EUROPEAN COMMISSION
Consumers, Health, Agriculture and Food Executive Agency
Director

GRANT AGREEMENT

NUMBER — 710033 — SCIROCCO

This **Agreement** ('the Agreement') is **between** the following parties:

on the one part,

the **Consumers, Health, Agriculture and Food Executive Agency (CHAFEA)** ('the Agency'), under the power delegated by the European Commission ('the Commission'),

represented for the purposes of signature of this Agreement by Jacques REMACLE, or his duly authorised representative,

and

on the other part,

1. 'the coordinator':

NHS 24 (SCOTLAND) (NHS 24), -, established in FIFTY PITCHES ROAD 140, GLASGOW G51 4EB, United Kingdom, GB654413544 represented for the purposes of signing the Agreement by Margo MCGURK

and the following other beneficiaries, if they sign their 'Accession Form' (see Annex 3 and Article 40):

2. **THE UNIVERSITY OF EDINBURGH (UEDIN)**, SC005336, established in OLD COLLEGE, SOUTH BRIDGE, EDINBURGH EH8 9YL, United Kingdom, GB592950700

3. **VRIJE UNIVERSITEIT BRUSSEL (VUB)**, 449012406, established in PLEINLAAN 2, BRUSSEL 1050, Belgium, BE0449012406

4. **UNIVERSITAT DE VALENCIA (UVEG)**, Decreto Nr 128/2004 , established in AVENIDA BLASCO IBANEZ 13, VALENCIA 46010, Spain, ESQ4618001D

5. **ASOCIACION CENTRO DE EXCELENCIA INTERNACIONAL EN INVESTIGACION SOBRE CRONICIDAD (KRONIKGUNE)** ES5, ASB161422011, established in RONDA DE AZKUE 1 TORRE DEL BILBAO EXHIBITION CENTRE, BARAKALDO 48902, Spain, ESG95646014

6. **Servicio Vasco de Salud Osakidetza (Osakidetza)**, established in Alava 45, Vitoria-Gasteiz 01006 , Spain, ESS5100023J

7. **AGENZIA REGIONALE SANITARIA PUGLIESE (ARES PUGLI)**, CF05747190725, established in VIA CADUTI DI TUTTE LE GUERRE 15, BARI 70126 , Italy, IT05747190725

8. **FAKULTNI NEMOCNICE OLOMOUC (FNOL)**, 00098892, established in I.P. PAVLOVA 185/6, OLOMOUC 775 20, Czech Republic, CZ00098892

9. **NORRBOTTENS LÄNS LANDSTING (NLL)**, 232100-0230 , established in ROBERTSVIKSGATAN 7, LULEA 97189, Sweden, SE232100023001

10. **EUROPEAN HEALTH TELEMATICS ASSOCIATION (EHTEL)** AISBL, 140482000, established in RUE DE TREVES 49 51, BRUXELLES 1040, Belgium, BE0472058913

Unless otherwise specified, references to ‘beneficiary’ or ‘beneficiaries’ include the coordinator.

The parties referred to above have agreed to enter into the Agreement under the terms and conditions below.

By signing the Agreement or the Accession Form, the beneficiaries accept the grant and agree to implement the action under their own responsibility and in accordance with the Agreement, with all the obligations and conditions it sets out.

The Agreement is composed of:

Terms and Conditions

Annex 1 Description of the action

Annex 2 Estimated budget for the action

Annex 3 Accession Forms

Annex 4 Model for the financial statements

Annex 5 Model for the certificate on the financial statements

TERMS AND CONDITIONS

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CHAPTER 1 GENERAL

ARTICLE 1 — SUBJECT OF THE AGREEMENT

This Agreement sets out the rights and obligations and the terms and conditions applicable to the grant awarded to the beneficiaries for implementing the action set out in Chapter 2.

CHAPTER 2 ACTION

ARTICLE 2 — ACTION TO BE IMPLEMENTED

The grant is awarded for the action entitled '***SCALING INTEGRATED CARE IN CONTEXT — SCIROCCO***' **('action')**, as described in Annex 1.

ARTICLE 3 — DURATION AND STARTING DATE OF THE ACTION

The duration of the action will be ***32*** **months** as of *the first day of the month following the date the Agreement enters into force (see Article 42)* ('**starting date of the action**').

ARTICLE 4 — ESTIMATED BUDGET AND BUDGET TRANSFERS

4.1 Estimated budget

The '**estimated budget**' for the action is set out in Annex 2.

It contains the estimated eligible costs and the forms of costs, broken down by beneficiary and budget category (see Articles 5, 6).

4.2 Budget transfers

The estimated budget breakdown indicated in Annex 2 may be adjusted by transfers of amounts between beneficiaries or between budget categories (or both). This does not require an amendment according to Article 39, if the action is implemented as described in Annex 1.

However, the beneficiaries may not add costs relating to subcontracts not provided for in Annex 1, unless such additional subcontracts are approved by an amendment or in accordance with Article 10.

CHAPTER 3 GRANT

ARTICLE 5 — GRANT AMOUNT, FORM OF GRANT, REIMBURSEMENT RATES AND FORMS OF COSTS

5.1 Maximum grant amount

The '**maximum grant amount**' is **EUR 1,322,775.00** (one million three hundred and twenty two thousand seven hundred and seventy five EURO).

5.2 Form of grant, reimbursement rates and forms of costs

The grant reimburses ***60% of the action's eligible costs*** (see Article 6) ('**reimbursement of eligible costs grant**') (see Annex 2).

The estimated eligible costs of the action are EUR **2,204,631.21** (two million two hundred and four thousand six hundred and thirty one EURO and twenty one eurocents).

Eligible costs (see Article 6) must be declared under the following forms ('**forms of costs**' or '**costs forms**'):

(a) for **direct personnel costs**: as actually incurred costs (**actual costs**);

(b) for **direct costs of subcontracting**: as actually incurred costs (**actual costs**);

(c) for **other direct costs**: as actually incurred costs (**actual costs**);

(d) for **indirect costs**: on the basis of a flat-rate applied as set out in Article 6.2.D ('**flat-rate costs**');

5.3 Final grant amount — Calculation

The '**final grant amount**' depends on the actual extent to which the action is implemented in accordance with the Agreement's terms and conditions.

This amount is calculated by the Agency — when the payment of the balance is made — in the following steps:

Step 1 – Application of the reimbursement rate to the eligible costs

Step 2 – Limit to the maximum grant amount

Step 3 – Reduction due to the no-profit rule

Step 4 – Reduction due to improper implementation or breach of other obligations

5.3.1 Step 1 — Application of the reimbursement rate to the eligible costs

The reimbursement rate (see Article 5.2) is applied to the eligible costs (actual costs and flat-rate costs; see Article 6) declared by the beneficiaries (see Article 15) and approved by the Agency (see Article 16).

5.3.2 Step 2 — Limit to the maximum grant amount

If the amount obtained following Step 1 is higher than the maximum grant amount set out in Article 5.1, it will be limited to the latter.

5.3.3 Step 3 — Reduction due to the no-profit rule

The grant must not produce a profit.

'**Profit**' means the surplus of the amount obtained following Steps 1 and 2 plus the action's total receipts, over the action's total eligible costs.

The '**action's total eligible costs**' are the consolidated total eligible costs approved by the Agency.

The '**action's total receipts**' are the consolidated total receipts generated during its duration (see Article 3).

The following are considered **receipts**:

(a) income generated by the action;

(b) financial contributions given by third parties to the beneficiary specifically to be used for costs that are eligible under the action.

The following are however **not** considered receipts:

(a) financial contributions by third parties, if they may be used to cover costs other than the eligible costs (see Article 6);

(b) financial contributions by third parties with no obligation to repay any amount unused at the end of the period set out in Article 3.

If there is a profit, it will be deducted in proportion to the final rate of reimbursement of the eligible actual costs approved by the Agency (as compared to the amount calculated following Steps 1 and 2).

5.3.4 Step 4 — Reduction due to improper implementation or breach of other obligations — Reduced grant amount — Calculation

If the grant is reduced (see Article 27), the Agency will calculate the reduced grant amount by deducting the amount of the reduction (calculated in proportion to the improper implementation of the action or to the seriousness of the breach of obligations in accordance with Article 27.2) from the maximum grant amount set out in Article 5.1.

The final grant amount will be the lower of the following two:

- the amount obtained following Steps 1 to 3 or

- the reduced grant amount following Step 4.

5.4 Revised final grant amount — Calculation

If — after the payment of the balance (in particular, after checks, reviews, audits or investigations; see Article 17) — the Agency rejects costs (see Article 26) or reduces the grant (see Article 27), it will calculate the '**revised final grant amount**' for the action.

This amount is calculated by the Agency on the basis of the findings, as follows:

- in case of **rejection of costs**: by applying the reimbursement rate to the revised eligible costs approved by the Agency for the action, limiting it to the maximum grant amount and making a reduction if there is a profit (see Article 5.3);

- in case of **reduction of the grant**: by deducting the amount of the reduction (calculated in proportion to the improper implementation of the action or to the seriousness of the breach of obligations in accordance with Article 27.2) from the maximum grant amount set out in Article 5.1.

In case of **rejection of costs and reduction of the grant**, the revised final grant amount for the action will be the lower of the two amounts above.

ARTICLE 6 — ELIGIBLE AND INELIGIBLE COSTS

6.1 General conditions for costs to be eligible

'**Eligible costs**' are costs that meet the following criteria:

(a) for **actual costs**:

(i) they must be actually incurred by the beneficiary;

(ii) they must be incurred in the period set out in Article 3, with the exception of costs relating to the submission of the periodic report for the last reporting period and the final report (see Article 15);

(iii) they must be indicated in the estimated budget set out in Annex 2;

(iv) they must be incurred in connection with the action as described in Annex 1 and necessary for its implementation;

(v) they must be identifiable and verifiable, in particular recorded in the beneficiary's accounts in accordance with the accounting standards applicable in the country where the beneficiary is established and with the beneficiary's usual cost accounting practices;

(vi) they must comply with the applicable national law on taxes, labour and social security, and

(vii) they must be reasonable, justified and must comply with the principle of sound financial management, in particular regarding economy and efficiency;

(b) for **flat-rate costs**:

(i) they must be calculated by applying the flat-rate set out in Annex 2, and

(ii) the costs (actual costs) to which the flat-rate is applied must comply with the conditions for eligibility set out in this Article.

6.2 Specific conditions for costs to be eligible

Costs are eligible if they comply with the general conditions (see above) and the specific conditions set out below, for each of the following budget categories:

A. direct personnel costs;

B. direct costs of subcontracting;

C. other direct costs;

D. indirect costs;

'Direct costs' are costs that are directly linked to the action implementation and can therefore be attributed to it directly. They must not include any indirect costs (see Point D below).

'Indirect costs' are costs that are not directly linked to the action implementation and therefore cannot be attributed directly to it.

A. Direct personnel costs

Types of eligible personnel costs

A.1 Personnel costs are eligible if they are related to personnel working for the beneficiary under an employment contract (or equivalent appointing act) and assigned to the action ('**costs for employees (or equivalent)**'). They must be limited to salaries (including during parental leave), social security contributions, taxes and other costs included in the **remuneration**, if they arise from national law or the employment contract (or equivalent appointing act).

They may also include **additional remuneration** for personnel assigned to the action (including payments on the basis of supplementary contracts regardless of their nature), if:

(a) it is part of the beneficiary's usual remuneration practices and is paid in a consistent manner whenever the same kind of work or expertise is required;

(b) the criteria used to calculate the supplementary payments are objective and generally applied by the beneficiary, regardless of the source of funding used.

A.2 The **costs for natural persons working under a direct contract** with the beneficiary other than an employment contract or seconded by a third party against payment are eligible personnel costs, if:

(a) the person works under the beneficiary's instructions and, unless otherwise agreed with the beneficiary, on the beneficiary's premises;

(b) the result of the work carried out belongs to the beneficiary, and

(c) the costs are not significantly different from those for personnel performing similar tasks under an employment contract with the beneficiary.

Calculation

Personnel costs must be calculated by the beneficiaries as follows:

{hourly rate

multiplied by

the number of actual hours worked on the action}.

The number of actual hours declared for a person must be identifiable and verifiable (see Article 13).

The total number of hours declared in EU or Euratom grants, for a person for a year, cannot be higher than the annual productive hours used for the calculations of the hourly rate. Therefore, the maximum number of hours that can be declared for the grant are:

{the number of annual productive hours for the year (see below)

minus

total number of hours declared by the beneficiary, for that person for that year, for other EU or Euratom grants}.

The '**hourly rate**' is the amount calculated as follows:

{actual annual personnel costs for the person

divided by

number of annual productive hours}.

The beneficiaries must use the annual personnel costs and the number of annual productive hours for each financial year covered by the reporting period. If a financial year is not closed at the end of the reporting period, the beneficiaries must use the hourly rate of the last closed financial year available.

For the 'number of annual productive hours', the beneficiaries may choose one of the following:

(i) 'fixed number of hours': 1 720 hours for persons working full time (or corresponding pro-rata for persons not working full time);

(ii) 'individual annual productive hours': the total number of hours worked by the person in the year for the beneficiary, calculated as follows:

{annual workable hours of the person (according to the employment contract, applicable collective labour agreement or national law)

plus

overtime worked

minus

absences (such as sick leave and special leave)}.

'Annual workable hours' means the period during which the personnel must be working, at the employer's disposal and carrying out his/her activity or duties under the employment contract, applicable collective labour agreement or national working time legislation.

If the contract (or applicable collective labour agreement or national working time legislation) does not allow to determine the annual workable hours, this option cannot be used;

(iii) 'standard annual productive hours': the 'standard number of annual hours' generally applied by the beneficiary for its personnel in accordance with its usual cost accounting practices. This number must be at least 90% of the 'standard annual workable hours'.

If there is no applicable reference for the standard annual workable hours, this option cannot be used.

For all options, the actual time spent on **parental leave** by a person assigned to the action may be deducted from the number of annual productive hours;

B. Direct costs of subcontracting (including related duties, taxes and charges, such as non-deductible value added tax (VAT) paid by beneficiaries that are not public bodies acting as public authority) are eligible if the conditions in Article 10.1.1 are met.

C. Other direct costs

C.1 **Travel costs and related subsistence allowances** (including related duties, taxes and charges, such as non-deductible value added tax (VAT) paid by beneficiaries that are not public bodies acting as public authority) are eligible if they are in line with the beneficiary's usual practices on travel.

C.2 The **depreciation costs of equipment, infrastructure or other assets** (new or second-hand) as recorded in the beneficiary's accounts are eligible, if they were purchased in accordance with Article 9.1.1 and written off in accordance with international accounting standards and the beneficiary's usual accounting practices.

