspects, the question how to communicate data and information effectively among the stakeholders involved may deserve particular attention when planning your VIGOUR scaling-up pilot in your region. Potentially, a wide range of aspects may be relevant in your specific region. The question which ICT and other tools are already in use or available and which professions have access to the information may deserve attention, for instance. Are there any telecare, tele-rehabilitation solutions or apps which are supposed to be utilized? If any new ICT tools are to be developed or purchased, how can this realistically be achieved within VIGOUR process wise, time wise and resource wise? Which resources do you need for utilising any existing and/or newly developed tools in the framework of the VIGOUR pilots? Figure 6 provides illustrative examples of further aspects potentially worth being considered for the purposes of planning the scaling-up pilot in your region.

Figure 6 – Possible aspects of ICT and other tools



Source: VIGOUR ©

The table below illustrates an exemplary work-plan with concrete tasks (list not exhaustive) for the implementation and pilot testing of an e-prescription platform in a PHC setting.

Table 4 Examples of documenting planned tasks in a tabular format
(not exhaustive)

No.	Description	Start Date	End Date	Responsible	Contributors	Tangible Outputs
1	Development of e-prescription platform	01/01/20	01/03/20	(IT-company)	Project team, PHC workforce	e-prescription platform established
2	Implementation of e-prescription platform in pilot PHC settings	02/03/20	30/04/20	(IT-company)	Project team, PHC workforce	e-prescription platform implemented in settings
3	Patient information and participation on voluntary basis (informed consent, data regulation!)	01/04/20	30/04/20	PHC workforce	Project team	Participating patients are informed
4	Test-run of e-prescription platform in settings	01/05/20	31/07/20	PHC workforce	Project team	Usage of e-prescription in daily routine
5	Evaluation of e-prescription platform	01/08/20	31/08/20	PHC workforce	Project team	Evaluation report

2.2.5. Pilot planning dimension # 6: Resources

This subsection focuses on planning any technical resources and human resources expected to be utilised in the framework of the VIGOUR scaling-up pilot in your region, including all care settings and core services to become involved in one or another way. Again, several issues may require attention from a planning perspective. For instance, do care professionals already work in inter- or multidisciplinary teams with agreed roles and responsibilities? If not, will it be required to establish such teams and if so who will need to be involved? Are there any decision- making tools for professionals and service users? Figure 7 provides illustrative examples of further aspects potentially worth to be considered for the purposes of planning the scaling-up pilot in your region.

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Figure 7 - Possible aspects of resources (not exhaustive)

Source: VIGOUR ©

The table below illustrates an exemplary work-plan with concrete tasks (list not exhaustive) for allocating higher organisational or financial resources for integrated care research.

Table 5 Examples of documenting planned tasks in a tabular format (not exhaustive)

No.	Description	Start Date	End Date	Responsible	Contributors	Tangible Outputs
1	Provision of financial resources for integrated care research	01/01/20	31/03/20	Financial department	Project team	Financial resources provided
2	Composition of an integrated care research team	01/04/20	30/04/20	Project team	Project organisations	Research team put together
3	Allocation of financial resources to newly established integrated care research	01/04/20	31/12/20	Financial department	Project team	Financial resources allocated
4	Implementation of integrated care research and research projects according to funding purposes	01/04/20	31/12/20	Project team		Integrated care research performed

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2.2.6. Pilot planning dimension # 7: Capacity building

This subsection focuses on planning any capacity building measures potentially required for successfully implementing the VIGOUR scaling-up pilot in your region. Diverse questions may deserve attention here again. For instance, is there a need to engage the staff in a process of

joint learning and continuous quality improvement? If so, how can this be achieved? Is there a need to increase or train special skills for a continuous improvement of work? If available, can you rely on any tools or platforms to assess and build your own capacity? Is there an evaluation of service improvements or cooperation on capacity building? It may also be worth considering opportunities to increase individual resilience. Which care settings and core services are to be involved in capacity building? Figure 8 provides illustrative examples of further aspects potentially worth being considered for the purposes of planning the scaling-up pilot in your region.

Figure 8 - Possible aspects of capacity building (not exhaustive)

Source: VIGOUR ©

The table below illustrates an exemplary work-plan with concrete tasks (list not exhaustive) for the implementation and pilot testing of a shared-decision making approach in the cardiology department of a regional hospital.

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Table 6 Examples of documenting planned tasks in a tabular format
(not exhaustive)

No.	Description	Start Date	End Date	Responsible	Contributors	Tangible Outputs
1	Education and training of the cardiology workforce in shared-decision making with a one-day seminar	10/01/20	10/01/20	(seminar administration)	Project team	Capability in shared-decision making acquired (Certificate)
2	Team meeting in small groups to plan implementation of shared-decision making in clinical routine	15/01/20	15/01/20	Team leader cardiology	Cardiology workforce	Shared-decision making approach determined
3	Pilot application of shared-decision making in clinical routine (interdisciplinary case conferences, inclusion of patients → options discussions, decision meetings,...)	15/01/20	31/03/20	Team cardiology	Patients eventually	Milestone: Successful care of 50 cases with the help of shared-decision making
4	Evaluating discussion and regular refresher courses	01/04/20	01/04/20	Team cardiology and seminar administration	Cardiology workforce	Benefits of shared-decision making outlined, reinforcement of capability

