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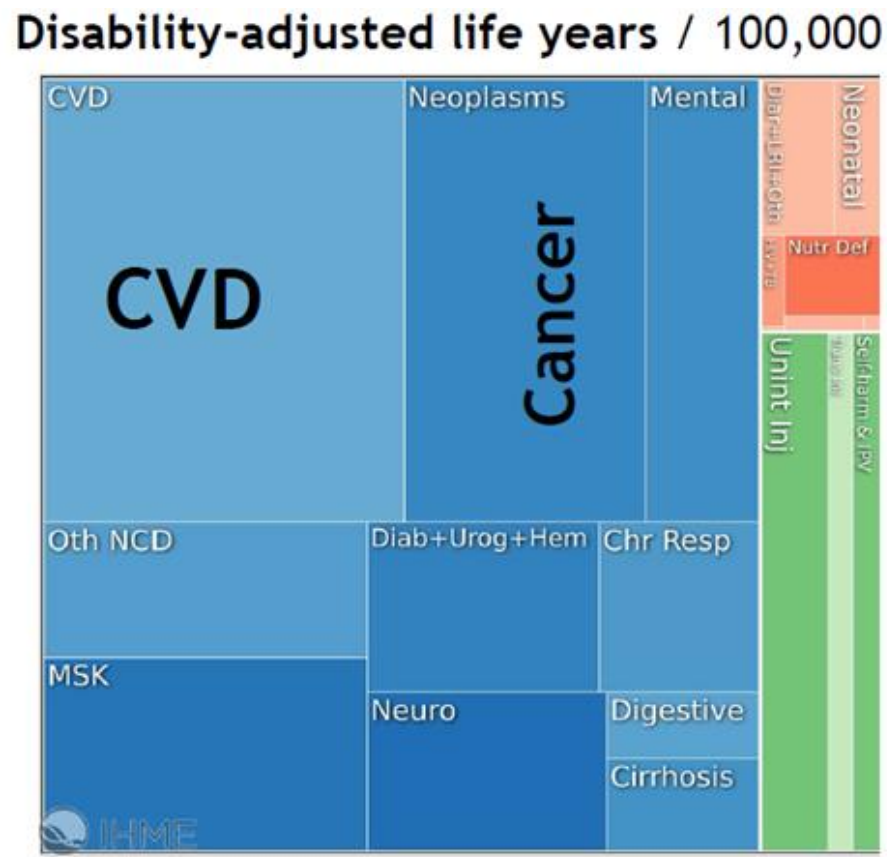
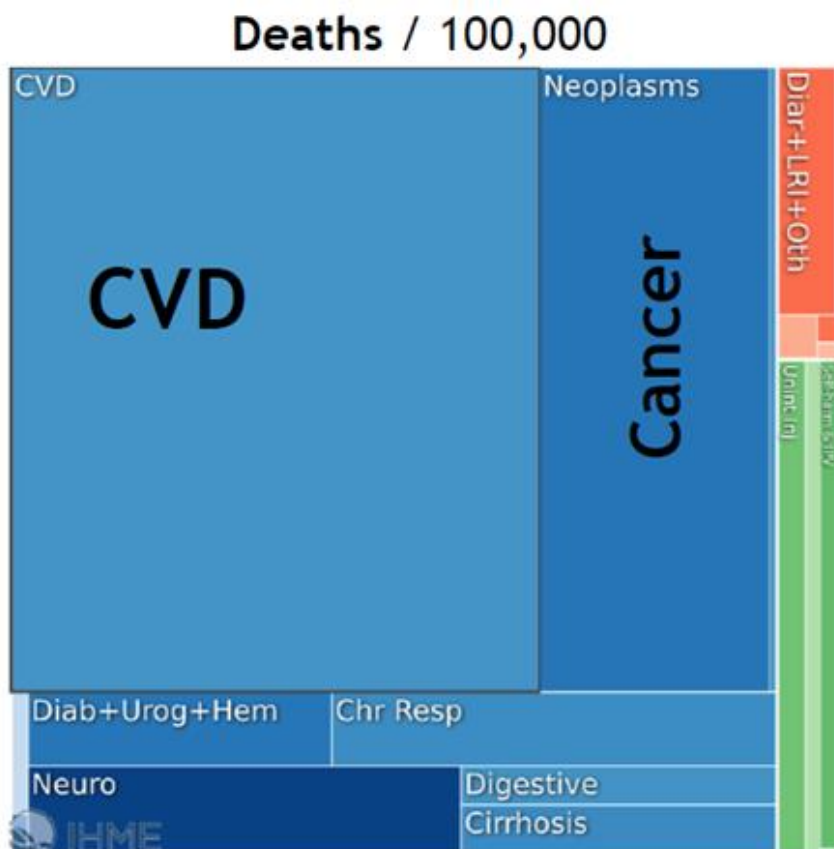
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