The **costs of renting or leasing** equipment, infrastructure or other assets (including related duties, taxes and charges, such as non-deductible value added tax (VAT) paid by beneficiaries that are not public bodies acting as public authority) are also eligible, if they do not exceed the depreciation costs of similar equipment, infrastructure or assets and do not include any financing fees.

The only portion of the costs that will be taken into account is that which corresponds to the duration of the action and rate of actual use for the purposes of the action.

C.3 **Costs of other goods and services** (including related duties, taxes and charges, such as non-deductible value added tax (VAT) paid by beneficiaries that are not public bodies acting as public authority) are eligible, if they are purchased specifically for the action and in accordance with Article 9.1.1.

Such goods and services include, for instance, consumables and supplies, dissemination, protection of results, certificates on the financial statements (if they are required by the Agreement), translations and publications.

D. Indirect costs

Indirect costs are eligible if they are declared on the basis of the flat-rate of 7% of the eligible direct costs (see Article 5.2 and Points A to C above).

Beneficiaries receiving an operating grant[1] financed by the EU or Euratom budget cannot declare indirect costs for the period covered by the operating grant.

6.3 Conditions for costs of affiliated entities to be eligible

not applicable

[1] For the definition, see Article 121(1)(b) of Regulation (EU, Euratom) No 966/2012 of the European Parliament and of the Council of 25 October 2012 on the financial rules applicable to the general budget of the Union and repealing Council Regulation (EC, Euratom) No 1605/2002 (OJ L 218, 26.10.2012, p.1) ('**Financial Regulation No 966/2012**'): '**operating grant**' means direct financial contribution, by way of donation, from the budget in order to finance the functioning of a body which pursues an aim of general EU interest or has an objective forming part of and supporting an EU policy.

6.4 Ineligible costs

'**Ineligible costs**' are:

(a) costs that do not comply with the conditions set out above (Article 6.1 to 6.3), in particular:

(i) costs related to return on capital;

(ii) debt and debt service charges;

(iii) provisions for future losses or debts;

(iv) interest owed;

(v) doubtful debts;

(vi) currency exchange losses;

(vii) bank costs charged by the beneficiary's bank for transfers from the Agency;

(viii) excessive or reckless expenditure;

(ix) deductible VAT;

(x) costs incurred during suspension of the implementation of the action (see Article 33);

(xi) in-kind contributions provided by third parties;

(b) costs declared under another EU or Euratom grant (including grants awarded by a Member State and financed by the EU or Euratom budget and grants awarded by bodies other than the Agency for the purpose of implementing the EU or Euratom budget); in particular, indirect costs if the beneficiary is already receiving an operating grant financed by the EU or Euratom budget in the same period.

6.5 Consequences of declaration of ineligible costs

Declared costs that are ineligible will be rejected (see Article 26).

This may also lead to any of the other measures described in Chapter 6.

CHAPTER 4 RIGHTS AND OBLIGATIONS OF THE PARTIES

SECTION 1 RIGHTS AND OBLIGATIONS RELATED TO IMPLEMENTING THE ACTION

ARTICLE 7 — GENERAL OBLIGATION TO PROPERLY IMPLEMENT THE ACTION

7.1 General obligation to properly implement the action

The beneficiaries must implement the action as described in Annex 1 and in compliance with the provisions of the Agreement and all legal obligations under applicable EU, international and national law.

7.2 Consequences of non-compliance

If a beneficiary breaches any of its obligations under this Article, the grant may be reduced (see Article 27).

Such breaches may also lead to any of the other measures described in Chapter 6.

ARTICLE 8 — RESOURCES TO IMPLEMENT THE ACTION — THIRD PARTIES INVOLVED IN THE ACTION

The beneficiaries must have the appropriate resources to implement the action.

If it is necessary to implement the action, the beneficiaries may:

- purchase goods, works and services (see Article 9);
- call upon subcontractors to implement action tasks described in Annex 1 (see Article 10);
- call upon affiliated entities to implement action tasks described in Annex 1 (see Article 11).

In these cases, the beneficiaries retain sole responsibility towards the Agency and the other beneficiaries for implementing the action.

ARTICLE 9 — PURCHASE OF GOODS, WORKS OR SERVICES

9.1 Rules for purchasing goods, works or services

9.1.1 If necessary to implement the action, the beneficiaries may purchase goods, works or services.

The beneficiaries must make such purchases ensuring the best value for money or, if appropriate, the lowest price. In doing so, they must avoid any conflict of interests (see Article 20).

The beneficiaries must ensure that the Agency, the Commission, the European Court of Auditors (ECA) and the European Anti-fraud Office (OLAF) can exercise their rights under Articles 17 and 18 also towards their contractors.

9.1.2 Beneficiaries that are ‘contracting authorities’ within the meaning of Directive 2004/18/EC[2] or ‘contracting entities’ within the meaning of Directive 2004/17/EC[3] must comply with the applicable national law on public procurement.

[2] Directive 2004/18/EC of the European Parliament and of the Council of 31 March 2004 on the coordination of procedures for the award of public work contracts, public supply contracts and public service contracts (OJ L 134, 30.04.2004, p. 114).

9.2 Consequences of non-compliance

If a beneficiary breaches any of its obligations under Article 9.1.1, the costs related to the contract concerned will be ineligible (see Article 6) and will be rejected (see Article 26).

If a beneficiary breaches any of its obligations under Article 9.1.2, the grant may be reduced (see Article 27).

Such breaches may also lead to any of the other measures described in Chapter 6.

ARTICLE 10 — IMPLEMENTATION OF ACTION TASKS BY SUBCONTRACTORS

10.1 Rules for subcontracting action tasks

10.1.1 If necessary to implement the action, the beneficiaries may award subcontracts covering the implementation of certain action tasks described in Annex 1.

Subcontracting may cover only a limited part of the action.

The beneficiaries must award the subcontracts ensuring the best value for money or, if appropriate, the lowest price. In doing so, they must avoid any conflict of interests (see Article 20).

The tasks to be implemented and the estimated cost for each subcontract must be set out in Annex 1 and the total estimated costs of subcontracting per beneficiary must be set out in Annex 2. The Agency may however approve subcontracts not set out in Annex 1 and 2 without amendment (see Article 39), if:

- they are specifically justified in the periodic technical report and

- they do not entail changes to the Agreement which would call into question the decision awarding the grant or breach the principle of equal treatment of applicants.

The beneficiaries must ensure that the Agency, the Commission, the European Court of Auditors (ECA) and the European Anti-Fraud Office (OLAF) can exercise their rights under Articles 17 and 18 also towards their subcontractors.

10.1.2 The beneficiaries must ensure that their obligations under Articles 20, 21, 22 and 30 also apply to the subcontractors.

Beneficiaries that are ‘contracting authorities’ within the meaning of Directive 2004/18/EC or ‘contracting entities’ within the meaning of Directive 2004/17/EC must comply with the applicable national law on public procurement.

10.2 Consequences of non-compliance

If a beneficiary breaches any of its obligations under Article 10.1.1, the costs related to the subcontract concerned will be ineligible (see Article 6) and will be rejected (see Article 26).

[3] Directive 2004/17/EC of the European Parliament and of the Council of 31 March 2004 coordinating the procurement procedures of entities operating in the water, energy, transport and postal services sectors (OJ L 134, 30.04.2004, p. 1).

If a beneficiary breaches any of its obligations under Article 10.1.2, the grant may be reduced (see Article 27).

Such breaches may also lead to any of the other measures described in Chapter 6.

ARTICLE 11 — IMPLEMENTATION OF ACTION TASKS BY AFFILIATED ENTITIES

Not applicable

SECTION 2 RIGHTS AND OBLIGATIONS RELATED TO THE GRANT ADMINISTRATIONFR

ARTICLE 12 — GENERAL OBLIGATION TO INFORM

12.1 General obligation to provide information upon request

The beneficiaries must provide — during implementation of the action or afterwards and in accordance with Article 25.2 — any information requested in order to verify eligibility of the costs, proper implementation of the action and compliance with any other obligation under the Agreement.

12.2 Obligation to keep information up to date and to inform about events and circumstances likely to affect the Agreement

Each beneficiary must keep information stored in the 'Beneficiary Register' (via the electronic exchange system; see Article 36) up to date, in particular, its name, address, legal representatives, legal form and organisation type.

Each beneficiary must immediately inform the coordinator — which must immediately inform the Agency and the other beneficiaries — of any of the following:

(a) **events** which are likely to affect significantly or delay the implementation of the action or the EU's financial interests, in particular:

  (i) changes in its legal, financial, technical, organisational or ownership situation

(b) **circumstances** affecting:

  (i) the decision to award the grant or

  (ii) compliance with requirements under the Agreement.

12.3 Consequences of non-compliance

If a beneficiary breaches any of its obligations under this Article, the grant may be reduced (see Article 27).

Such breaches may also lead to any of the other measures described in Chapter 6.

ARTICLE 13 — KEEPING RECORDS — SUPPORTING DOCUMENTATION

13.1 Obligation to keep records and other supporting documentation

The beneficiaries must — for a period of *five* years after the payment of the balance — keep records and other supporting documentation, in order to prove the proper implementation of the action and the costs they declare as eligible.

They must make them available upon request (see Article 12) or in the context of checks, reviews, audits or investigations (see Article 17).

If there are on-going checks, reviews, audits, investigations, litigation or other pursuits of claims under the Agreement (including the extension of findings; see Articles 17), the beneficiaries must keep the records and other supporting documentation until the end of these procedures.

The beneficiaries must keep the original documents. Digital and digitalised documents are considered originals if they are authorised by the applicable national law. The Agency may accept non-original documents if it considers that they offer a comparable level of assurance.

13.1.1 Records and other supporting documentation on the scientific and technical implementation

The beneficiaries must keep records and other supporting documentation on the technical implementation of the action, in line with the accepted standards in the respective field.

13.1.2 Records and other documentation to support the costs declared

The beneficiaries must keep the records and documentation supporting the costs declared, in particular the following:

(a) for **actual costs**: adequate records and other supporting documentation to prove the costs declared, such as contracts, subcontracts, invoices and accounting records. In addition, the beneficiaries' usual cost accounting practices and internal control procedures must enable direct reconciliation between the amounts declared, the amounts recorded in their accounts and the amounts stated in the supporting documentation;

(b) for **flat-rate costs**: adequate records and other supporting documentation to prove the eligibility of the costs to which the flat-rate is applied. The beneficiaries do not need to identify the costs covered or provide supporting documentation (such as accounting statements) to prove the amount declared at a flat-rate.

In addition, for **personnel costs** (declared as actual costs), the beneficiaries must keep **time records** for the number of hours declared. The time records must be in writing and approved by the persons working on the action and their supervisors, at least monthly. In the absence of reliable time records of the hours worked on the action, the *Agency* may accept alternative evidence supporting the number of hours declared, if it considers that it offers an adequate level of assurance.

As an exception, for **persons working exclusively on the action**, there is no need to keep time records, if the beneficiary signs a **declaration** confirming that the persons concerned have worked exclusively on the action.

13.2 Consequences of non-compliance

If a beneficiary breaches any of its obligations under this Article, costs insufficiently substantiated will be ineligible (see Article 6) and will be rejected (see Article 26), and the grant may be reduced (see Article 27).

Such breaches may also lead to any of the other measures described in Chapter 6.

ARTICLE 14 — SUBMISSION OF DELIVERABLES

14.1 Obligation to submit deliverables

The coordinator must submit the '**deliverables**' identified in Annex 1 (if any), in accordance with the timing and conditions set out in it.

14.2 Consequences of non-compliance

If the coordinator breaches any of its obligations under this Article, the Agency may apply any of the measures described in Chapter 6.

ARTICLE 15 — REPORTING — PAYMENT REQUESTS

15.1 Obligation to submit reports

The coordinator must submit to the Agency (see Article 36) the technical and financial reports set out in this Article. These reports include the requests for payment and must be drawn up using the forms and templates provided in the electronic exchange system (see Article 36).

15.2 Reporting periods

The action is divided into the following '**reporting periods**':

- RP1: from month 1 to month 16
- *RP2: from month 17 to month 32*

15.3 Periodic reports — Requests for interim payments

The coordinator must submit a periodic report within 60 days following the end of each reporting period.

The **periodic report** must include the following:

(a) a '**periodic technical report**' containing:

(i) an **explanation of the work carried out** by the beneficiaries;

(ii) an **overview of the progress** towards the objectives of the action, including milestones and deliverables identified in Annex 1.

This report must include explanations justifying the differences between work expected to be carried out in accordance with Annex 1 and that actually carried out;

(iii) a **summary** for publication by the Agency;

(iv) *the answers to the '**questionnaire**', covering issues related to the action implementation and its impact, if required in Annex 1;*

(b) a '**periodic financial report**' containing:

(i) an '**individual financial statement**' (see Annex 4) from each beneficiary, for the reporting period concerned.

The individual financial statement must detail the eligible costs (actual costs and flat-rate costs; see Article 6) for each budget category (see Annex 2).

The beneficiaries must declare all eligible costs, even if — for actual costs and flat-rate costs — they exceed the amounts indicated in the estimated budget (see Annex 2). Amounts which are not declared in the individual financial statement will not be taken into account by the Agency.

If an individual financial statement is not submitted for a reporting period, it may be included in the periodic financial report for the next reporting period.

The individual financial statements of the last reporting period must also detail the **receipts of the action** (see Article 5.3.3).

Each beneficiary must **certify** that:

- the information provided is full, reliable and true;
- the costs declared are eligible (see Article 6);
- the costs can be substantiated by adequate records and supporting documentation (see Article 13) that will be produced upon request (see Article 12) or in the context of checks, reviews, audits and investigations (see Article 17), and
- for the last reporting period: that all the receipts have been declared (see Article 5.3.3);

(ii) an **explanation of the use of resources** and the information on subcontracting (see Article 10) from each beneficiary, for the reporting period concerned;

(iii) *not applicable;*

(iv) a '**periodic summary financial statement**' (see Annex 4), created automatically by the electronic exchange system, consolidating the individual financial statements for the reporting period concerned and including — except for the last reporting period — the **request for interim payment**.

(v) a '**certificate on the financial statements**' (drawn up in accordance with Annex 5) for each beneficiary, if:

- the (cumulative) amount of payments it requests as reimbursement of actual costs (and for which no certificate has yet been submitted) is EUR 325 000 or more and

- the maximum grant amount indicated, for that beneficiary, in the estimated budget (see Annex 2) as reimbursement of actual costs is EUR 750 000 or more.

15.4 Final report — Request for payment of the balance

In addition to the periodic report for the last reporting period, the coordinator must submit the final report within 60 days following the end of the last reporting period.