2.2.7. Pilot planning dimension # 8: Funding streams

This subsection focuses on planning any funding streams, which may need to be secured to successfully implement the VIGOUR pilot in your region, thereby considering different settings of care or core services expected to become involved. Questions deserving attention in your region may for instance include whether or not any existing funding streams may be available to support the move towards integrated care in the framework of VIGOUR. Is it only available for the pilot project or on a regular basis? At which level

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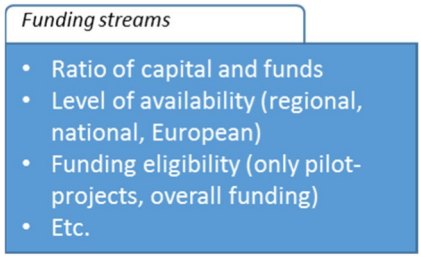
(regional/national/European) is funding available and from which sources? Figure 9 provides illustrative examples of further aspects potentially worth being considered for the purposes of planning the scaling-up pilot in your region.

Figure 9 - Possible aspects of funding streams



Source: VIGOUR ©

The table below illustrates an exemplary work-plan with concrete tasks (list not exhaustive) for a health research department for submitting more project proposals in integrated care funding schemes.

Table 7 Examples of documenting planned tasks in a tabular format
(not exhaustive)

No.	Description	Start Date	End Date	Responsible	Contributors	Tangible Outputs
1	Systematic search for open funding calls for integrated care projects	01/01/20	15/01/20	Project team	Research management in organisation	Funding calls detected
2	Check funding eligibility of projects and the organisation	15/01/20	15/01/20	Project team	Research management in organisation	Funding eligibility clarified
3	Write project proposal according to requirements in collaboration with project partners	15/01/20	15/02/20	Project team	Research management in organisation	Project proposal
4	Submit project proposal	15/02/20	15/02/20	Project team	Research management in organisation	Project proposal submitted

2.2.8. Pilot planning dimension # 9: Planning Ethics / regulation

This subsection focuses on planning any aspect of the VIGOUR scaling-up pilot in your region when it comes to ethical aspects and/or potentially existing regulation. Again, a diverse range of issues may potentially have relevance for the pilot scheme envisaged to be implemented in your region. For instance, which ethical regulations do exist locally, regionally, nationally and Europe-wide with relevance to the integration approach expected to be piloted in your region? Do you need the approval of an ethics commission and/or an informed consent? Are there any special considerations for your target population (e.g. children, people with dementia, people with a custodianship)? Please consider different care settings and core services expected to become involved in your regional pilot scheme. Figure 10 provides illustrative examples of further aspects potentially worth being considered for the purposes of planning the scaling- up pilot in your region.

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Figure 10 - Possible aspects of ethics/regulation

Source: VIGOUR ©

The table below illustrates an exemplary work-plan with concrete tasks (list not exhaustive) for complying with ethical regulations (if required/applicable) in your organisation for projects.

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Table 8 Examples of documenting planned tasks in a tabular format
(not exhaustive)

No.	Description	Start Date	End Date	Responsible	Contributors	Tangible Outputs
1	Gather information about necessity of an ethical approval for project (→ ethics committee or other institutional information point)	01/01/20	15/01/20	Project team	Ethics committee	Information if ethical approval is required gained
2	If necessary: Make application for ethical approval with all documents required	15/01/20	31/01/20	Project team	Ethics committee	Ethical approval application completed
3	Submit application for ethical approval	01/02/20	01/02/20	Project team	Ethics committee	Submission completed
(4)	(Revise application if necessary according to statements of ethics committee)	(01/02/20)	(28/02/20)	(Project team)	(Ethics committee)	(Revision completed)
4	Start project upon reception of ethical approval	01/03/20	31/12/20	Project team members	Ethics committee	Ethical approval gained

2.2.9. Pilot planning dimension # 10: Readiness to change

This subsection focuses on planning any tasks that concern the readiness to change of the different stakeholders, which are expected to become involved in the VIGOUR scaling-up pilot in your region. For instance, is there any political consensus or social support to foster change management in the framework of VIGOUR and/or beyond? Is there any strategic plan, vision or a care of urgency to scale-up integrated care in the framework of VIGOUR? How is the climate towards changes in your team/organisation? Please consider different settings of care and core services that are expected to become involved in the framework of VIGOUR.

Figure 11 provides illustrative examples of further aspects potentially worth being considered for the purposes of planning the scaling-up pilot in your region.

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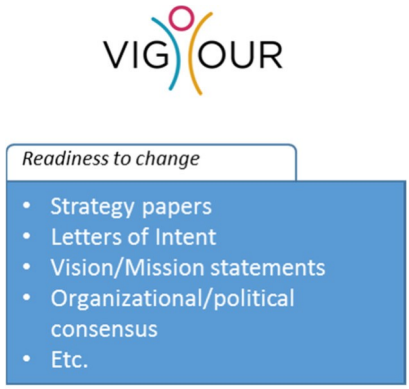
Figure 11 - Possible aspects of readiness to change



Source: VIGOUR ©

The table below illustrates an exemplary work-plan with concrete tasks (list not exhaustive) for a kick-off initiative for a long-term system change approach in order to enable a full inclusion of integrated care in policy and healthcare systems of a project setting.