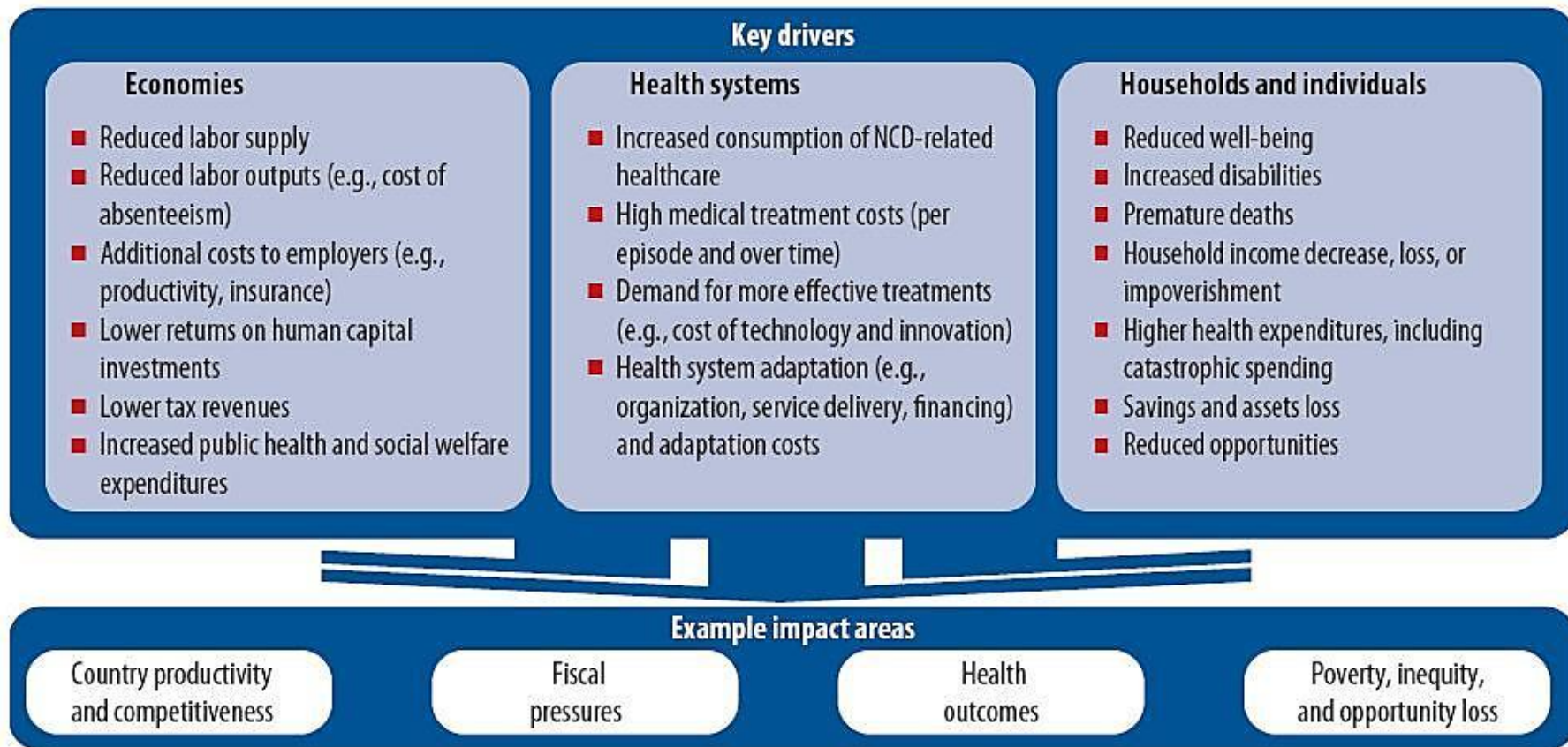
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# Chronic diseases dominate the causes of both overall mortality and DALYs