The **final report** must include the following:

(a) a '**final technical report**' with a **summary** for publication containing:

(i) an overview of the results and their dissemination;

(ii) the conclusions on the action and

(iii) *the impact of the action;*

(b) a '**final financial report**' containing:

(i) a '**final summary financial statement**' (see Annex 4), created automatically by the electronic exchange system, consolidating the individual financial statements for all reporting periods and including the **request for payment of the balance** and

(ii) a '**certificate on the financial statements**' (drawn up in accordance with Annex 5) for each beneficiary, if:

- the cumulative amount of payments it requests as reimbursement of actual costs (and for which no certificate has been submitted) is EUR 325 000 or more and

- the maximum grant amount indicated, for that beneficiary, in the estimated budget (see Annex 2) as reimbursement of actual costs is EUR 750 000 or more.

15.5 Currency for financial statements and conversion into euro

Financial statements must be drafted in euro.

Beneficiaries with accounting established in a currency other than the euro must convert the costs recorded in their accounts into euro at the average of the daily exchange rates published in the C series of the *Official Journal of the European Union*, calculated over the corresponding reporting period.

If no daily euro exchange rate is published in the *Official Journal of the European Union* for the currency in question, they must be converted at the average of the monthly accounting rates published on the Commission's website, calculated over the corresponding reporting period.

Beneficiaries with accounting established in euro must convert costs incurred in another currency into euro according to their usual accounting practices.

15.6 Language of reports

All reports (technical and financial reports, including financial statements) must be submitted in the language of the Agreement.

15.7 Consequences of non-compliance — Suspension of the payment deadline — Termination

If the reports submitted do not comply with this Article, the Agency may suspend the payment deadline (see Article 31) and apply any of the other measures described in Chapter 6.

If the coordinator breaches its obligation to submit the reports and if it fails to comply with this obligation within 30 days following a written reminder sent by the Agency, the Agreement may be terminated (see Article 34).

ARTICLE 16 — PAYMENTS AND PAYMENT ARRANGEMENTS

16.1 Payments to be made

The following payments will be made to the coordinator:

- one **pre-financing payment**;
- one or more **interim payments**, on the basis of the request(s) for interim payment (see Article 15), and
- one **payment of the balance**, on the basis of the request for payment of the balance (see Article 15).

16.2 Pre-financing payment — Amount

The aim of the pre-financing is to provide the beneficiaries with a float.

It remains the property of the EU until the payment of the balance.

The amount of the pre-financing payment will be EUR **396,832.50** (three hundred and ninety six thousand eight hundred and thirty two EURO and fifty eurocents).

The Agency will — except if Article 32 applies — make the pre-financing payment to the coordinator within 30 days, either from the entry into force of the Agreement (see Article 42) or from 10 days before the starting date of the action (see Article 3), whichever is the latest.

16.3 Interim payments — Amount — Calculation

Interim payments reimburse the eligible costs incurred for the implementation of the action during the corresponding reporting periods.

The Agency will pay to the coordinator the amount due as interim payment within 60 days from receiving the periodic report (see Article 15.3), except if Articles 31 or 32 apply.

Payment is subject to the approval of the periodic report. Its approval does not imply recognition of the compliance, authenticity, completeness or correctness of its content.

The **amount due as interim payment** is calculated by the Agency in the following steps:

Step 1 – Application of the reimbursement rate

Step 2 – Limit to 90% of the maximum grant amount

16.3.1 Step 1 — Application of the reimbursement rate

The reimbursement rate (see Article 5.2) is applied to the eligible costs (actual costs and flat-rate costs; see Article 6) declared by the beneficiaries (see Article 15) and approved by the Agency (see above) for the concerned reporting period.

16.3.2 Step 2 — Limit to 90% of the maximum grant amount

The total amount of pre-financing and interim payments must not exceed 90% of the maximum grant amount set out in Article 5.1. The maximum amount for the interim payment will be calculated as follows:

{90% of the maximum grant amount (see Article 5.1)

minus

{pre-financing and previous interim payments}}.

16.4 Payment of the balance — Amount — Calculation

The payment of the balance reimburses the remaining part of the eligible costs incurred by the beneficiaries for the implementation of the action.

If the total amount of earlier payments is greater than the final grant amount (see Article 5.3), the payment of the balance takes the form of a recovery (see Article 28).

If the total amount of earlier payments is lower than the final grant amount, the Agency will pay the balance within 60 days from receiving the final report (see Article 15.4), except if Articles 31 or 32 apply.

Payment is subject to the approval of the final report. Its approval does not imply recognition of the compliance, authenticity, completeness or correctness of its content.

The **amount due as the balance** is calculated by the Agency by deducting the total amount of pre-financing and interim payments (if any) already made, from the final grant amount determined in accordance with Article 5.3:

{final grant amount (see Article 5.3)

minus

{pre-financing and interim payments (if any) made}}.

If the balance is positive, it will be paid to the coordinator.

The amount to be paid may however be offset — without the beneficiary's consent — against any other amount owed by a beneficiary to the Agency, the Commission or another executive agency (under the EU or Euratom budget), up to the maximum EU contribution indicated, for that beneficiary, in the estimated budget (see Annex 2).

If the balance is negative, it will be recovered.

16.5 Notification of amounts due

When making payments, the Agency will formally notify to the coordinator the amount due, specifying whether it concerns an interim payment or the payment of the balance.

For the payment of the balance, the notification will also specify the final grant amount.

In the case of reduction of the grant or recovery of undue amounts, the notification will be preceded by the contradictory procedure set out in Articles 27 and 28.

16.6 Currency for payments

The Agency will make all payments in euro.

16.7 Payments to the coordinator — Distribution to the beneficiaries

Payments will be made to the coordinator.

Payments to the coordinator will discharge the Agency from its payment obligation.

The coordinator must distribute the payments between the beneficiaries without unjustified delay.

Pre-financing may however be distributed only:

(a) if 90% of the beneficiaries have acceded to the Agreement (see Article 40) and

(b) to beneficiaries that have acceded to the Agreement (see Article 40).

16.8 Bank account for payments

All payments will be made to the following bank account:

Name of bank: NATIONAL WESTMINSTER BANK PLC
Address of branch: LEICESTER CSC,BEDE HOUSE: 11 WESTER LEICESTER, United Kingdom
Full name of the account holder: NHS 24
Full account number (including bank codes):
IBAN code: GB08NWBK60720385014915

16.9 Costs of payment transfers

The cost of the payment transfers is borne as follows:

- the Agency bears the cost of transfers charged by its bank;

- the beneficiary bears the cost of transfers charged by its bank;

- the party causing a repetition of a transfer bears all costs of the repeated transfer.

16.10 Date of payment

Payments by the Agency are considered to have been carried out on the date when they are debited to its account.

16.11 Consequences of non-compliance

16.11.1 If the Agency does not pay within the payment deadlines (see above), the beneficiaries are entitled to **late-payment interest** at the rate applied by the European Central Bank (ECB) for its main refinancing operations in euros ('reference rate'), plus three and a half points. The reference rate is the rate in force on the first day of the month in which the payment deadline expires, as published in the C series of the *Official Journal of the European Union*.

If the late-payment interest is lower than or equal to EUR 200, it will be paid to the coordinator only upon request submitted within two months of receiving the late payment.

Late-payment interest is not due if all beneficiaries are EU Member States (including regional and local government authorities or other public bodies acting on behalf of a Member State for the purpose of this Agreement).

Suspension of the payment deadline or payments (see Articles 31 and 32) will not be considered as late payment.

Late-payment interest covers the period running from the day following the due date for payment (see above), up to and including the date of payment.

Late-payment interest is not considered for the purposes of calculating the final grant amount.

16.11.2 If the coordinator breaches any of its obligations under this Article, the grant may be reduced (see Article 27) and the Agreement or the participation of the coordinator may be terminated (see Article 34).

Such breaches may also lead to any of the other measures described in Chapter 6.

ARTICLE 17 — CHECKS, REVIEWS, AUDITS AND INVESTIGATIONS — EXTENSION OF FINDINGS

17.1 Checks, reviews and audits by the Agency and the Commission

17.1.1 Right to carry out checks

The Agency or the Commission will — during the implementation of the action or afterwards — check the proper implementation of the action and compliance with the obligations under the Agreement, including assessing deliverables and reports.

For this purpose, the Agency or the Commission may be assisted by external persons or bodies.

The Agency or the Commission may also request additional information in accordance with Article 12. The Agency or the Commission may request beneficiaries to provide such information to it directly.

Information provided must be accurate, precise and complete and in the format requested, including electronic format.

17.1.2 Right to carry out reviews

The Agency or the Commission may — during the implementation of the action or afterwards — carry out reviews on the proper implementation of the action (including assessment of deliverables and reports) and compliance with the obligations under the Agreement.

Reviews may be started **up to *five* years after the payment of the balance**. They will be formally notified to the coordinator or beneficiary concerned and will be considered to have started on the date of the formal notification.

If the review is carried out on a third party (see Articles 9, 10, 11), the beneficiary concerned must inform the third party.

The Agency or the Commission may carry out reviews directly (using its own staff) or indirectly (using external persons or bodies appointed to do so). It will inform the coordinator or beneficiary concerned of the identity of the external persons or bodies. They have the right to object to the appointment on grounds of commercial confidentiality.

The coordinator or beneficiary concerned must provide — within the deadline requested — any information and data in addition to deliverables and reports already submitted (including information on the use of resources). The Agency or the Commission may request beneficiaries to provide such information to it directly.

The coordinator or beneficiary concerned may be requested to participate in meetings, including with external experts.

For **on-the-spot** reviews, the beneficiaries must allow access to their sites and premises, including to external persons or bodies, and must ensure that information requested is readily available.

Information provided must be accurate, precise and complete and in the format requested, including electronic format.

On the basis of the review findings, a '**review report**' will be drawn up.

The Agency or the Commission will formally notify the review report to the coordinator or beneficiary concerned, which has 30 days to formally notify observations ('**contradictory review procedure**').

Reviews (including review reports) are in the language of the Agreement.

17.1.3 Right to carry out audits

The Agency or the Commission may — during the implementation of the action or afterwards — carry out audits on the proper implementation of the action and compliance with the obligations under the Agreement.

Audits may be started **up to *five* years after the payment of the balance**. They will be formally notified to the coordinator or beneficiary concerned and will be considered to have started on the date of the formal notification.

If the audit is carried out on a third party (see Articles 9, 10, 11), the beneficiary concerned must inform the third party.

The Agency or the Commission may carry out audits directly (using its own staff) or indirectly (using external persons or bodies appointed to do so). It will inform the coordinator or beneficiary concerned of the identity of the external persons or bodies. They have the right to object to the appointment on grounds of commercial confidentiality.

The coordinator or beneficiary concerned must provide — within the deadline requested — any information (including complete accounts, individual salary statements or other personal data) to verify compliance with the Agreement. The Agency or the Commission may request beneficiaries to provide such information to it directly.

For **on-the-spot** audits, the beneficiaries must allow access to their sites and premises, including to external persons or bodies, and must ensure that information requested is readily available.

Information provided must be accurate, precise and complete and in the format requested, including electronic format.

On the basis of the audit findings, a '**draft audit report**' will be drawn up.

The Agency or the Commission will formally notify the draft audit report to the coordinator or beneficiary concerned, which has 30 days to formally notify observations ('**contradictory audit procedure**'). This period may be extended by the Agency or the Commission in justified cases.

The '**final audit report**' will take into account observations by the coordinator or beneficiary concerned. The report will be formally notified to it.

Audits (including audit reports) are in the language of the Agreement.

The Agency or the Commission may also access the beneficiaries' statutory records for the periodical assessment of flat-rate amounts.

17.2 Investigations by the European Anti-Fraud Office (OLAF)

Under Regulations No 883/2013[5] and No 2185/96[6] (and in accordance with their provisions and procedures), the European Anti-Fraud Office (OLAF) may — at any moment during implementation of the action or afterwards — carry out investigations, including on-the-spot checks and inspections, to establish whether there has been fraud, corruption or any other illegal activity affecting the financial interests of the EU.

[5] Regulation (EU, Euratom) No 883/2013 of the European Parliament and of the Council of 11 September 2013 concerning investigations conducted by the European Anti-Fraud Office (OLAF) and repealing Regulation (EC) No 1073/1999 of the European Parliament and of the Council and Council Regulation (Euratom) No 1074/1999 (OJ L 232, 18.09.2013, p. 1).

[6] Council Regulation (Euratom, EC) No 2185/1996 of 11 November 1996 concerning on-the-spot checks and inspections carried out by the Commission in order to protect the European Communities' financial interests against fraud and other irregularities (OJ L 292, 15.11.1996, p. 2).

17.3 Checks and audits by the European Court of Auditors (ECA)

Under Article 287 of the Treaty on the Functioning of the European Union (TFEU) and Article 161 of the Financial Regulation No 966/2012[7], the European Court of Auditors (ECA) may — at any moment during implementation of the action or afterwards — carry out audits.

The ECA has the right of access for the purpose of checks and audits.

17.4 Checks, reviews, audits and investigations for international organisations

Not applicable

17.5 Consequences of findings in checks, reviews, audits and investigations —Extension of findings

17.5.1 Findings in this grant

Findings in checks, reviews, audits or investigations carried out in the context of this grant may lead to the rejection of ineligible costs (see Article 26), reduction of the grant (see Article 27), recovery of undue amounts (see Article 28) or to any of the other measures described in Chapter 6.

Rejection of costs or reduction of the grant after the payment of the balance will lead to a revised final grant amount (see Article 5.4).

Findings in checks, reviews, audits or investigations may lead to a request for amendment for the modification of Annex 1 (see Article 39).

Checks, reviews, audits or investigations that find systemic or recurrent errors, irregularities, fraud or breach of obligations may also lead to consequences in other EU or Euratom grants awarded under similar conditions ('**extension of findings from this grant to other grants**').

Moreover, findings arising from an OLAF investigation may lead to criminal prosecution under national law.

17.5.2 Findings in other grants

The Agency or the Commission may extend findings from other grants to this grant ('**extension of findings from other grants to this grant**'), if:

(a) the beneficiary concerned is found, in other EU or Euratom grants awarded under similar conditions, to have committed systemic or recurrent errors, irregularities, fraud or breach of obligations that have a material impact on this grant and

(b) those findings are formally notified to the beneficiary concerned — together with the list of grants affected by the findings — **no later than *five* years after the payment of the balance** of this grant.

[7] Regulation (EU, Euratom) No 966/2012 of the European Parliament and of the Council of 25 October 2012 on the financial rules applicable to the general budget of the Union and repealing Council Regulation (EC, Euratom) No 1605/2002 ('**Financial Regulation No 966/2012**') (OJ L 298, 26.10.2012, p. 1).

The extension of findings may lead to the rejection of costs (see Article 26), reduction of the grant (see Article 27), recovery of undue amounts (see Article 28), suspension of payments (see Article 32), suspension of the action implementation (see Article 33) or termination (see Article 34).