Table 9 Examples of documenting planned tasks in a tabular format (not exhaustive)

No.	Description	Start Date	End Date	Responsible	Contributors	Tangible Outputs
1	Expression of commitment of health policy, health professions and health insurance organisations in project region for collaboration	01/01/20	31/01/20	Project team	Key stakeholders (policy, health care, ...)	Commitment expressed, open for collaboration
2	Coordination meeting of key stakeholders	15/02/20	15/02/20	Project team	Key stakeholders	Meeting held
3	Signing of Letter of Intent to acknowledge integrated care as	15/02/20	15/02/20	Project team	Key stakeholders	LOI signed

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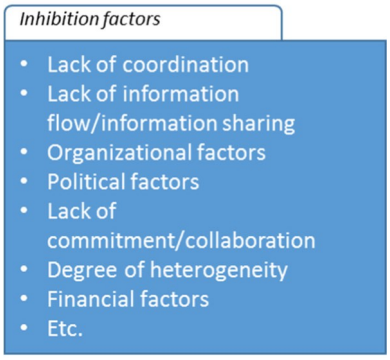
	strategic priority within project region					
4	Set the course for fostering systemic collaboration in integrated care (next possible steps could be: inform relevant institutions, develop guidelines and frameworks, coordination meetings, ...)	15/02/20	31/12/20	Project team	Key stakeholders	System change introduced

2.2.10. Pilot planning dimension # 11: Inhibition factors

This subsection focuses on planning any measures addressing factors that may inhibit the successful preparation, launching and/or operation of the VIGOUR scaling-up pilot in your region. For instance, is there a need for any particular measures/activities to address any organisational or financial factors that may inhibit the VIGOUR pilot scheme? Will any specific measures be required to address any legal or ethics related inhibitors that may exist in relation to the planned VIGOUR pilot scheme? How do you deal with inhibition factors within the pilot team?

Figure 12 provides illustrative examples of further aspects potentially worth being considered for the purposes of planning the scaling-up pilot in your region.

Figure 12 - Possible inhibition factors



Source: VIGOUR ©

The table below illustrates an exemplary work-plan with concrete tasks (list not exhaustive) for the planning and implementation of any desired integrated care project by focusing on inhibiting organizational factors. By clarifying the project aim and developing a clear management structure and proceeding

stepwise (model-like), potential organizational barriers may be inhibited.

Table 10 Examples of documenting planned tasks in a tabular format
(not exhaustive)

No.	Description	Start Date	End Date	Responsible	Contributors	Tangible Outputs
1	Formation of a steering group to build a structured process on how to implement an integrated care project	01/01/20	15/01/20	Project team	Organisation concerned	Steering group built
2	Development of an organigram and management structure	15/01/20	31/01/20	Project team	Organisation concerned	Organigram and management structure developed
3	Project plan: Definition of aim, tasks and regulatory framework (who is responsible for what and does what)	01/02/20	15/02/20	Project team	Organisation concerned	Project plan developed
4	Step-based approach towards project goal (focus on small tasks and milestones)	15/02/20	30/06/20	Project team	Organisation concerned	Project results/Milestones

2.3. Risk Management and Monitoring

Following completion of the task planning described in the previous sections, a dedicated effort should be made towards monitoring and risk assessment measures. The following chapter provides a spectrum of tools to meet the requirements for adequate project monitoring and risk assessment. The structure of this section is built as follows:

1) Gantt-chart: The Gantt-chart helps to keep the overview of upcoming tasks with regards to the timeframe. It supports the VIGOUR project regions in easily checking where they stand and what the next activities will be. Please note that the gantt chart below is intended to serve illustrative purposes only.
Please feel free to use your own designed gantt chart or other charts, which you deem most appropriate to illustrate and monitor the timeframe of project activities in your region.

2) Risk plan: In case of any deviation, it is highly recommended to timely come up with appropriate

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measures in order to avoid damage and secure project progress. Such a risk planning should be as comprehensive as possible. By additionally rating the occurrence probability and the degree of impact, the extent of certain risks is visible and prioritization of measures is possible.

3) Lessons learned and actions recording: In any project, lessons learned will emerge. They constitute highly valuable experiences, sometimes resulting from risks, problems or issues that came up during the project implementation. Lessons learned should be noted down as they may lead to future success, improvements or new opportunities. The action items comprise high prioritized, unexpected work mainly linked to uprising issues or risk management and often form during meetings and discussions. The project success also depends on the identification and completion of these unplanned action tasks; therefore, they should be recorded as well (adapted from Carewell project, 2014).

4) Project status report: This tool enables indicating the status quo of the project and any problems associated. Internal reporting and monitoring activities facilitate a successful control of project progression. Monitoring should be conducted on a regular basis; however, the frequency highly depends on the project context. At least biannual monitoring processes should be carried out, thus minimizing the risk of severe problems that evolve beyond control.