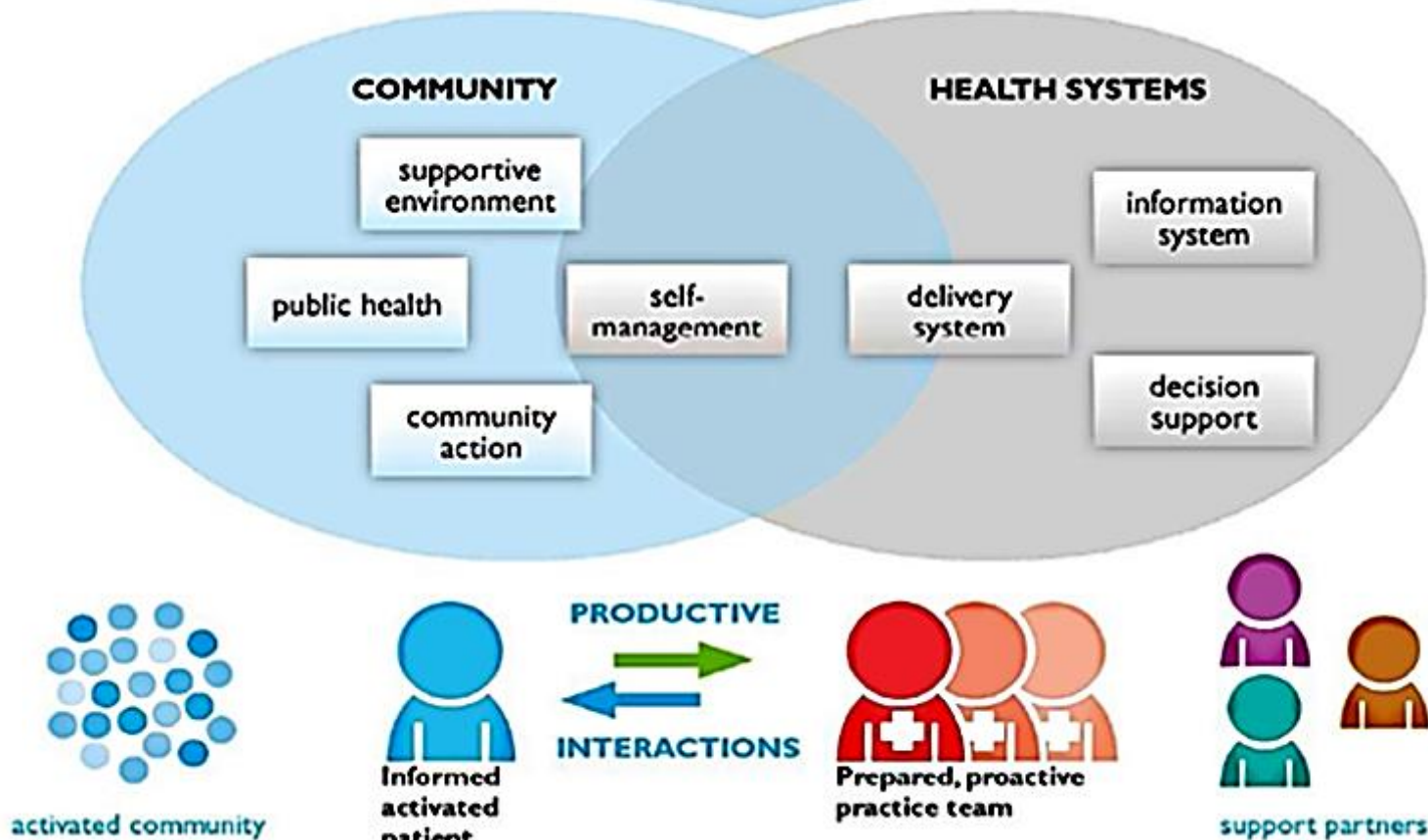
# Socioeconomic impact of CDs

High Cost to Economies, Health Systems, Households and Individuals



Sources: World Bank analysis in "Chronic Emergency: Why NCDs Matter." *Health, Nutrition, and Population Discussion Paper*. 2011. Washington DC: World Bank.<sup>2</sup>

# INTEGRATED CARE



## improved outcomes



# Is the CCM / IC implemented?

	Organisation of healthcare	Self-management	Decision support	Delivery system design	Clinical information systems	Community and policies
DK	X	X	X	X	X	(X)
D	(X)	(X)	-	-	X	-
FI	X	X	X	X	X	-
FR	(X)	X	X	X	(X)	(X)
I	X	(X)	(X)	(X)	(X)	(X)
NL	X	X	(X)	X	(X)	X
PL	(X)	-	-	-	(X)	-
SC	X	X	X	X	X	X
SK	(X)	-	-	-	-	-
SP	X	X	X	X	(X)	(X)

Notes: X Implemented

(X) Systematic steps towards implementation

- Not implemented



# Who we are?

## 9 Health and Social Care Authorities:

- ▶ Flanders Agency for Health and Care, Belgium
- ▶ Optimedis, Germany
- ▶ AReSS Puglia, Italy
- ▶ Vilnius University Hospital, Latvia
- ▶ National Health Fund, Poland
- ▶ **TEC Division, Scottish Government (Coordinator)**
- ▶ Pavol Jozef Safarik University, Slovakia
- ▶ Social Protection Institute of the Republic of Slovenia
- ▶ Osakidetza, Basque Country, Spain

## 3 Universities and Competence Centers

- ▶ University of Edinburgh, Scotland
- ▶ University of Valencia, Spain
- ▶ Kronikgune, Basque Country, Spain

## 2 Membership Organisations

- ▶ EHTEL (European Health Telematics Association), Belgium
- ▶ AER (Assembly of European Regions), France

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**Budget: €2,649,587**