17.5.3 Procedure

The Agency or the Commission will formally notify the beneficiary concerned the systemic or recurrent errors and its intention to extend these audit findings, together with the list of grants affected.

17.5.3.1 If the findings concern **eligibility of costs**: the formal notification will include:

(a) an invitation to submit observations on the list of grants affected by the findings;

(b) the request to submit **revised financial statements** for all grants affected;

(c) the **correction rate for extrapolation** established by the Agency or the Commission on the basis of the systemic or recurrent errors, to calculate the amounts to be rejected, if the beneficiary concerned:

(i) considers that the submission of revised financial statements is not possible or practicable or

(ii) does not submit revised financial statements.

The beneficiary concerned has 90 days from receiving notification to submit observations, revised financial statements or to propose a duly substantiated **alternative correction method**. This period may be extended by the Agency or the Commission in justified cases.

The Agency or the Commission may then start a rejection procedure in accordance with the procedure set out in Article 26, either on the basis of the revised financial statements or the rate announced.

17.5.3.2 If the findings concern **improper implementation** or a **breach of another obligation**: the formal notification will include:

(a) an invitation to submit observations on the list of grants affected by the findings and

(b) the flat-rate the Agency or the Commission intends to apply according to the principle of proportionality.

The beneficiary concerned has 90 days from receiving notification to submit observations or to propose a duly substantiated alternative flat-rate.

The Agency or the Commission may then start a reduction procedure in accordance with the procedure set out in Article 27, either on the basis of the alternative flat-rate or the flat-rate announced.

17.6 Consequences of non-compliance

If a beneficiary breaches any of its obligations under this Article, any insufficiently substantiated costs will be ineligible (see Article 6) and will be rejected (see Article 26).

Such breaches may also lead to any of the other measures described in Chapter 6.

ARTICLE 18 — EVALUATION OF THE IMPACT OF THE ACTION

18.1 Right to evaluate the impact of the action

The Agency or the Commission may carry out interim and final evaluations of the impact of the action measured against the objective of the EU programme.

Evaluations may be started during implementation of the action and **up to *five* years after the payment of the balance**. The evaluation is considered to start on the date of the formal notification to the coordinator or beneficiaries.

The Agency or the Commission may make these evaluations directly (using its own staff) or indirectly (using external bodies or persons it has authorised to do so).

The coordinator or beneficiaries must provide any information relevant to evaluate the impact of the action, including information in electronic format.

18.2 Consequences of non-compliance

If a beneficiary breaches any of its obligations under this Article, the Agency may apply the measures described in Chapter 6.

SECTION 3 OTHER RIGHTS AND OBLIGATIONS

ARTICLE 19 — PRE-EXISTING RIGHTS AND OWNERSHIP OF THE RESULTS (INCLUDING INTELLECTUAL AND INDUSTRIAL PROPERTY RIGHTS)

19.1 Pre-existing rights and access rights to pre-existing rights

Where industrial and intellectual property rights (including rights of third parties) exist prior to the Agreement, the beneficiaries must establish a list of these pre-existing industrial and intellectual property rights, specifying the owner and any persons that have a right of use.

The coordinator must — before starting the action — submit this list to the Agency.

The beneficiaries must give each other (and their affiliated entities) access to any pre-existing industrial and intellectual property rights needed for the implementation of the action and compliance with the obligations under the Agreement.

19.2 Ownership of results and rights of use

The results of the action (including the reports and other documents relating to it) are owned by the beneficiaries.

The beneficiaries must give the Agency and the Commission the right to use the results for their communication activities under Article 22.

19.3 Consequences of non-compliance

If a beneficiary breaches any of its obligations under this Article, the grant may be reduced (see Article 27).

Such a breach may also lead to any of the other measures described in Chapter 6.

ARTICLE 20 — CONFLICT OF INTERESTS

20.1 Obligation to avoid a conflict of interests

The beneficiaries must take all measures to prevent any situation where the impartial and objective implementation of the action is compromised for reasons involving economic interest, political or national affinity, family or emotional ties or any other shared interest (‘**conflict of interests**’).

They must formally notify to the Agency without delay any situation constituting or likely to lead to a conflict of interests and immediately take all the necessary steps to rectify this situation.

The Agency may verify that the measures taken are appropriate and may require additional measures to be taken by a specified deadline.

20.2 Consequences of non-compliance

If a beneficiary breaches any of its obligations under this Article, the grant may be reduced (see Article 27) and the Agreement or participation of the beneficiary may be terminated (see Article 34).

Such breaches may also lead to any of the other measures described in Chapter 6.

ARTICLE 21 — CONFIDENTIALITY

21.1 General obligation to maintain confidentiality

During implementation of the action and for **five years after the payment of the balance**, the parties must keep confidential any data, documents or other material (in any form) that is identified as confidential at the time it is disclosed (‘**confidential information**’).

They may use confidential information to implement the Agreement.

The confidentiality obligations no longer apply if:

(a) the disclosing party agrees to release the other party;

(b) the information becomes generally and publicly available, without breaching any confidentiality obligation;

(c) the disclosure of the confidential information is required by EU or national law.

21.2 Consequences of non-compliance

If a beneficiary breaches any of its obligations under this Article, the grant may be reduced (see Article 27).

Such breaches may also lead to any of the other measures described in Chapter 6.

ARTICLE 22 — PROMOTING THE ACTION — VISIBILITY OF EU FUNDING

22.1 Communication activities by the beneficiaries

22.1.1 General obligation to promote the action and its results

The beneficiaries must promote the action and its results.

22.1.2 Information on EU funding — Obligation and right to use of the EU emblem

Unless the Agency requests or agrees otherwise, any communication activity related to the action (including at conferences, seminars, in information material, such as brochures, leaflets, posters, presentations, etc., in electronic form, via social media, etc.) and any infrastructure, equipment or major results funded by the grant must:

(a) display the EU emblem and

(b) include the following text:

> *"This [insert appropriate description, e.g. report, publication, conference, infrastructure, equipment, insert type of result, etc.] is part of the project / joint action '710033 / SCIROCCO' which has received funding from the European Union's Health Programme (2014-2020)."*

When displayed in association with another logo, the EU emblem must have appropriate prominence.

For the purposes of their obligations under this Article, the beneficiaries may use the EU emblem without first obtaining approval from the Agency.

This does not, however, give them the right to exclusive use.

Moreover, they may not appropriate the EU emblem or any similar trademark or logo, either by registration or by any other means.

22.1.3 Disclaimer excluding Agency/Commission responsibility

Any communication activity related to the action must indicate the following disclaimer:

> *"The content of this [insert appropriate description, e.g. report, publication, conference, etc.] represents the views of the author only and is his/her sole responsibility; it can not be considered to reflect the views of the European Commission and/or the Consumers, Health, Agriculture and Food Executive Agency or any other body of the European Union. The European Commission and the Agency do not accept any responsibility for use that may be made of the information it contains."*

22.2 Communication activities by the Agency

22.2.1 Right to use the beneficiaries' materials, documents or information

The Agency may use information relating to the action, documents notably summaries for publication and public deliverables as well as any other material, such as pictures or audio-visual material that it receives from any beneficiary (including in electronic form).

This does not change the confidentiality obligations in Article 21, which still apply.

The right to use the beneficiary's materials, documents and information includes:

(a) **use for its own purposes** (in particular, making them available to persons working for the Agency or any other EU institution, body, office or agency or body or institutions in EU Member States; and copying or reproducing them in whole or in part, in unlimited numbers);

(b) **distribution to the public** (in particular, publication as hard copies and in electronic or digital format, publication on the internet, as a downloadable or non-downloadable file, broadcasting by any channel, public display or presentation, communicating through press information services, or inclusion in widely accessible databases or indexes);

(c) **editing or redrafting** for communication and publicising activities (including shortening, summarising, inserting other elements (such as meta-data, legends, other graphic, visual, audio or text elements), extracting parts (e.g. audio or video files), dividing into parts, use in a compilation);

(d) **translation**;

(e) giving **access in response to individual requests** under Regulation No 1049/2001[8], without the right to reproduce or exploit;

(f) **storage** in paper, electronic or other form;

(g) **archiving**, in line with applicable document-management rules, and

(h) the right to authorise **third parties** to act on its behalf or sub-license the modes of use set out in Points (b),(c),(d) and (f) to third parties if needed for the communication and publicising activities of the Agency.

If the right of use is subject to rights of a third party (including personnel of the beneficiary), the beneficiary must ensure that it complies with its obligations under this Agreement (in particular, by obtaining the necessary approval from the third parties concerned).

Where applicable (and if provided by the beneficiary), the Agency will insert the following information:

> "© – [year] – [name of the copyright owner]. All rights reserved. Licensed to the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) under conditions."

22.3 Consequences of non-compliance

If the beneficiary breaches any of its obligations under this Article, the grant may be reduced (see Article 27).

Such breaches may also lead to any of the other measures described in Chapter 6.

ARTICLE 23 — PROCESSING OF PERSONAL DATA

[8] Regulation (EC) No 1049/2001 of the European Parliament and of the Council of 30 May 2001 regarding public access to European Parliament, Council and Commission documents, OJ L 145, 31.5.2001, p. 43.

23.1 Processing of personal data by the Agency and the Commission

Any personal data under the Agreement will be processed by the Agency or the Commission under Regulation No 23/2001[9] and according to the 'notifications of the processing operations' to the Data Protection Officer (DPO) of the Agency or the Commission (publicly accessible in the DPO register).

Such data will be processed by the '**data controller**' of the Agency or the Commission, for the purposes of implementing, managing and monitoring the Agreement or protecting the financial interests of the EU or Euratom (including checks, reviews, audits and investigations; see Article 17).

The persons whose personal data are processed have the right to access and correct their own personal data. For this purpose, they must send any queries about the processing of their personal data to the data controller, via the contact point indicated in the privacy statement(s) on the Agency and Commission websites.

They also have the right to have recourse at any time to the European Data Protection Supervisor (EDPS).

23.2 Processing of personal data by the beneficiaries

The beneficiaries must process personal data under the Agreement in compliance with applicable EU and national law on data protection (including authorisations or notification requirements).

The beneficiaries may grant their personnel access only to data that is strictly necessary for implementing, managing and monitoring the Agreement.

The beneficiaries must inform the personnel whose personal data are collected and processed by the Agency or the Commission. For this purpose, they must provide them with the privacy statement(s) (see above), before transmitting their data to the Agency or the Commission.

23.3 Consequences of non-compliance

If a beneficiary breaches any of its obligations under Article 23.2, the Agency may apply any of the measures described in Chapter 6.

ARTICLE 24 — ASSIGNMENTS OF CLAIMS FOR PAYMENT AGAINST THE AGENCY

The beneficiaries may not assign any of their claims for payment against the Agency to any third party, except if approved by the Agency on the basis of a reasoned, written request by the coordinator (on behalf of the beneficiary concerned).

If the Agency has not accepted the assignment or the terms of it are not observed, the assignment will have no effect on it.

In no circumstances will an assignment release the beneficiaries from their obligations towards the Agency.

[9] Regulation (EC) No 45/2001 of the European Parliament and of the Council of 18 December 2000 on the protection of individuals with regard to the processing of personal data by the Community institutions and bodies and on the free movement of such data (OJ L 8, 12.01.2001, p. 1).

CHAPTER 5 DIVISION OF BENEFICIARIES' ROLES AND RESPONSIBILITIES

ARTICLE 25 — DIVISION OF BENEFICIARIES' ROLES AND RESPONSIBILITIES

25.1 Roles and responsibilities towards the Agency

The beneficiaries have full responsibility for implementing the action and complying with the Agreement.

The beneficiaries are jointly and severally liable for the **technical implementation** of the action as described in Annex 1. If a beneficiary fails to implement its part of the action, the other beneficiaries become responsible for implementing this part (without being entitled to any additional EU funding for doing so), unless the Agency expressly relieves them of this obligation.

The **financial responsibility** of each beneficiary is governed by Articles 28, 29 and 30.

25.2 Internal division of roles and responsibilities

The internal roles and responsibilities of the beneficiaries are divided as follows:

(a) Each **beneficiary** must:

(i) keep information stored in the 'Beneficiary Register' (via the electronic exchange system) up to date (see Article 12);

(ii) inform the coordinator immediately of any events or circumstances likely to affect significantly or delay the implementation of the action (see Article 12);

(iii) submit to the coordinator in good time:

- individual financial statements for itself and, if required, certificates on the financial statements (see Article 15);
- the data needed to draw up the technical reports (see Article 15);
- any other documents or information required by the Agency or the Commission under the Agreement, unless the Agreement requires the beneficiary to submit this information directly to the Agency or the Commission.

(b) The **coordinator** must:

(i) monitor that the action is implemented properly (see Article 7);

(ii) act as the intermediary for all communications between the beneficiaries and the Agency (in particular, providing the Agency with the information described in Article 12), unless the Agreement specifies otherwise;

(iii) provide a pre-financing guarantee if requested by the Agency (see Article 16.2);

(iv) request and review any documents or information required by the Agency and verify their completeness and correctness before passing them on to the Agency;

(v) submit the deliverables and reports to the Agency (see Articles 14 and 15);

(vi) ensure that all payments are made to the other beneficiaries without unjustified delay (see Article 16).

The coordinator may not delegate the above-mentioned tasks to any other beneficiary or subcontract them to any third party.

25.3 Internal arrangements between beneficiaries — Consortium agreement

The beneficiaries must have internal arrangements regarding their operation and co-ordination to ensure that the action is implemented properly. These internal arrangements must be set out in a written '**consortium agreement**' between the beneficiaries, which may cover:

- internal organisation of the consortium;
- management of access to the electronic exchange system;
- distribution of EU funding;
- additional rules on rights and obligations related to background and results (including whether access rights remain or not, if a beneficiary is in breach of its obligations) (see Section 3 of Chapter 4);
- settlement of internal disputes;
- liability, indemnification and confidentiality arrangements between the beneficiaries.

The consortium agreement must not contain any provision contrary to the Agreement.

CHAPTER 6 REJECTION OF COSTS — REDUCTION OF THE GRANT — RECOVERY — PENALTIES — DAMAGES — SUSPENSION — TERMINATION — FORCE MAJEURE

SECTION 1 REJECTION OF COSTS — REDUCTION OF THE GRANT — RECOVERY — PENALTIES

ARTICLE 26 — REJECTION OF INELIGIBLE COSTS

26.1 Conditions

26.1.1 The Agency will — at the time of an **interim payment, at the payment of the balance** or **afterwards** — reject any costs which are ineligible (see Article 6), in particular following checks, reviews, audits or investigations (see Article 17).

26.1.2 The rejection may also be based on the **extension of findings from other grants to this grant**, under the conditions set out in Article 17.5.2.

26.2 Ineligible costs to be rejected — Calculation — Procedure

Ineligible costs will be rejected in full.