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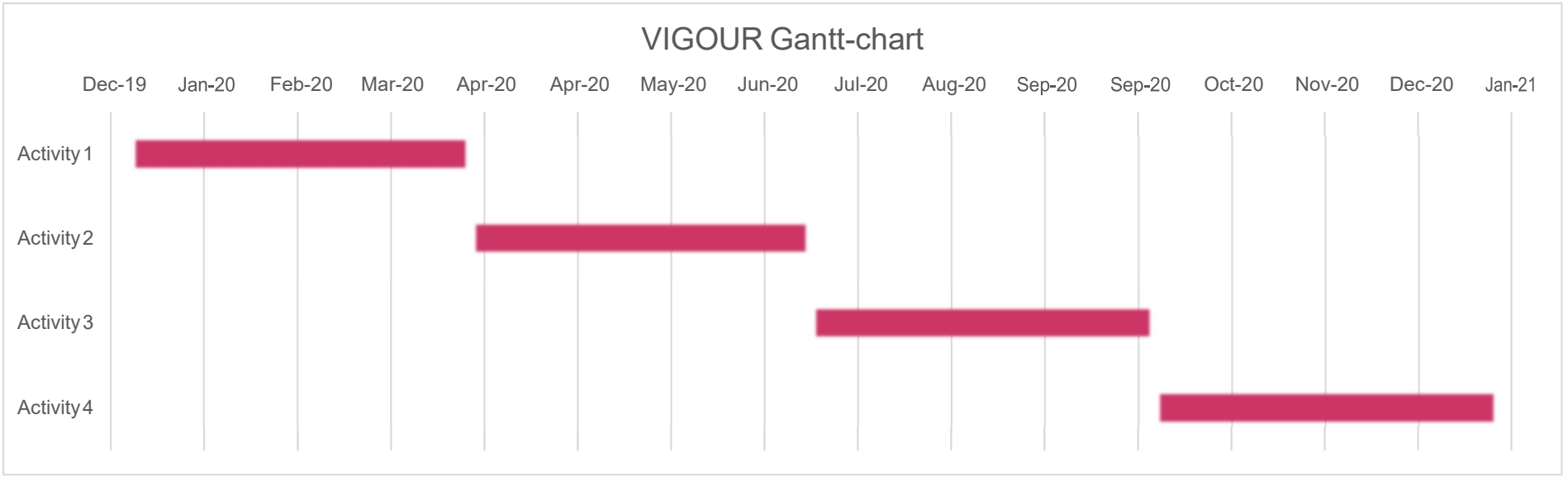
2.3.1. Gantt-chart

Figure 13 Gantt-chart - example



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2.3.2. Risk and contingency plan

Table 11 Risk and contingency plan - example

Domain	Risks	Probability of occurence	Impact degree	Remarks to risk assessment	Countermeasures
Domain	Fill in possible risks 1. 2. 3.	Choose between: - Very likely - Likely - unlikely	Choose between: - Severe - Moderately severe - mild	Fill in any information with regards to risk assessment (e.g. methods), if applicable and available	Fill in Countermeasures 1. 2. 3.
Target population	1. High drop-out rate during intervention	Likely	Severe		1. Keeping close contact with participants and keeping open the possibility for follow-up recruitment/enrolment
Interventions	1. Intervention does not address target populations' needs 2. Intervention proves to be ineffective	Unlikely Unlikely	Severe Severe		1. Implementation of quality management with regular effectiveness control loops 2. Intervention modification
...					

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2.3.3. Lessons learned and action recording

Table 12 Lessons learned recording - example

Serial number	Detail of problem or issue	Type of lesson	Description of lesson learned	Action taken	Date lesson learned raised
1	(e.g. timescale, cost, quality, staff)	**Start** (suggestion for improvement) **Stop** (stop continuation in future) **Continue** (something went well and should be continued)	Detailed description of lesson learned	Action taken to address problem or issue	When was lesson learned raised?
1	Timescale	Stop	Keeping shorter deadlines for feedback	All participants of the project meeting have now 5 working days (instead of 10) to give feedback on the draft of minutes in order to stay on time schedule.	March 3rd, 2021

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Table 13 Action recording - example

Serial number	Initiated by	Action date	Priority	Description of Action	Deadline	Progress/notes
1	Who started action?	When initiated?	High, medium, low	Detailed description of action to be taken	By when should action be done?	Any further information necessary
1	…	April 17th, 2021	High	Organization of originally unplanned staff meeting in order to clarify questions and details for Task …	April 30th, 2021	All participants are informed and invited, staff meeting will take place on April 27th, 2021

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2.3.4. Project status report

Table 14 Project status report - example

Name and Date:	Max Mustermann	31.03.2020
Project name:	Integrated Care in …	
Start date:	01.01.2020	
End date:	31.12.2021	
Project progress in %:	12,5% (1st Quarter 2020)	

Overall project status:

Here you can give a short overview about the current project status and report where you stand and what the next steps are. Please also bear in mind to inform about achieved tasks and milestones and any modifications done during the reporting period.

Legend for status assessment:

Green =	Project activity, task, milestone or indicator is on schedule, no problems occur
Yellow =	There are problems or delays, but effective countermeasures are already implemented Severe
Red =	deviations occur and project milestones, indicators or goals are endangered

Activity/Task/Milestone/Indicator	Target deadline	Current deadline	Status			Remarks
Please insert the activity, task, milestone or indicator to be monitored here	Insert targeted date for completion	Actual date with achieved completion				After crossing applicable status in the column left, insert any informative remarks here
A1	31.01.2020	15.02.2020		x		Minor delay but no further problems
M1	15.02.2020	15.02.2020	x			Milestone 1 achieved in time
Ind. 1	28.02.2020	15.03.2020			x	Target population recruiting delayed: contingency plan!
…						

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2.4. Follow-Up

Upon the completion of the VIGOUR scaling-up pilot in your region, results and effects should not only be made visible, but the impact of results should be disseminated beyond project duration and context. Documentation, dissemination and scaling-up serve the purpose to communicate project outcomes to the target group and to a broad audience as well as to increase awareness about the project context in general. Results and ideas stemming from the VIGOUR scaling-up pilot may be taken up and transferred to different settings and broader contexts. The following subsections provide input and guidance on how to design the overall follow-up phase of the VIGOUR scaling up pilot in your region.