**Start: 1 January 2019**

# Aim of SCIROCCO Exchange

“To support the readiness and capacity of health and social care authorities for the adoption and scaling up of integrated care by facilitating their access to tailored, evidence-based assets on integrated care and supporting personalised knowledge transfer and improvement planning.”

# Why Integrated Care?

The evidence suggests that developing more integrated person-centred care has the potential to generate significant improvements in the health and care of all citizens, including better access to care, health and clinical outcomes, health literacy and self-care; increased satisfaction with care; and improved job satisfaction for health and care professionals, efficiency of services and reduced overall costs.



**crosscutting, connecting & engaging stakeholders across sectors,  
from private & public sector**



# Local context matters!

- ▶ What conditions enables the successful adoption and scaling-up of integrated care?
- ▶ How to change existing boundaries and behaviours to work differently; in more co-ordinated and integrated way?
- ▶ How to support leaders and all stakeholders involved to adopt a long journey of change towards the transformation and succeed in their efforts?
- ▶ How to share learning more widely to build sustainable integrated care systems?



## Maturity Model for Integrated Care

# B3 Maturity Model for Integrated Care



Qualitative assessment based on interviews and desk research

Phase 1: Interviews with 6 regions involved in EIP AHA (Feb – April 2014)

Athens; Basque Country; Catalonia; Galicia; N Ireland; Saxony

Phase 2 Interviews with 6 regions involved in EIP AHA (Jan– March 2015)