If the Agency rejects costs **without reduction of the grant** (see Article 27) or **recovery of undue amounts** (see Article 28), it will formally notify the coordinator or beneficiary concerned the rejection of costs, the amounts and the reasons why (if applicable, together with the notification of amounts due; see Article 16.5). The coordinator or beneficiary concerned may — within 30 days of receiving notification — formally notify the Agency of its disagreement and the reasons why.

If the Agency rejects costs **with reduction of the grant** or **recovery of undue amounts** , it will formally notify the rejection in the '**pre-information letter**' on reduction or recovery set out in Articles 27 and 28.

26.3 Effects

If the Agency rejects costs at the time of an **interim payment** or **the payment of the balance**, it will deduct them from the total eligible costs declared, for the action, in the periodic or final summary financial statement (see Articles 15.3 and 15.4). It will then calculate the interim payment or payment of the balance as set out in Articles 16.3 or 16.4.

If the Agency — **after an interim payment but before the payment of the balance** — rejects costs declared in a periodic summary financial statement, it will deduct them from the total eligible costs declared, for the action, in the next periodic summary financial statement or in the final summary financial statement. It will then calculate the interim payment or payment of the balance as set out in Articles 16.3 or 16.4.

If the Agency rejects costs **after the payment of the balance**, it will deduct the amount rejected from the total eligible costs declared, by the beneficiary, in the final summary financial statement. It will then calculate the revised final grant amount as set out in Article 5.4.

ARTICLE 27 — REDUCTION OF THE GRANT

27.1 Conditions

27.1.1 The Agency may — **at the payment of the balance or afterward** — reduce the maximum grant amount (see Article 5.1), if the action has not been implemented properly as described in Annex 1 to the Specific Agreement concerned or another obligation under the Agreement has been breached.

27.1.2 The Agency may also reduce the maximum grant amount on the basis of the **extension of findings from other grants to this grant**, under the conditions set out in Article 17.5.2.

27.2 Amount to be reduced — Calculation — Procedure

The amount of the reduction will be proportionate to the improper implementation of the action or to the seriousness of the breach.

Before reduction of the grant, the Agency will formally notify a '**pre-information letter**' to the coordinator or beneficiary concerned:

- informing it of its intention to reduce the grant, the amount it intends to reduce and the reasons why and

- inviting it to submit observations within 30 days of receiving notification.

If the Agency does not receive any observations or decides to pursue reduction despite the observations it has received, it will formally notify **confirmation** of the reduction (if applicable, together with the notification of amounts due; see Article 16).

27.3 Effects

If the Agency reduces the grant **at the time of the payment of the balance**, it will calculate the reduced grant amount for the action and then determine the amount due as payment of the balance (see Article 5.3.4 and Article 16.4).

If the Agency reduces the grant **after the payment of the balance**, it will calculate the revised final grant amount (see Article 5.4). If the revised final grant amount is lower than the final grant amount, the Agency will recover the difference (see Article 28).

ARTICLE 28 — RECOVERY OF UNDUE AMOUNTS

28.1 Amount to be recovered — Calculation — Procedure

The Agency will — **at the payment of the balance** or **afterwards** — claim back amount that was paid but is not due under the Agreement.

The coordinator is fully liable for repaying debts of the consortium (under the Agreement) even if it has not been the final recipient of those amounts.

In addition, the beneficiaries (including the coordinator) are jointly and severally liable for repaying any unpaid debts under the Agreement (due by the consortium or any beneficiary, including late-payment interest) — up to the maximum EU contribution indicated, for each beneficiary, in the estimated budget (as last amended; see Annex 2).

28.1.1 Recovery at payment of the balance

If the payment of the balance takes the form of a recovery (see Article 16.4), the Agency will formally notify a '**pre-information letter**' to the coordinator:

- informing it of its intention to recover, the amount due as the balance and the reasons why and

- inviting the coordinator to submit observations within 30 days of receiving notification.

If no observations are submitted or the Agency decides to pursue recovery despite the observations it has received, it will **confirm** the amount to be recovered and formally notify to the coordinator a **debit note** with the terms and the date for payment (together with the notification of amounts due; see Article 16.5).

If payment is not made by the date specified in the debit note, the Agency or the Commission will **recover** the amount:

(a) by '**offsetting**' it — without the coordinator's consent — against any amounts owed to the coordinator by the Agency, Commission or another executive agency (from the EU or Euratom budget).

In exceptional circumstances, to safeguard the EU's financial interests, the Agency may offset before the payment date specified in the debit note;

(b) *not applicable;*

(c) *by holding the other beneficiaries jointly and severally liable — up to the maximum EU contribution indicated, for each beneficiary, in the estimated budget (as last amended; see Annex 2);*

(d) by **taking legal action** (see Article 41) or by **adopting an enforceable decision** under Article 299 of the Treaty on the Functioning of the EU (TFEU) and Article 79(2) of the Financial Regulation No 966/2012.

If payment is not made by the date in the debit note, the amount to be recovered (see above) will be increased by **late-payment interest** at the rate set out in Article 16.11, from the day following the payment date in the debit note, up to and including the date the Agency or the Commission receives full payment of the amount.

Partial payments will be first credited against expenses, charges and late-payment interest and then against the principal.

Bank charges incurred in the recovery process will be borne by the beneficiary, unless Directive 2007/64/EC applies.

28.1.2 Recovery of amounts after payment of the balance

If — after the payment of the balance — the Agency revised the final grant amount for the action (see Article 5.4), due to a rejection of costs or reduction of the grant, and the revised final grant amount is lower than the final grant amount (see Article 5.3), the Agency will:

- if the rejection or reduction does *not* concern a specific beneficiary (or its affiliated entities): claim back the difference from the coordinator (even if it has not been the final recipient of the amount in question)

or

- otherwise: claim back the difference from the beneficiary concerned.

The Agency will formally notify a **pre-information letter** to the coordinator or beneficiary concerned:

- informing it of its intention to recover, the amount to be repaid and the reasons why and

- inviting it to submit observations within 30 days of receiving notification.

If no observations are submitted or the Agency decides to pursue recovery despite the observations it has received, it will **confirm** the amount to be recovered and formally notify to the coordinator or beneficiary concerned a **debit note**. This note will also specify the terms and the date for payment.

If payment is not made by the date specified in the debit note, the Agency or the Commission will **recover** the amount:

(a) by '**offsetting**' it — without the coordinator's or beneficiary's consent — against any amounts owed to the coordinator or beneficiary by the Agency, Commission or another executive agency (from the EU or Euratom budget).

In exceptional circumstances, to safeguard the EU's financial interests, the Agency may offset before the payment date specified in the debit note;

(b) *by holding the other beneficiaries jointly and severally liable, up to the maximum EU contribution indicated, for each beneficiary, in the estimated budget (as last amended; see Annex 2);*

(c) by **taking legal action** (see Article 41) or by **adopting an enforceable decision** under Article 299 of the Treaty on the Functioning of the EU (TFEU) and Article 79(2) of the Financial Regulation No 966/2012.

If payment is not made by the date in the debit note, the amount to be recovered (see above) will be increased by **late-payment interest** at the rate set out in Article 16.11, from the day following the date for payment in the debit note, up to and including the date the Agency or the Commission receives full payment of the amount.

Partial payments will be first credited against expenses, charges and late-payment interest and then against the principal.

Bank charges incurred in the recovery process will be borne by the beneficiary, unless Directive 2007/64/EC applies.

ARTICLE 29 — ADMINISTRATIVE AND FINANCIAL PENALTIES

29.1 Conditions

Under Articles 109 and 131(4) of the Financial Regulation No 966/2012, the Agency may impose **administrative** and **financial penalties** if a beneficiary:

(a) has committed substantial errors, irregularities or fraud or is in serious breach of its obligations under the Agreement or

(b) has made false declarations about information required under the Agreement or for the submission of the proposal (or has not supplied such information).

Each beneficiary is responsible for paying the financial penalties imposed on it.

Under Article 109(3) of the Financial Regulation No 966/2012, the Agency or the Commission may — under certain conditions and limits — publish decisions imposing administrative or financial penalties.

29.2 Duration — Amount of penalty — Calculation

Administrative penalties exclude the beneficiary from all contracts and grants financed from the EU or Euratom budget for a maximum of five years from the date the infringement is established by the Agency.

If the beneficiary commits another infringement within five years of the date the first infringement is established, the Agency may extend the exclusion period up to 10 years.

Financial penalties will be between 2% and 10% of the maximum EU contribution indicated, for the beneficiary concerned, in the estimated budget (see Annex 2).

If the beneficiary commits another infringement within five years of the date the first infringement is established, the Agency may increase the rate of financial penalties to between 4% and 20%.

29.3 Procedure

Before applying a penalty, the Agency will formally notify the beneficiary concerned:

- informing it of its intention to impose a penalty, its duration or amount and the reasons why and
- inviting it to submit observations within 30 days.

If the Agency does not receive any observations or decides to impose the penalty despite of observations it has received, it will formally notify **confirmation** of the penalty to the beneficiary concerned and — in case of financial penalties — deduct the penalty from the payment of the balance or formally notify a **debit note**, specifying the amount to be recovered, the terms and the date for payment.

If payment is not made by the date specified in the debit note, the Agency or the Commission may **recover** the amount:

(a) by **offsetting** it — without the beneficiary's consent — against any amounts owed to the beneficiary concerned by the Agency, Commission or another executive agency (from the EU or Euratom budget).

In exceptional circumstances, to safeguard the EU's financial interests, the Agency may offset before the payment date in the debit note;

(b) by **taking legal action** (see Article 41) or by **adopting an enforceable decision** under Article 299 of the Treaty on the Functioning of the EU (TFEU) and Article 79(2) of the Financial Regulation No 966/2012.

If payment is not made by the date in the debit note, the amount to be recovered (see above) will be increased by **late-payment interest** at the rate set out in Article 16.11, from the day following the payment date in the debit note, up to and including the date the Agency or the Commission receives full payment of the amount.

Partial payments will be first credited against expenses, charges and late-payment interest and then against the principal.

Bank charges incurred in the recovery process will be borne by the beneficiary, unless Directive 2007/64/EC applies.

SECTION 2 LIABILITY FOR DAMAGES

ARTICLE 30 — LIABILITY FOR DAMAGES

30.1 Liability of the Agency

The Agency cannot be held liable for any damage caused to the beneficiaries or to third parties as a consequence of implementing the Agreement, including for gross negligence.

The Agency cannot be held liable for any damage caused by any beneficiaries or third parties involved in the action, as a consequence of implementing the Agreement.

30.2 Liability of the beneficiaries

30.2.1 Conditions

Except in case of force majeure (see Article 35), the beneficiaries must compensate the Agency for any damage it sustains as a result of the implementation of the actione or because the action was not implemented in full compliance with the Agreement.

Each beneficiary is responsible for paying the damages claimed from it.

30.2.2 Amount of damages - Calculation

The amount the Agency can claim from a beneficiary will correspond to the damage caused by that beneficiary.

30.2.3 Procedure

Before claiming damages, the Agency will formally notify the beneficiary concerned:

- informing it of its intention to claim damages, the amount and the reasons why and
- inviting it to submit observations within 30 days.

If the Agency does not receive any observations or decides to claim damages despite the observations it has received, it will formally notify **confirmation** of the claim for damages and a **debit note**, specifying the amount to be recovered, the terms and the date for payment.

If payment is not made by the date specified in the debit note, the Agency or the Commission may **recover** the amount:

(a) by **offsetting** it — without the beneficiary's consent — against any amounts owed to the beneficiary concerned by the Agency, Commission or another executive agency (from the EU or Euratom budget).

In exceptional circumstances, to safeguard the EU's financial interests, the Agency may offset before the payment date in the debit note;

(b) by **taking legal action** (see Article 41) or by **adopting an enforceable decision** under Article 79(2) of the Financial Regulation No 966/2012 and Article 299 of the Treaty on the Functioning of the EU (TFEU).

If payment is not made by the date in the debit note, the amount to be recovered (see above) will be increased by **late-payment interest** at the rate set out in Article 16.11, from the day following the

payment date in the debit note, up to and including the date the Agency or the Commission receives full payment of the amount.

Partial payments will be first credited against expenses, charges and late-payment interest and then against the principal.

Bank charges incurred in the recovery process will be borne by the beneficiary, unless Directive 2007/64/EC applies.

SECTION 3 SUSPENSION AND TERMINATION

ARTICLE 31 — SUSPENSION OF PAYMENT DEADLINE

31.1 Conditions

The Agency may — at any moment — suspend the payment deadline (see Article 16.2 to 16.4) if a request for payment (see Article 15) cannot be approved because:

(a) it does not comply with the provisions of the Agreement (see Article 15);

(b) the technical reports or financial reports have not been submitted or are not complete or additional information is needed, or

(c) there is doubt about the eligibility of the costs declared in the financial statements and additional checks, reviews, audits or investigations are necessary.

31.2 Procedure

The Agency will formally notify the coordinator of the suspension and the reasons why.

The suspension will **take effect** the day notification is sent by the Agency (see Article 36).

If the conditions for suspending the payment deadline are no longer met, the suspension will be **lifted** — and the remaining period will resume.

If the suspension exceeds two months, the coordinator may request the Agency if the suspension will continue.

If the payment deadline has been suspended due to the non-compliance of the technical or financial reports (see Article 15) and the revised report or statement is not submitted or was submitted but is also rejected, the Agency may also terminate the Agreement or the participation of the beneficiary (see Article 34.3.1).

ARTICLE 32 — SUSPENSION OF PAYMENTS

32.1 Conditions

The Agency may — at any moment — suspend, in whole or in part, the pre-financing payment and interim payments for one or more beneficiaries or the payment of the balance for all beneficiaries, if a beneficiary:

(a) has committed or is suspected of having committed substantial errors, irregularities, fraud or serious breach of obligations in the award procedure or under this Agreement or

(b) has committed — in other EU or Euratom grants awarded to it under similar conditions — systemic or recurrent errors, irregularities, fraud or serious breach of obligations that have a material impact on this grant (**extension of findings from other grants to this grant**; see Article 17.5.2).

32.2 Procedure

Before suspending payments, the Agency will formally notify the coordinator:

- informing it of its intention to suspend payments and the reasons why and
- inviting it to submit observations within 30 days of receiving notification.

If the Agency does not receive observations or decides to pursue the procedure despite the observations it has received, it will formally notify **confirmation** of the suspension. Otherwise, it will formally notify that the suspension procedure is not continued.

The suspension will **take effect** the day the confirmation notification is sent by the Agency.

If the conditions for resuming payments are met, the suspension will be lifted. The Agency will formally notify the coordinator.

During the suspension, the periodic report(s) (see Article 15.3) must not contain any individual financial statements from the beneficiary concerned. When the Agency resumes payments, the coordinator may include them in the next periodic report.