2.4.1. Dissemination and documentation of results and project sustainability

Indicate how the dissemination and documentation of results as well as communication to the target population are organized and how you plan to ensure the project sustainability. In this context, the following aspects should be covered:

- Dissemination and communication objectives
- Dissemination and communication measures
- Documentation measures
- Dissemination, communication and documentation schedule (see example below)
- Dissemination evaluation aspects (if applicable)

The dissemination, communication and documentation schedule can be prepared with a table as the example below illustrates:

Table 15 Dissemination schedule - example

Measure	Expected target audience	Suspected deadline
Project report	General audience	Month 24 (Project end)
Flyer	Scientists, Health Professionals	Month 10
…		

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2.4.2. Potential for Transferability/Scaling-Up

Scaling-up means to expand or replicate innovative pilot or small-scale projects to reach more people and/or broaden the effectiveness of an intervention (World Health Organization, 2016). Once the VIGOUR pilot is finished, its potential for transferability or scaling-up should be put into concrete consideration. Again, the PIET-T model (Schloemer & Schröder-Bäck, 2018) or the following approach explained by particular phases, introduced by the Ministry of Health in New South Wales, Australia (World Health Organization, 2016) may be of help in this matter:

1) Assess scalability
2) Develop a scaling-up plan
3) Prepare for scaling-up
4) Scale-up the intervention

Especially during the assessment phase, potential promoting and hindering factors for further scaling-up the VIGOUR pilot scheme should be analysed. Also, the following questions should be considered: Could the VIGOUR pilots scheme address further target groups? Could it address further topics? Is further support (organisational, political, and financial) required? Is the outcome/result of the VIGOUR pilot useful, effective and feasible enough to be further scaled-up? Is the context/environment where it should be further scaled-up stable? Are willingness/acceptability, motivation and required expertise of involved partners available? If answers to these questions point in the direction of further scaling-up, a detailed plan needs to be set up.

In general, the plan gives insight about the following aspects: What are we going to do exactly? What are the goals? Who are the relevant stakeholders? How are we going to do it? Especially the factors of the pilot intervention that need to be modified for the further scaling-up need to be elaborated cautiously. Other aspects may be transferred as supplied before during the VIGOUR scaling-up pilot implementation. If further information in this regard is required, the World Health Organization provided a detailed guidance document (2016).

References

Carewell. (2014). Internal Deliverable: Lessons Learned, Issues, Actions and Risks (LIAR) Pilot Management Tool.

Schloemer T, Schröder-Bäck P. (2018). Criteria for evaluating transferability of health interventions: a systematic review and thematic synthesis. Implement Sci. 2018;13(1):88. Published 2018 Jun 26. doi:10.1186/s13012-018-0751-8

World Health Organization.(2016). Scaling up projects and initiatives for better health: from concepts to practice. Copenhagen: WHO Regional Office for Europe. http://www.euro.who.int/data/assets/pdf_file/0004/318982/Scaling-up-reports-projects-concepts-practice.pdf?ua=1

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(access 20.11.2019).

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Annex IV

VIGOUR
Evidence-based Guidance to Scale-up Integrated Care in Europe

Task 6.1 “Local scaling-up pilots”

REPORTING STRUCTURE

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Content

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1 Introduction

The present document responds to the objective "to scale up good practice in integrated care under day-to-day conditions prevailing in VIGOUR regions", providing a template of the common reporting structure that will be applied by each VIGOUR care authority in order to document their pilot activities.

The template has been created based on both the dimensions (implementation tasks) identified in the Operational Pilot Plan and a comprehensive review of the currently available knowledge base on existing change management models (SELFIE), in order to collect all the necessary information about what have been already done with regard to the pilot's implementation and how should it be done, taking into account the specific context of the pilot.

Operational Pilot Plan Task dimensions

SELFIE project dimensions

Implementation Tasks	Implementation approach		Implementation activities	
			during pilot	after pilot ?
• Target population • Interventions • Pathways • Readiness to change	Service delivery (A)	Incremental growth model vs disruptive innovation approach		
	Service delivery (B)	Balance between flexibility and formal structures of integration		
	Leadership & governance (A)	Collaborative governance by engaging stakeholder		
	Leadership & governance (B)	Distribution leadership throughout all levels of the system		
	Health and social care system	Alignment work		
• Resources • Capacity building	Workforce (A)	Team culture		
	Workforce (B)	New roles and competencies		
• Funding streams	Financing	Funding typology / Innovative payments		
• ICT & tools	ICT (technology & medical devices)	Collaboration support / Communication support		
• Risk planning • Execution monitoring & evaluation	Information & research	Feedback loops / Continuous monitoring system		