S Denmark; Skane; Scotland; Puglia; Delft; Olomouc



European Innovation  
Partnership on Active  
and Healthy Ageing

# SCIROCCO Tool for Integrated Care

<https://scirocco-exchange-tool.inf.ed.ac.uk>

Online

self-assessment tool

to address the challenge  
of adoption and scaling-  
up of integrated care

Validated and tested in over  
65 regions/organisations





READINESS  
TO CHANGE

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

## Assessment scale

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

# Using the SCIROCCO Tool

<https://scirocco-exchange-tool.inf.ed.ac.uk>

## New Maturity Model Questionnaire

Please reply to all of the questions

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

2. Structure & Governance \* Required 

- Fragmented structure and governance in place
- Recognition of the need for structural and governance
- Formation of task forces, alliances and other infrastructure
- Governance established at a regional or national level
- Roadmap for a change programme defined and agreed
- Full, integrated programme established, with full implementation

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

How confident are you of your rating?

Who do you think could provide a more confident judgement?

Questionnaire name: \*

ALEC DEMO

Save questionnaire

### Q2. Structure and Governance: Objectives

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

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

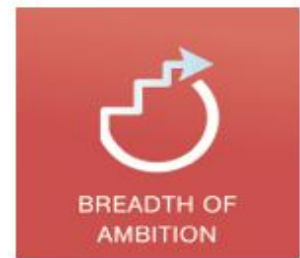
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# Are we ready for integrated care?

## Strengths



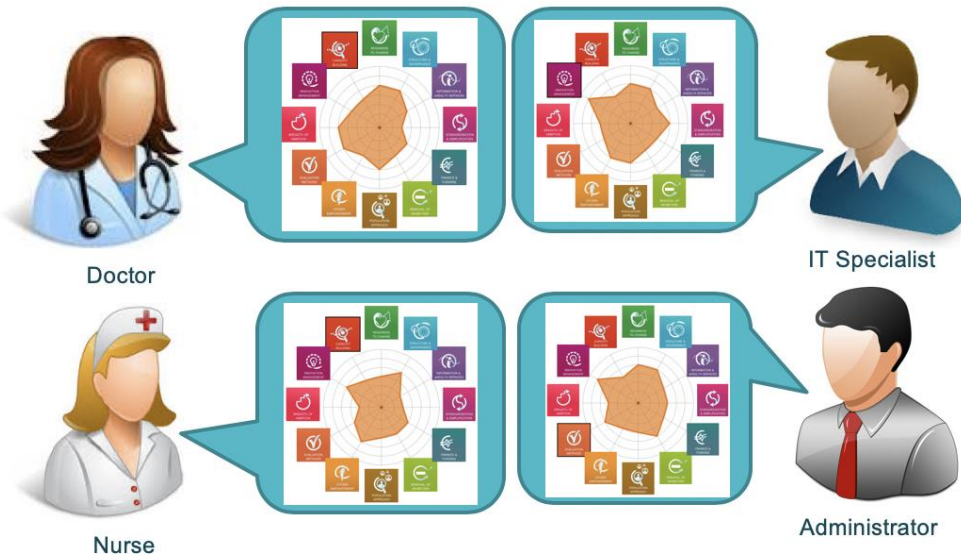
## Weaknesses





# Are all stakeholders involved?





Can we agree on common priorities?



# Can we learn from others?



**COMMONALITIES**

- Capacity building
- Innovation Management
- Structure and Governance
- eHealth

*Local conditions enable transferability of learning*



**DIFFERENCES**

- Readiness to change
- Standardisation & Simplification
- Population approach
- Citizen Empowerment
- Evaluation methods
- Breadth of ambition

*Not feasible to transfer*



**STRENGTHS**

- 5. Finance and funding
- 6. Removal of inhibitors

*No need for adaptation except for Dimension 6 that needs further work*

# Knowledge transfer as an enabler of capacity-building support

*“Knowledge transfer is a “contact sport”; it works better when people meet to exchange ideas and spot new opportunities” – Tim Minshall*

**1. Maturity assessment for integrated care**

**4. Improvement Plans**

**SCIROCCO Exchange  
Knowledge Management Hub**

*Integrator and facilitator of  
capacity-building support  
for integrated care*

**2. Capacity-building  
assets**

**3. Knowledge transfer**







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