The beneficiaries may suspend implementation of the action (see Article 33.1) or terminate the Agreement or the participation of the beneficiary concerned (see Article 34.1 and 34.2).

ARTICLE 33 — SUSPENSION OF THE ACTION IMPLEMENTATION

33.1 Suspension of the action implementation, by the beneficiaries

33.1.1 Conditions

The beneficiaries may suspend implementation of the action or any part of it, if exceptional circumstances — in particular *force majeure* (see Article 35) — make implementation impossible or excessively difficult.

33.1.2 Procedure

The coordinator must immediately formally notify to the Agency the suspension (see Article 36), stating:

- the reasons why and
- the expected date of resumption.

The suspension will **take effect** the day this notification is received by the Agency.

Once circumstances allow for implementation to resume, the coordinator must immediately formally notify the Agency and request an **amendment** of the Agreement, to set the date on which the action will be resumed, extend the duration of the action and make other changes necessary to adapt the action to the new situation (see Article 39) — unless the Agreement or the participation of a beneficiary has been terminated (see Article 34).

The suspension will be **lifted** with effect from the resumption date set out in the amendment. This date may be before the date on which the amendment enters into force.

Costs incurred during suspension of the action implementation are not eligible (see Article 6).

33.2 Suspension of the action implementation, by the Agency

33.2.1 Conditions

The Agency may suspend implementation of the action or any part of it:

(a) if a beneficiary has committed or is suspected of having committed substantial errors, irregularities, fraud or serious breach of obligations in the award procedure or under this Agreement or

(b) if a beneficiary has committed — in other EU or Euratom grants awarded to it under similar conditions — systemic or recurrent errors, irregularities, fraud or serious breach of obligations that have a material impact on this grant (**extension of findings from other grants to this grant**; see Article 17.5.2).

33.2.2 Procedure

Before suspending implementation of the action, the Agency will formally notify the coordinator:

- informing it of its intention to suspend the implementation and the reasons why and
- inviting it to submit observations within 30 days of receiving notification.

If the Agency does not receive observations or decides to pursue the procedure despite the observations it has received, it will formally notify **confirmation** of the suspension. Otherwise, it will formally notify that the procedure is not continued.

The suspension will **take effect** five days after confirmation notification is received by the coordinator (or on a later date specified in the notification).

It will be **lifted** if the conditions for resuming implementation of the action are met.

The coordinator will be formally notified of the lifting and the Agreement will be **amended**, to set the date on which the action will be resumed, extend the duration of the action and make other changes necessary to adapt the action to the new situation (see Article 39) — unless the Agreement has already been terminated (see Article 34).

The suspension will be lifted with effect from the resumption date set out in the amendment. This date may be before the date on which the amendment enters into force.

Costs incurred during suspension are not eligible (see Article 6).

The beneficiaries may not claim damages due to suspension by the Agency (see Article 30).

Suspension of the action implementation does not affect the Agency's right to terminate the Agreement or participation of a beneficiary (see Article 34), reduce the grant or recover amounts unduly paid (see Articles 27 and 28).

ARTICLE 34 — TERMINATION OF THE AGREEMENT OR OF THE PARTICIPATION OF ONE OR MORE BENEFICIARIES

34.1 Termination of the Agreement, by the beneficiaries

34.1.1 Conditions and procedure

The beneficiaries may terminate the Agreement.

The coordinator must formally notify termination to the Agency (see Article 36), stating:

- the reasons why and
- the date the termination will take effect. This date must be after the notification.

If no reasons are given or if the Agency the Agreement will be considered to have been '**terminated improperly**'.

The termination will **take effect** on the day specified in the notification.

34.1.2 Effects

The coordinator must — within 60 days from when termination takes effect — submit:

(i) a periodic report (for the open reporting period until termination; see Article 15.3) and

(ii) the final report (see Article 15.4).

If the Agency does not receive the reports within the deadline (see above), only costs which are included in an approved periodic report will be taken into account.

The Agency will **calculate** the final grant amount (see Article 5.3) and the balance (see Article 16.4) on the basis of the reports submitted. Only costs incurred until termination are eligible (see Article 6). Costs relating to contracts due for execution only after termination are not eligible.

Improper termination may lead to a reduction of the grant (see Article 27).

After termination, the beneficiaries' obligations (in particular, Articles 15, 17, 18, Section 3 of Chapter 4, 21, 22 and 24) continue to apply.

34.2 Termination of the Specific Agreement, by the Agency

34.2.1 Conditions and procedure

The participation of one or more beneficiaries may be terminated by the coordinator, on request of the beneficiary concerned or on behalf of the other beneficiaries.

The coordinator must formally notify termination to the Agency (see Article 36) and inform the beneficiary concerned.

If the coordinator's participation is terminated without its agreement, the formal notification must be done by another beneficiary (acting on behalf of the other beneficiaries).

The notification must include:

- the reasons why;
- the opinion of the beneficiary concerned (or proof that this opinion has been requested in writing);
- the date the termination takes effect. This date must be after the notification, and
- a request for amendment (see Article 39), with a proposal for reallocation of the tasks and the estimated budget of the beneficiary concerned (see Annexes 1 and 2) and, if necessary, the addition of one or more new beneficiaries (see Article 40). If termination takes effect after the period set out in Article 3, no request for amendment must be included, unless the beneficiary concerned is the coordinator. In this case, the request for amendment must propose a new coordinator.

If this information is not given or if the Agency considers that the reasons do not justify termination, the participation will be considered to have been **terminated improperly**.

The termination will **take effect** on the day specified in the notification.

34.2.2 Effects

The beneficiary concerned must submit to the coordinator:

(i) a technical report and

(ii) a financial statement covering the period from the end of the last reporting period to the date when termination takes effect.

This information must be included by the coordinator in the periodic report for the next reporting period (see Article 15.3).

If the request for amendment is rejected by the Agency (because it calls into question the decision awarding the grant or breaches the principle of equal treatment of applicants), the Agreement may be terminated according to Article 34.3.1(c).

If the request for amendment is accepted by the Agency, the Agreement is amended to introduce the necessary changes (see Article 39).

Improper termination may lead to a reduction of the grant (see Article 27) or termination of the Agreement (see Article 34).

After termination, the concerned beneficiary's obligations (in particular Articles 15, 17, 18, Section 3 of Chapter 4, 21, 22 and 24) continue to apply.

34.3 Termination of the Agreement or of the participation of one or more beneficiaries, by the Agency

34.3.1 Conditions

The Agency may terminate the Agreement or the participation of one or more beneficiaries, if:

(a) one or more beneficiaries do not accede to the Agreement (see Article 40);

(b) a change to their legal, financial, technical, organisational or ownership situation is likely to substantially affect or delay the implementation of the action or calls into question the decision to award the grant;

(c) following termination of participation for one or more beneficiaries (see above), the necessary changes to the Agreement would call into question the decision awarding the grant or breach the principle of equal treatment of applicants (see Article 39);

(d) implementation of the action is prevented by force majeure (see Article 35) or suspended by the coordinator (see Article 33.1) and either:

  (i) resumption is impossible, or

  (ii) the necessary changes to the Agreement would call into question the decision awarding the grant or breach the principle of equal treatment of applicants;

(e) a beneficiary is declared bankrupt, being wound up, having its affairs administered by the courts, has entered into an arrangement with creditors, has suspended business activities, or is subject to any other similar proceedings or procedures under national law;

(f) a beneficiary (or a natural person who has the power to represent or take decisions on its behalf) has been found guilty of professional misconduct, proven by any means;

(g) a beneficiary does not comply with the applicable national law on taxes and social security;

(h) a beneficiary (or a natural person who has the power to represent or take decisions on its behalf) has committed fraud, corruption, or is involved in a criminal organisation, money laundering or any other illegal activity affecting the EU's financial interests;

(i) a beneficiary (or a natural person who has the power to represent or take decisions on its behalf) has — in the award procedure or under the Agreement — committed:

  (i) substantial errors, irregularities, fraud or

  (ii) serious breach of obligations, including improper implementation of the action, submission of false information, failure to provide required information, breach of ethical principles;

(j) a beneficiary has committed — in other EU or Euratom grants awarded to it under similar conditions — systemic or recurrent errors, irregularities, fraud or serious breach of obligations that have a material impact on this grant ('**extension of findings from other grants to this grant**').

34.3.2 Procedure

Before terminating the Agreement or participation of one or more beneficiaries, the Agency will formally notify the coordinator:

- informing it of its intention to terminate and the reasons why and

- inviting it, within 30 days of receiving notification, to submit observations and — in case of Point (i.ii) above — to inform the Agency of the measures to ensure compliance with the obligations under the Agreement.

If the Agency does not receive observations or decides to pursue the procedure despite the observations it has received, it will formally notify to the coordinator **confirmation** of the termination and the date it will take effect. Otherwise, it will formally notify that the procedure is not continued.

The termination will **take effect**:

- for terminations under Points (b), (c), (e), (g) and (i.ii) above: on the day specified in the notification of the confirmation (see above);

- for terminations under Points (a), (d), (f), (h), (i.i) and (j) above: on the day after the notification of the confirmation is received by the coordinator.

34.3.3 Effects

(a) for **termination of the Agreement**:

The coordinator must — within 60 days from when termination takes effect — submit:

(i) a periodic report (for the last open reporting period until termination; see Article 15.3) and

(ii) a final report (see Article 15.4).

If the Agreement is terminated for breach of the obligation to submit the reports (see Articles 15.7 and 34.3.1), the coordinator may not submit any reports after termination.

If the Agency does not receive the reports within the deadline (see above), only costs which are included in an approved periodic report will be taken into account.

The Agency will **calculate** the final grant amount (see Article 5.3) and the balance (see Article 16.4) on the basis of the reports submitted. Only costs incurred until termination takes effect are eligible (see Article 6). Costs relating to contracts due for execution only after termination are not eligible.

This does not affect the Agency's right to reduce the grant (see Article 27) or to impose administrative and financial penalties (Article 29).

The beneficiaries may not claim damages due to termination by the Agency (see Article 30).

After termination, the beneficiaries' obligations (in particular Articles 15, 17, 18, Section 3 of Chapter 4, 21, 22 and 24) continue to apply.

(b) for **termination of the participation of one or more beneficiaries**:

The coordinator must — within 60 days from when termination takes effect — submit a request for amendment (see Article 39), with a proposal for reallocation of the tasks and estimated budget of the beneficiary concerned (see Annexes 1 and 2) and, if necessary, the addition of one or more new beneficiaries (see Article 40). If termination is notified after the period set out in Article 3, no request for amendment must be submitted unless the beneficiary concerned is the coordinator. In this case the request for amendment must propose a new coordinator.

The beneficiary concerned must submit to the coordinator:

(i) a technical report and

(ii) a financial statement covering the period from the end of the last reporting period to the date when termination takes effect.

This information must be included by the coordinator in the periodic report for the next reporting period (see Article 15.3).

If the request for amendment is rejected by the Agency (because it calls into question the decision awarding the grant or breaches the principle of equal treatment of applicants), the Agreement may be terminated according to Article 34.3.1(c).

If the request for amendment is accepted by the Agency, the Agreement is **amended** to introduce the necessary changes (see Article 39).

After termination, the concerned beneficiary's obligations (in particular Articles 15, 17, 18, Section 3 of Chapter 4, 21, 22 and 24) continue to apply.

SECTION 4 FORCE MAJEURE

ARTICLE 35 — FORCE MAJEURE

'Force majeure' means any situation or event that:

- prevents either party from fulfilling their obligations under the Agreement,
- was unforeseeable, exceptional situation and beyond the parties' control,
- was not due to error or negligence on their part (or on the part of third parties involved in the action), and
- proves to be inevitable in spite of exercising all due diligence.

The following cannot be invoked as force majeure:

- any default of a service, defect in equipment or material or delays in making them available, unless they stem directly from a relevant case of force majeure,

- labour disputes or strikes, or

- financial difficulties.

Any situation constituting force majeure must be formally notified to the other party without delay, stating the nature, likely duration and foreseeable effects.

The parties must immediately take all the necessary steps to limit any damage due to force majeure and do their best to resume implementation of the action as soon as possible.

The party prevented by force majeure from fulfilling its obligations under the Agreement cannot be considered in breach of them.

CHAPTER 7 FINAL PROVISIONS

ARTICLE 36 — COMMUNICATION BETWEEN THE PARTIES

36.1 Form and means of communication

Communication under the Agreement (information, requests, submissions, 'formal notifications', etc.) must:

- be made in writing and

- bear the number of the Agreement.

Until the payment of the balance: all communication must be made through the electronic exchange system and using the forms and templates provided there.

After the payment of the balance: formal notifications must be made by registered post with proof of delivery (‘formal notification on paper’).

Communications in the electronic exchange system must be made by persons authorised according to the ‘Terms and Conditions of Use of the electronic exchange system’. For naming the authorised persons, the partner must have designated— before the signature of the Framework Partnership Agreement — a ‘Legal Entity Appointed Representative (LEAR)’. The role and tasks of the LEAR are stipulated in his/her appointment letter (see Terms and Conditions of Use of the electronic exchange system).

If the electronic exchange system is temporarily unavailable, instructions will be given on the Agency and Commission websites.

36.2 Date of communication

Communications are considered to have been made when they are sent by the sending party (i.e. on the date and time they are sent through the electronic exchange system).

Formal notifications through the **electronic** exchange system are considered to have been made when they are received by the receiving party (i.e. on the date and time of acceptance by the receiving party, as indicated by the time stamp). A formal notification that has not been accepted within 10 days after sending is considered to have been accepted.

Formal notifications **on paper** sent by **registered post** with proof of delivery (only after the payment of the balance) are considered to have been made on either:

- the delivery date registered by the postal service or
- the deadline for collection at the post office.

If the electronic exchange system is temporarily unavailable, the sending party cannot be considered in breach of its obligation to send a communication within a specified deadline.

36.3 Addresses for communication

The **electronic** exchange system must be accessed via the following URL:

https://ec.europa.eu/research/participants/portal/desktop/en/projects/

The Agency will formally notify the coordinator and beneficiaries in advance any changes to this URL.

Formal notifications on paper (only after the payment of the balance) addressed **to the Agency** must be sent to the following address:

Consumers, Health, Agriculture and Food Executive Agency (CHAFEA)
Health Health
Drosbach Building
L-2920 Luxembourg

Formal notifications on paper (only after the payment of the balance) addressed **to the beneficiaries** must be sent to their legal address as specified in the 'Beneficiary Register'.

ARTICLE 37 — INTERPRETATION OF THE AGREEMENT

37.1 Precedence of the Terms and Conditions over the Annexes

The provisions in the Terms and Conditions of the Agreement take precedence over its Annexes.

Annex 2 takes precedence over Annex 1.

37.2 Privileges and immunities

Not applicable

ARTICLE 38 — CALCULATION OF PERIODS, DATES AND DEADLINES

In accordance with Regulation No 1182/71[10], periods expressed in days, months or years are calculated from the moment the triggering event occurs.