In particular, to define a common framework, ProMIS studied, looked into and took into consideration different European project results and deliverables such as a recent publication[13] produced in the framework of the EU-funded Horizon2020 project "Sustainable Integrated Care Models for Multi-Morbidity Delivery, Financing and Performance – SELFIE"[14]. The Project has deepened several European Projects and

[13] Drivers of successful implementation of integrated care for multi-morbidity: mechanisms identified in 17 case studies from 8 European countries - Social Science and Medicine. 25 January 2021. https://www.sciencedirect.com/science/article/pii/S0277953621000605

[14] SELFIE Project website: https://www.selfie2020.eu/selfie-project/

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related deliverables. As well as the framework of the INTEGRATE Project, which provided practical guidance to managers and planners. Moreover, in the context of the SCIROCCO[15] Project, the designed tool to assess whether the health care system is mature enough to provide integrated care has turned particularly useful to identify the implementation strategies for integrated care[16].

The publication coming from the SELFIE Project provides a deeper understanding of the mechanisms underlying implementation strategies for integrated care, and for this purpose 17 integrated care programmes, addressing multi-morbidity from eight European countries, were selected and studied. Data was extracted from 'thick descriptions' of the 17 programmes and analysed both inductively and deductively using an implementation theory. This analysis finally revealed ten empirically derived mechanisms for successful implementation of integrated care:

1. With regards to *service delivery*, successful implementers (a) commonly adopted an incremental growth model rather than a disruptive innovation approach.
2. Also - when it comes to *service delivery* - they found (b) a balance between flexibility and formal structures of integration, as follows.
3. For *leadership & governance*, they (a) applied collaborative governance by engaging all stakeholders.
4. When it comes to *leadership & governance*, they (b) also distributed leadership throughout all levels of the system.
5. For the *workforce*, successful integrated care implemented were able to build a multidisciplinary team culture with mutual recognition of each other's roles.
6. Moreover – with respect to the *workforce* - they (b) stimulated the development of new roles and competencies for integrated care.
7. With respect to *financing*, secured long-term funding and innovative payments were applied as means to overcome fragmented financing of health and social care.
8. Successful implementers emphasised the implementation of ICT that was specifically developed to support collaboration and communication rather than administrative procedures (*technology & medical devices*),
9. They also created feedback loops and a continuous monitoring system (*information & research*).
10. As an overarching mechanism, successful implementers engaged in alignment work across the different components and levels of the *health and social care system*.

[15] SCIROCCO Project website: https://www.scirocco-project.eu/

[16] Grooten, L., Borgermans, L., & Vrijhoef, H. (2018). An instrument to measure maturity of integrated care: a first validation study. IJIC, 18.

These evidence-based mechanisms for implementation are applicable in different local, regional, and national contexts as a guide in managing/innovating the organisational model of integrated care, enhancing the cultural heritage of different contexts.

In order to learn about other care authorities, the reporting structure (template) has the objective of helping VIGOUR care authorities to document final scaling-up activities and achievements. The outcome will be an easy-to-use synthesis of evidence-based mechanisms for implementation of each local activity, identifying also common features and existing differences among all scaling-up pilot regions.

2 Summary of the integrated care practice(s) piloted in VIGOUR

Please summarise how current care practices will be integrated in the VIGOUR pilots. Please bear in mind that your summary is intended to be understood by external readers who may not yet have familiarised themselves with any interim outputs generated in the framework of the VIGOUR project. To this end, please briefly summarise the situation before VIGOUR and then describe how integration is taking place as part of your pilot. In total, your description should not exceed one page.

Please insert your text here.

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3 Description of implementation activities

This Chapter focuses on describing in more detail how integrated care practices are practically implemented in your pilot. In relation to each of the generic integration mechanisms identified by the SELFIE project (see introduction), please summarise the specific approach adopted for the purpose of your pilot. Moreover, please describe tangible activities carried out for putting this approach into practice during the pilot duration. Please also describe any activities planned to be carried out after the pilot duration, as far as they concern the further implementation of your specific integration approach.

3.1 Service delivery A (incremental vs. disruptive approach)

This section focuses on the approach taken by the Pilot region in terms of services provided. In particular, it is required to specify if you have adopted a gradual approach to change, building on what was already existing (incremental growth model) or a disruptive innovation approach which implied the radical creation of new products or new environments.

Example: stakeholders adopted a stepwise approach to change by building upon what was already there (e.g., existing collaborative networks) and gradually expanded and broadened the scope of the integrated care programmes.

Key words: market regulation; policies to integrate care across organisations and sectors; service availability & access; organisational and structural integration; continuous quality improvement system; person-centred; tailored; self-management; pro-active; informal care givers involvement; treatment interaction; continuity

N.B. INSTRUCTION FOR THE TABLE COMPILATION

Please note that just the section with the implementation approach and the implementation activities needs to be filled in (input from the regions are required).

Implementation tasks (Operational Pilot Plan)	Implementation approach
• Target population • Interventions • Pathways • Readiness to change (NOT TO BE FILLED)	**Incremental growth model vs disruptive innovation approach?** (Please describe the approach adopted) .....

Implementation activities	
During the pilot	After the pilot

(Please describe the implemented activities)	(Please describe if future activities are planned) .....