The day during which that event occurs is not considered as falling within the period.

ARTICLE 39 — AMENDMENTS TO THE AGREEMENT

39.1 Conditions

The Agreement may be amended, unless the amendment entails changes to the Agreement which would call into question the decision awarding the grant or breach the principle of equal treatment of applicants.

Amendments may be requested by any of the parties.

39.2 Procedure

The party requesting an amendment must submit a request for amendment signed in the electronic exchange system (see Article 36).

The coordinator submits and receives requests for amendment on behalf of the beneficiaries (see Annex 3).

If a change of coordinator is requested without its agreement, the submission must be done by another beneficiary (acting on behalf of the other beneficiaries).

The request for amendment must include:

- the reasons why;
- the appropriate supporting documents, and
- for a change of coordinator without its agreement: the opinion of the coordinator (or proof that this opinion has been requested in writing).

The Agency may request additional information.

If the party receiving the request agrees, it must sign the amendment in the electronic exchange system within 45 days of receiving notification (or any additional information the Agency has requested). If it does not agree, it must formally notify its disagreement within the same deadline. The deadline may be extended, if necessary for the assessment of the request. If no notification is received within the deadline, the request is considered to have been rejected.

An amendment **enters into force** on the day of the signature of the receiving party.

An amendment **takes effect** on the date agreed by the parties or, in the absence of such an agreement, on the date on which the amendment enters into force.

ARTICLE 40 — ACCESSION TO THE AGREEMENT

[10] Regulation (EEC, Euratom) No 1182/71 of the Council of 3 June 1971 determining the rules applicable to periods, dates and time-limits (OJ L 124, 8/6/1971, p. 1).

40.1 Accession of the beneficiaries mentioned in the Preamble

The other beneficiaries must accede to the Agreement by signing the Accession Form (see Annex 3) in the electronic exchange system (see Article 36) within 30 days after its entry into force (see Article 42).

They will assume the rights and obligations under the Agreement with effect from the date of its entry into force (see Article 42).

If a beneficiary does not accede to the Agreement within the above deadline, the coordinator must — within 30 days — request an amendment to make any changes necessary to ensure proper implementation of the action. This does not affect the Agency's right to terminate the Agreement (see Article 34).

40.2 Addition of new beneficiaries

In justified cases, the beneficiaries may request the addition of a new beneficiary.

For this purpose, the coordinator must submit a request for amendment in accordance with Article 39. It must include an Accession Form (see Annex 3) signed by the new beneficiary in the electronic exchange system (see Article 36).

New beneficiaries must assume the rights and obligations under the Agreement with effect from the date of their accession specified in the Accession Form (see Annex 3).

ARTICLE 41 — APPLICABLE LAW AND SETTLEMENT OF DISPUTES

41.1 Applicable law

The Agreement is governed by the applicable EU law, supplemented if necessary by the law of Belgium.

41.2 Dispute settlement

If a dispute concerning the interpretation, application or validity of the Agreement cannot be settled amicably, the General Court — or, on appeal, the Court of Justice of the European Union — has sole jurisdiction. Such actions must be brought under Article 272 of the Treaty on the Functioning of the EU (TFEU).

If a dispute concerns administrative or financial penalties, offsetting or an enforceable decision under Article 79(2) of the Financial Regulation No 966/2012 and Article 299 TFEU (see Articles 28, 29 and 30), the beneficiaries must bring action before the General Court — or, on appeal, the Court of Justice of the European Union — under Article 263 TFEU. Actions against enforceable decisions must be brought against the Commission (not against the Agency).

ARTICLE 42 — ENTRY INTO FORCE OF THE AGREEMENT

The Agreement will enter into force on the day of signature by the Agency or the coordinator, depending on which is later.

SIGNATURES

For the coordinator

For the Agency

EUROPEAN COMMISSION

Consumers, Health, Agriculture and Food Executive Agency

Health

ANNEX 1 (part A)

Project

NUMBER — 710033 — SCIROCCO

Table of Contents

1.1. The project summary

Project Number [1]	710033	Project Acronym [2]	SCIROCCO

One form per project

General information	
Project title [3]	SCALING INTEGRATED CARE IN CONTEXT
Starting date [4]	The first day of the month after the signature by the Commission
Duration in months [5]	32
Call (part) identifier [6]	HP-PJ-2015
Topic	PJ-04-2015 Support for the implementation and scaling up of good practices in the areas of integrated care, frailty prevention, adherence to medical plans and age-friendly communities
Fixed EC Keywords	Integrated care
Free keywords	Ageing, benchmarking, coaching, context, good practice, knowledge transfer, maturity, partnership, scale-up, twinning

Abstract [7]

Grounded in the extensive experience of the European Innovation Partnership on Active and Healthy Ageing (EIP on AHA), SCIROCCO aims to provide a validated and tested tool that facilitates the successful scaling-up and transfer of good practices in integrated care across European regions. SCIROCCO will specifically focus on successful local interventions (good practices) that have demonstrated significant benefits to citizens, communities and service providers and that feature moving towards community-based, integrated health and social care service models.SCIROCCO will deliver an assessment of the contextual requirements necessary for the scale-up of these interventions and the capacity of regions to adopt them. SCIROCCO will also compare the readiness of five European regions to adopt good practices in the provision of integrated care, to demonstrate the effectiveness of the tool in practice.SCIROCCO explores how matching regions that have complementary strengths and weaknesses can deliver two major benefits: a strong basis for successful twinning and coaching that facilitates shared learning and effective knowledge transfer; and practical support for the scaling-up of good practices that promote active and healthy ageing and participation in the community.Finally, SCIROCCO captures the lessons learned from twinning, coaching and knowledge transfer activities as a significant contribution to supporting the broader implementation and scaling-up of local integrated care interventions in Europe, in line with the European Commission's 'European Scaling-up Strategy in Active & Healthy Ageing'.

1.2. List of Beneficiaries

Project Number [1]	710033	Project Acronym [2]	SCIROCCO

List of Beneficiaries

No	Name	Short name	Country	Project entry month[8]	Project exit month
1	NHS 24 (SCOTLAND)	NHS 24	United Kingdom	1	32
2	THE UNIVERSITY OF EDINBURGH	UEDIN	United Kingdom	1	32
3	VRIJE UNIVERSITEIT BRUSSEL	VUB	Belgium	1	32
4	UNIVERSITAT DE VALENCIA	UVEG	Spain	1	32
5	ASOCIACION CENTRO DE EXCELENCIA INTERNACIONAL EN INVESTIGACION SOBRE CRONICIDAD	KRONIKGUNE	Spain	1	32
6	Servicio Vasco de Salud Osakidetza	Osakidetza	Spain	1	32
7	AGENZIA REGIONALE SANITARIA PUGLIESE	ARES PUGLI	Italy	1	32
8	FAKULTNI NEMOCNICE OLOMOUC	FNOL	Czech Republic	1	32
9	NORRBOTTENS LÄNS LANDSTING	NLL	Sweden	1	32
10	EUROPEAN HEALTH TELEMATICS ASSOCIATION	EHTEL	Belgium	1	32

1.3. Workplan Tables - Detailed implementation

1.3.1. WT1 List of work packages

WP Number [9]	WP Title	Lead beneficiary [10]	Person-months [11]	Start month [12]	End month [13]
WP1	Coordination of the project	1 - NHS 24	14.00	1	32
WP2	Dissemination and Exploitation	10 - EHTEL	17.00	1	32
WP3	Evaluation	3 - VUB	32.00	1	32
WP4	Maturity requirements in selected good practices	5 - KRONIKGUNE	30.00	2	6
WP5	Refinement of the B3-MM	2 - UEDIN	20.00	4	27
WP6	Self-assessment	9 - NLL	63.00	11	19
WP7	Knowledge Transfer	7 - ARES PUGLI	60.00	17	27
WP8	Lessons learned and policy implications	4 - UVEG	27.00	6	32
		Total	263.00		

1.3.2. WT2 list of deliverables

Deliverable Number [14]	**Deliverable Title**	**WP number** [9]	**Lead beneficiary**	**Type** [15]	**Dissemination level** [16]	**Due Date (in months)** [17]
D1.1	Interim Report	WP1	1 - NHS 24	Report	Public	16
D1.2	Final Report	WP1	1 - NHS 24	Report	Public	32
D2.1	Disemination Strategy and Action Plan	WP2	10 - EHTEL	Report	Public	32
D2.2	Leaflet	WP2	10 - EHTEL	Report	Public	3
D2.3	Layman version of final report	WP2	10 - EHTEL	Report	Public	32
D2.4	Website	WP2	10 - EHTEL	Websites, patents filling, etc.	Public	3
D3.1	Assessment level of knowledge transfer	WP3	3 - VUB	Report	Public	30
D4.1	Maturity requirements of good practices viable for scaling up	WP4	5 - KRONIKGUNE	Report	Public	6
D5.1	SCIROCCO online assessment tool	WP5	2 - UEDIN	Demonstrator	Public	27
D6.1	Guidance (process) for twinning and coaching	WP6	9 - NLL	Report	Public	19
D7.1	Five Action Plans	WP7	7 - ARES PUGLI	Report	Public	27
D8.1	White Paper on the issues of scaling up	WP8	4 - UVEG	Report	Public	30

1.3.3. WT3 Work package descriptions

Work package number [9]	WP1	**Lead beneficiary** [10]	1 - NHS 24
Work package title	Coordination of the project		
Start month	1	**End month**	32

Objectives

WP1 aims to manage the project effectively, making sure that it is implemented on time and as planned, through the establishment of regular communication processes and channels for and between the consortium partners.

Description of work and role of partners

WP1 - Coordination of the project [Months: 1-32]
NHS 24, UEDIN, VUB, UVEG, KRONIKGUNE, ARES PUGLI, NLL , EHTEL
The work will be carried out through the completion of the following tasks:

Task 1.1 Coordinator responsibilities, M1-M32
Lead partner: NHS 24
Acting as the point of contact between the EC and the consortium, distribution of the financial contribution, reviewing and approval of all reports and deliverables including financial claims will be performed by the coordinator. The coordinator will support the consortium partners in delivery of the project with respect to their obligations defined in the CHAFEA Grant Agreement.

Task 1.2 Establishment of consortium bodies, planning, organisation and administration of consortium meetings, M1 – M32
Lead partner: NHS 24; Contributors: All
The coordinator will implement and record meetings of the consortium. Advanced planning and communication to all partners will ensure that meetings are arranged to meet the needs of the project and partners. The location of consortium meetings will be at the partners' offices or another mutually convenient location. Efficient and effective use of the project budget will be considered when making arrangements. Agendas and minutes of all consortium meetings will be circulated in a timely manner to ensure all partners are allowed sufficient time to prepare for meetings.

Task 1.3 Management of the consolidation of technical and financial partner reports and communications with CHAFEA, M1 – M32
Lead partner: NHS 24; Contributing partners: UEDIN, VUB, UVEG, Kronikgune, ARES PUGLI, NLL, EHTEL
Management of the consolidation of technical and financial partner reports in a timely and professional manners as required, meeting the needs of the Commission. Latest communications tools and techniques will be utilised including web portal services, common document areas and integrated financial data recording systems.

Task 1.4 Financial management, M1 – M32
Lead partner: NHS 24;
Working closely with the Finance Departments of the participating organisations to ensure that all budget related actions are performed correctly and within the rules and regulations set out by the CHAFEA Grant Agreement. This includes the establishment of efficient good operating procedures for financial management, adapted for the financial system of each partner, to ensure that received funds are correctly distributed and accounted for, that cost statements are received and appropriate and regular audits undertaken. Facilitation of decisions regarding any reallocation of budgets between beneficiaries.

Participation per Partner

Partner number and short name	WP1 effort
1 - NHS 24	7.00
2 - UEDIN	1.00
3 - VUB	1.00

Partner number and short name	WP1 effort
4 - UVEG	1.00
5 - KRONIKGUNE	1.00
7 - ARES PUGLI	1.00
9 - NLL	1.00
10 - EHTEL	1.00
Total	14.00

List of deliverables

Deliverable Number [14]	Deliverable Title	Lead beneficiary	Type [15]	Dissemination level [16]	Due Date (in months) [17]
D1.1	Interim Report	1 - NHS 24	Report	Public	16
D1.2	Final Report	1 - NHS 24	Report	Public	32

Description of deliverables

Deliverables linked to this work package:

MD1. Interim report (M18) - This report describes the activities carried out, milestones and results achieved in the first half of the project. The project deliverables will be annexed.

MD2. Final Report (M32) - This report describes the project implementation and the results achieved. The project deliverables will be annexed.

D1.1 : Interim Report [16]

This report describes the activities carried out, milestones and results achieved in the first half of the project. The other project deliverables are annexed.

D1.2 : Final Report [32]

This report describes the project implementation and the results achieved. The other project deliverables are annexed.

Schedule of relevant Milestones

Milestone number [18]	Milestone title	Lead beneficiary	Due Date (in months)	Means of verification
MS1	Project Kick-off Meeting in Luxembourg	1 - NHS 24	1	Project kick-off meeting in Luxembourg.
MS2	First Project Assembly Meeting	1 - NHS 24	7	First Project Assembly meeting for consortium partners.
MS3	Second Project Assembly meeting	1 - NHS 24	14	Second project assembly meeting for consortium partners.
MS4	Acceptance of Interim Report	1 - NHS 24	16	Acceptance of consortium partners and EC of interim project report.

Schedule of relevant Milestones

Milestone number [18]	Milestone title	Lead beneficiary	Due Date (in months)	Means of verification
MS5	Third Project Assembly meeting	1 - NHS 24	21	Third project assembly meeting for consortium partners.
MS6	Fourth Project Assembly meeting	1 - NHS 24	28	Fourth project assembly meeting for consortium partners.
MS7	Final Project Assembly meeting, linked to Project Final Conference	1 - NHS 24	32	Final project assembly and final conference.
MS8	Acceptance of Final Report	1 - NHS 24	32	Acceptance of Final Report by consortium partners and EC.

Work package number [9]	WP2	Lead beneficiary [10]	10 - EHTEL
Work package title	Dissemination and Exploitation		
Start month	1	End month	32

Objectives

P2 has two main objectives:

1. Dissemination: raising awareness at European and national/regional level about the project's ambitions, lessons learned during the testing and validation phase of the B3-MM tool and finally the project end results/outcomes.

2. Exploitation: creating the necessary organisational elements to enable the use of the B3-MM beyond the project's end by regions seeking to scale-up services or benefit from relevant good practices identified in other regions.