3.2 Service delivery B (flexible vs. formal structures)

This section aims to identify the approach adopted on delivery service in terms of balance between flexibility and formal structures of integration. A person-centred approach is flexible by definition in terms of service delivery (meaning that systems in place a priori expect the unexpected and are ready and able to truly personalize care), so a balance between flexibility and formal structures of integration means that a service is delivered taking into account both of the need of the person that is not static and the establishing of formalized structures and responsibilities. This happens through an integration across health- and social care sectors.

Example: division of tasks in multidisciplinary teams, the use of protocols for specific groups of patients or protocols around common themes and the use of standardised procedures or tools etc.

Key words: market regulation; policies to integrate care across organisations and sectors; service availability & access; organisational and structural integration; continuous quality improvement system; person-centred; tailored; self-management; pro-active; informal care givers involvement; treatment interaction; continuity

N.B. INSTRUCTION FOR THE TABLE COMPILATION

Please note that just the section with the implementation approach and the implementation activities needs to be filled in (input from the regions are required).

Implementation tasks (Operational Pilot Plan)	Implementation approach
• Target population • Interventions • Pathways • Readiness to change (NOT TO BE FILLED)	**Balance between flexibility and formal structures of integration** (Please describe the approach adopted) .....

Implementation activities	
During the pilot	After the pilot
(Please describe the implemented activities)	(Please describe if future activities are planned) .....

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3.3 Leadership & governance A (collaborative governance)

This process of engaging different stakeholders, building trust and solid relationships is known as collaborative governance.[17]

The specific context of each region shapes the way leadership and governance is exercised, but common ingredients of good practice in leadership and governance can be identified. In this section we ask to describe if and how the pilot provides a collaborative governance by engaging stakeholders.

Example: promoting communication and consensus-oriented decision-making and continuously invest in building good relationships between professionals and the management, between professionals, and with payers, politicians, patient representatives and the community

Key words: political commitment; supportive leadership; clear accountability; performance-based management; culture of shared vision, ambitions, values; shared decision-making; individualised care planning; coordination tailored to complexity; trust; common vocabulary

N.B. INSTRUCTION FOR THE TABLE COMPILATION
Please note that just the section with the implementation approach and the implementation activities needs to be filled in (input from the regions are required).

Implementation tasks (Operational Pilot Plan)	Implementation approach
• Target population • Interventions • Pathways • Readiness to change (NOT TO BE FILLED)	**Collaborative governance by engaging stakeholder** (Please specify the kind of collaboration established) ...

Implementation activities	
During the pilot	After the pilot
(Please describe the implemented activities)	(Please describe if future activities are planned) .....

[17] Ansell & Gash, 2008

3.4 Leadership & governance B (leadership distribution)

Whereas in the previous mechanism on collaborative governance the focus was on the ways in which actors were brought together in forming a network (engagement of stakeholders etc), it is also of importance underlining how these networks/relationships are organized and led.

Supportive leadership throughout all levels of integrated care that promotes open discussion is seen as an important success factor for inter-professional collaboration. Furthermore, a good leadership should carefully avoid opportunistic behaviour, but instead creates a culture of continuous improvement and sharing of responsibilities.

The aim of this section is to identify if the pilot has benefit from any kind of distribution of the leadership throughout all levels of the system and which are the actions adopted for this purpose.

Example: setting up of specific management boards overseeing the integrated care initiative

Key words: political commitment; supportive leadership; clear accountability; performance-based management; culture of shared vision, ambitions, values; shared decision-making; individualised care planning; coordination tailored to complexity; trust; common vocabulary.

N.B. INSTRUCTION FOR THE TABLE COMPILATION
Please note that just the section with the implementation approach and the implementation activities needs to be filled in (input from the regions are required).

Implementation tasks (Operational Pilot Plan)	Implementation approach
• Target population • Interventions • Pathways • Readiness to change (NOT TO BE FILLED)	**Distribution leadership throughout all levels of the system** (Please specify the way leadership has been distributed)

Implementation activities	
During the pilot	After the pilot
(Please describe the implemented activities)	(Please describe if future activities are planned) .....

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3.5 Health and social care system

Good governance is only possible with a good work alignment across the different components and levels of the health and social care system.

This section aims to identify what approach was taken by the pilot to align health care, public health, and social services aspects to better address the goals and needs of the people and communities involved.

Example: optimising multidisciplinary residential care towards supporting self-management, self-sufficiency of patients at home[18] / foster communication between multidisciplinary professionals involved / build an enabling environment to co-create integrated care initiatives

Key words: housing; welfare services; community; holistic understanding; communication; enabling environment; social determinants.

N.B. INSTRUCTION FOR THE TABLE COMPILATION
Please note that just the section with the implementation approach and the implementation activities needs to be filled in (input from the regions are required).

Implementation tasks (Operational Pilot Plan)	Implementation approach
• Target population • Interventions • Pathways • Readiness to change (NOT TO BE FILLED)	**Work alignment** (Please describe the approach adopted) .....

Implementation activities	
During the pilot	After the pilot
(Please describe the implemented activities)	(Please describe if future activities are planned) .....

[18] https://www.sciencedirect.com/topics/social-sciences/autonomy

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3.6 Workforce A (team culture)

This section aims to collect information about the actions undertaken by the pilot to build a multidisciplinary team culture with mutual recognition of each other's roles.

Example: New ways of working in teams and collaborations / meetings with professionals and managers from different disciplines and organisations / exchange of information and joint contributions of different professionals / co-creation of integrated services with respectful acknowledgement of each other's competencies

Key words: team culture; multi-disciplinarity; inter-professional relationship; co-creation

N.B. INSTRUCTION FOR THE TABLE COMPILATION
Please note that just the section with the implementation approach and the implementation activities needs to be filled in (input from the regions are required).

Implementation tasks (Operational Pilot Plan)	Implementation approach
• Resources • Capacity building (NOT TO BE FILLED)	**Team culture** (Please describe the approach adopted)

Implementation activities	
During the pilot	After the pilot
(Please describe the implemented activities)	(Please describe if future activities are planned) .....

3.7 Workforce B (new roles and competencies)

A well performing workforce is one that is responsive to the needs and expectations of people, is fair and efficient to achieve the best outcomes possible given available resources and circumstances (WHO).

This section is meant to identify the development of new roles and competencies for integrated care implemented by the pilot region.

Example: recruitment of new professionals to engage in the teamwork; creation of new roles (trained); task-shifting to counterbalance the shortage of health care; development of new competencies specifically related to the changing role of patients

Key words: new professionals' roles; new competencies; task-shifting.

N.B. INSTRUCTION FOR THE TABLE COMPILATION

Please note that just the section with the implementation approach and the implementation activities needs to be filled in (input from the regions are required).

Implementation tasks (Operational Pilot Plan)	Implementation approach
• Resources • Capacity building (NOT TO BE FILLED)	**New roles and competencies**

Implementation activities	
During the pilot	After the pilot
(Please describe the implemented activities)	(Please describe if future activities are planned) .....

3.8 Financing

Health financing can be a key policy instrument to improve health and reduce health inequalities.

Apart from financing, it is generally acknowledged that we need innovative payment models that incentivise integration instead of fragmentation (Leijten et al., 2018; Struckmann et al., 2017).

In this section we ask to describe the funding typology applied and if innovative payment methods have been provided.

Example: payment incentives used to motivate professionals to participate in the integrated care programmes / stipulation of long-term contracts / payment models in which budgets are pooled, shared-savings/loss agreements are included.

Key words: stimulating investments in innovative care models; incentives to collaborate; risks adjustments; secured budget; equity & access; out of pocket costs; coverage and reimbursements

N.B. INSTRUCTION FOR THE TABLE COMPILATION

Please note that just the section with the implementation approach and the implementation activities needs to be filled in (input from the regions are required).

Implementation tasks (Operational Pilot Plan)	Implementation approach
• Funding streams (NOT TO BE FILLED)	**Funding typology / Innovative payments** (Please specify the type of funding/innovative payments if applicable) **.....**

Implementation activities	
During the pilot	After the pilot
(Please describe the implemented activities)	(Please describe if future activities are planned) .....

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3.9 ICT (technology & medical devices)

Information and communications technology (ICT) can be a facilitator of integrated and coordinated care.[19] ICT innovation should line up with cultural and organisational change with the aim to generate a fit between technology and working practices.

This section aims at identifying the pilot's approach in the use of technologies and medical devices and the implementation of ICT to support collaboration and communication rather than administrative procedures.

Example: implementation of EHRs (Electronic Health Records) to enhanced communication and information flows; use of open-source algorithm that predicts individual patient risks; use of telemedicine

Key words: E-health tools; remote monitoring; EMRs and patient's portal; assistive technologies; remote monitoring; shared information systems; interoperability; policies fostering technological innovations.

N.B. INSTRUCTION FOR THE TABLE COMPILATION

Please note that just the section with the implementation approach and the implementation activities needs to be filled in (input from the regions are required).

Implementation tasks (Operational Pilot Plan)	Implementation approach
• ICT & tools (NOT TO BE FILLED)	**Collaboration support / Communication support** (Please specify the support provided by ICT tools) ……

Implementation activities	
During the pilot	After the pilot
(Please describe the implemented activities) ……	(Please describe if future activities are planned) …..

[19] N. Goodwin, A. Dixon, G. Anderson, W. Wodchis "Providing integrated care for older people with complex needs: Lessons from seven international case studies", The King's Fund, London (2014)

3.10 Information & research

Feedback and monitoring of the activities implemented, and their results are crucial strategies for the implementation of the integrated care programmes and might guarantee the inclusion of all the stakeholders involved. Feedback from the patient as from the professionals, managers and other stakeholders involved are very important to identify problems and needs, make evidence-based decisions on health policy, and allocate scarce resources optimally.

This section aims to collect information on how the pilot has conducted feedback loops and continuous monitoring of the information, processes and outcomes reached.

Example: outcomes of quality indicators related to integrated care systematically collected; provision of continuous monitoring of working processes and outcomes at different levels of the organisations and of different stakeholders involved in the integrated care programmes; provision of access to data / information.

Key words: process monitoring; innovative research methods; access to information

N.B. INSTRUCTION FOR THE TABLE COMPILATION
Please note that just the section with the implementation approach and the implementation activities needs to be filled in (input from the regions are required).

Implementation tasks (Operational Pilot Plan)	Implementation approach
• Risk planning • Execution monitoring & evaluation (NOT TO BE FILLED)	**Feedback loops / Continuous monitoring system** (Please specify the approach adopted) ……

Implementation activities	
During the pilot	After the pilot
(Please describe the implemented activities) ……	(Please describe if future activities are planned) …..

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