Description of work and role of partners

WP2 - Dissemination and Exploitation [Months: 1-32]
EHTEL, NHS 24, UEDIN, VUB, UVEG, KRONIKGUNE, Osakidetza , ARES PUGLI, FNOL, NLL
The work will be carried out through the completion of the following tasks:

T2.1: Project web site and branding, M1-M3
Lead partner: EHTEL; Contributors: All
The objective of this task is to create SCIROCCO's website and other dissemination materials. The project web site will work as a project-related repository of information. Its purpose will be to create a reference point for all future dissemination activities. This task will also include the preparation of a preliminary Dissemination Plan, outlining key tasks, including the organisation of Editorial Committee for the project, web site, on-going management of the Committee and
regular updating of the web site to share lessons learned and progress on an on-going basis throughout the project lifespan.
For branding of the project, the consortium will develop a unique visual identity for the project based on the project values (logo, presentation templates, graphical charter for the web site and other dissemination material). The branding will also be used during the exploitation of the results of the project, i.e. beyond the duration of the project.

T2.2: Project leaflets, M1-M32
Lead partner EHTEL; Contributors: All
The objective of this task is to promote the use of SCIROCCO's web site. Social media activities and paper-based material (to be distributed during workshops and conferences), will be used to incentivise stakeholders to visit the web site. There will be two generations of paper-based materials produced: the first one will be aimed at presenting an overview of the project's ambition, values and objectives; and the second one will be a lay version of the Project Final Report and will present testimonials from those who have used the B3 -MM.

T2.3: Dissemination Strategy and Action Plan, M6
Lead partner: EHTEL; Contributors: All
The objective of this task is to develop a targeted Dissemination Strategy and Action Plan. This Dissemination Plan will be organised combining several axes of activities such as regional and European dissemination as well as operational and policy-oriented dissemination. It will,furthermore, include liaison with other EU projects and the EIP on AHA community e.g. to organise joint focus groups or workshops. To ensure high visibility of the project its whole lifecycle, the Dissemination Strategy will furthermore be organised into three phases:
Phase One: A focus on the development of the project branding / graphical identity and its web site.
Phase Two: A focus on gathering and disseminating the lessons learned by the consortium during the testing phase of the model and its use for twining / coaching.
Phase Three: Promotion of the results of the project and organisation of the exploitation arrangements for after the end of the project.
All project dissemination activities will seek to take advantage of the well-established networks of each member of the consortium. EHTEL will also take a lead role in working with other identified pan-European and multi-stakeholder network – EIP on AHA, CORAL, IFIC, AER, EUREGHA, ECHA and ERRIN – to further disseminate the work and impact of the project. This
will enable the project's Dissemination Strategy to work as an "impact multiplier".

This Strategy will also aim to create synergies with already planned key local, national and European stakeholder engagement activities (conference, workshops, etc.) to organise the exploitation of the project results.

T2.4: Project presentations to conferences, workshops and other meetings, M6-M32
Lead partner: EHTEL; Contributors: All
The objective of this task is to raise awareness and validate the findings of the SCRIOCCO project. Under this task, the participation of all the project representatives will be actively promoted in relevant regional, national or European dissemination activities to present lessons learned and interim results of the project.

T2.5: Final conference, M32
Lead partner: EHTEL; Contributors: All
The objective of this task is to organise the final conference as a final milestone for presenting lessons learned, and final results of the project. The final conference will be designed to attract an audience of 100 participants.

T2.6: Exploitation organisation, M30 and M32
Lead partner: EHTEL; Contributors: All
The objective of this task is to develop the Exploitation Plan for the use of B3-MM - SCIROCCO's final deliverable beyond the duration of the project. The B3-MM deliverable is a tool that will be publicly available at the end of the project. Support actions will be required to accelerate the actual use of the tool and implicitly, the implementation or scaling-up of good practices in and across Europe.

The supportive actions that will be considered are: education and training workshops on the B3-MM for local stakeholders in regions and match-making activities to facilitate knowledge transfer through twinning and coaching to transfer or scale-up good practices. Self-funded mechanisms will be required to be identified as these supportive actions will run after the end of the project.

Participation per Partner

Partner number and short name	WP2 effort
1 - NHS 24	2.00
2 - UEDIN	1.00
3 - VUB	1.00
4 - UVEG	1.00
5 - KRONIKGUNE	1.00
6 - Osakidetza	1.00
7 - ARES PUGLI	1.00
8 - FNOL	1.00
9 - NLL	1.00
10 - EHTEL	7.00
Total	17.00

List of deliverables

Deliverable Number [14]	Deliverable Title	Lead beneficiary	Type [15]	Dissemination level [16]	Due Date (in months) [17]
D2.1	Disemination Strategy and Action Plan	10 - EHTEL	Report	Public	32
D2.2	Leaflet	10 - EHTEL	Report	Public	3

List of deliverables

Deliverable Number [14]	Deliverable Title	Lead beneficiary	Type [15]	Dissemination level [16]	Due Date (in months) [17]
D2.3	Layman version of final report	10 - EHTEL	Report	Public	32
D2.4	Website	10 - EHTEL	Websites, patents filling, etc.	Public	3

Description of deliverables

Deliverables linked to this work package:
D2.1 Dissemination Strategy and Action Plan (M6-M32) - The document that describes the Dissemination Plan and Strategy for SCIROCCO, including project branding, participation of all the project representatives in any regional, national and European dissemination activities and organisation of SCIROCCO final conference.
MD3 Project Leaflet (M3)
MD4 Project Flyer v02 (layman version of the final report) (M32)
MD5 Project Web Site (M3)

D2.1 : Disemination Strategy and Action Plan [32]

The document that describes the Dissemination Plan and Strategy for SCIROCCO, including project branding, participation of all the project representatives in any regional, national and European dissemination activities and organisation of SCIROCCO final conference.

D2.2 : Leaflet [3]

A leaflet to promote the project will be produced at the beginning of the project.

D2.3 : Layman version of final report [32]

This is short report is a condensed version of the project final report, written for the interested public as a target group.

D2.4 : Website [3]

This will be the project's web-site and will feature information about the project's vision, values and objectives, on-going progress updates and final outcomes / deliverables.

Schedule of relevant Milestones

Milestone number [18]	Milestone title	Lead beneficiary	Due Date (in months)	Means of verification
MS9	Availability of website	10 - EHTEL	3	Website set up and accessible to partners and public.
MS10	Availabilty of dissemination materials	10 - EHTEL	3	Early project information for dissemination purposes available.
MS11	Availability of Disemination Strategy and Action Plan	10 - EHTEL	6	Dissemination Strategy and Action Plan available to guide and monitor impact of dissemination activities.
MS12	SCIROCCO interim findings presented in public	10 - EHTEL	19	Interim findings disseminated to public appropriately.

Schedule of relevant Milestones

Milestone number [18]	Milestone title	Lead beneficiary	Due Date (in months)	Means of verification
MS13	Final Conference	10 - EHTEL	32	Final project conference organised.

Work package number [9]	WP3	Lead beneficiary [10]	3 - VUB
Work package title	Evaluation		
Start month	1	End month	32

Objectives

WP3 has four objectives:

1. To test the validity and reliability of B3-MM as instrument to measure the level of maturity of integrated care;
2. To measure the level of maturity of integrated care in selected sites at baseline and after scaling up activities;
3. To measure the level of knowledge translation in selected sites at baseline and after scaling up activities
4. To assess to what extent SCIROCCO adheres to program fidelity i.e. is implemented as intended and according to the goals that underlie its conception.

Description of work and role of partners

WP3 - Evaluation [Months: 1-32]
VUB, NHS 24, UVEG, KRONIKGUNE, ARES PUGLI, FNOL, NLL
The work will be carried out through completion of the following tasks:

T3.1. Testing of validity and reliability of B3-MM M1-M4
Lead partner VUB; Contributing partners: UVEG;
First, a review literature will be undertaken to compare B3-MM with other instruments developed to measure the level of maturity of integrated care. For this, three databases will be used (PubMed, Cochrane and the Internet), snowballing and an inventory of 10 experts in the field of integrated care, and its evaluation and measurement (purposive sampling). The review should provide a conceptual underpinning of the dimensions of B3-MM, its components and results categories. Following on from the review, an international Delphi Study will be performed with 20 experts to test the appropriateness of B3-MM to measure maturity of integrated care. In Round 1, experts will receive a link to an online version of B3-MM and asked to rate the appropriateness of each dimension to assess the maturity of integrated care on a nine-point Likert-Scale. Experts will be asked to comment on any of the features, to suggest possible rephrasing, and to highlight any features that may have been missed in the initial list. In Round 2, experts will be invited to discuss the results of Round 1 and to reassess the appropriateness of features of the B3-MM. Rounds 1 and 2 together will provide information about the face validity of B3-MM and enable the instrument to be optimised. By applying B3-MM to measure the level of maturity of integrated care (see T3.2) at baseline and 2 follow-up measurements, quantitative data-analysis will be performed to assess the underlying structure, test-retest reliability and internal consistency of B3-MM. For this, factor analysis and Cronbach's Alpha will be calculated using SPSS software, version 22.0. It is envisaged for Task 3.1 to be technical activities for underpinning the psychometric properties of the B3-MM (mid-term evaluation).

T3.2. Measuring of knowledge transfer M11-M27
Lead partner: VUB; Contributors: NHS 24, UVEG, Kronikgune, ARES PUGLI, FNOL, NLL
To measure knowledge translation, use will be made of a survey based on the Development Model for Integrated Care (DMIC) by Minkman 97. This survey has been developed and validated to assess the relevance and implementation of elements of integrated care. It consists of 89 items grouped in 9 clusters. The clusters are: 'patient-centeredness', 'delivery system', 'performance management', 'quality of care', 'result-focused learning', 'inter-professional teamwork', 'roles and tasks', 'commitment', and 'transparent entrepreneurship'. As with B3-MM, stakeholders identified from the participating sites will be invited to fill out the DMIC survey at baseline and 2 follow-up measurements. Data analyses will be executed per site and for all sites by means of descriptive statistics, frequency analyses, Chi Square, ANOVA and Kruskal-Wallis H, using SPSS software, version 22.0. It is envisaged for Task 3.2 to be functional activities for underpinning the applicability of the B3-MM (Final-term evaluation).

T3.3 Assessing implementation fidelity of SCIROCCO M1-M32
Lead partner: VUB; Contributors: UVEG
The most complete conceptual framework for implementation fidelity (Carroll et al.98)will be used for evaluation of implementation fidelity of SCIROCCO. This framework includes components of implementation fidelity and factors that may influence the degree of fidelity, referred to as moderating factors. The measurement of implementation fidelity is a measurement of adherence, with its subcategories: content, frequency, duration, and coverage (dose). Moderating factors are: intervention complexity, facilitation strategies, quality of delivery, and participant responsiveness.

Data will be collected for each of the participating sites during the entire intervention period and a multi-method approach will be used. Data collection methods will include key informant interviews, non-participant observations, questionnaire studies (including B3-MM, DMIC) analysis of participants' logbooks and other project document analysis.

Participation per Partner

Partner number and short name	WP3 effort
1 - NHS 24	1.00
3 - VUB	20.00
4 - UVEG	7.00
5 - KRONIKGUNE	1.00
7 - ARES PUGLI	1.00
8 - FNOL	1.00
9 - NLL	1.00
Total	32.00

List of deliverables

Deliverable Number [14]	Deliverable Title	Lead beneficiary	Type [15]	Dissemination level [16]	Due Date (in months) [17]
D3.1	Assessment level of knowledge transfer	3 - VUB	Report	Public	30

Description of deliverables

D3.1 Assessment level of knowledge translation (M30) - The document that describes the evaluation outcomes of the B3-MM as a tool facilitating knowledge transfer.

D3.1 : Assessment level of knowledge transfer [30]

The document that describes evaluation outcomes of the B3-MM as a tool to facilitate knowledge transfer.

Schedule of relevant Milestones

Milestone number [18]	Milestone title	Lead beneficiary	Due Date (in months)	Means of verification
MS14	Literature review	3 - VUB	4	Literature review to compare and contrast existing self-assessment tools with the B3-MM.
MS15	Validated B3-MM through Delphi study	3 - VUB	4	First refinement of the B3-MM based on the outcomes of Delphi study.
MS16	Assessment level of maturity of integrated care	3 - VUB	19	Report about the level of maturity of integrated care in five European regions.

Work package number [9]	WP4	Lead beneficiary [10]	5 - KRONIKGUNE
Work package title	Maturity requirements in selected good practices		
Start month	2	End month	6

Objectives

WP4 has two objectives:

1. Identify 30 good practices with a potential for scaling-up in five European regions by means of viability assessment.

2. Define the maturity requirements of a minimum of 15 selected good practices for their adoption in Europe.

The work of this WP will contribute to the dissemination of the selected good practices amongst EIP on AHA network and in the selected communication channel in collaboration with WP2. The outcomes of this WP will feed directly to WP5 as the inputs for the refinement of the B3-MM.

Description of work and role of partners

WP4 - Maturity requirements in selected good practices [Months: 2-6]
KRONIKGUNE, NHS 24, Osakidetza , ARES PUGLI, FNOL, NLL
The work will be carried out through the completion of the following tasks:

Task 4.1 Viability assessment of good practices, M2-M3
Lead partner: KRONIKGUNE; Contributors: NHS 24, Osakidetza, ARES PUGLI, FNOL, NLL
The objective of this task is to map and select good practices in five European regions for the purpose of the viability assessment. These good practices will address the issues of active and healthy ageing and highlight the benefits of integration of health and social care and of benefits of moving towards community based health and care. The viability criteria will be applied to assess the potential of these good practices for scaling-up across European health and care systems. Minimum 30 good practices in five European regions will be identified.

Task 4.2 Data collection, M2-M4
Lead partner: KRONIKGUNE; Contributors: NHS 24, Osakidetza, ARES PUGLI, FNOL, NLL
The objective of this task is to collect data on 30 good practices selected in Task 4.1. The template for the data collection will be developed using potentially, the existing templates for the description of good practices, to ensure the consistence of data collection in five European regions. Data on 30 good practices will be collected.

Task 4.3 Maturity requirements of identified good practices, M4-M6
Lead partner: KRONIKGUNE; Contributors: NHS 24, Osakidetza, ARES PUGLI, FNOL, NLL
The objective of this task is to define the maturity requirements for 15 good practices selected from the collection of good practices in Task 4.1. These good practices are identified as those with a potential for scaling-up and adoption across European regions. The B3-MM will be applied to each of these good practices to assess their maturity requirements for the potential adoption across Europe along each of the dimension of the B3-MM. This will result in a guide to potential adopters of the context in which the good practice has arisen. The outcomes of this task will also directly inform the WP3 which will seek the refinement of the B3-MM.

Participation per Partner

Partner number and short name	WP4 effort
1 - NHS 24	4.00
5 - KRONIKGUNE	10.00
6 - Osakidetza	4.00
7 - ARES PUGLI	4.00
8 - FNOL	4.00
9 - NLL	4.00

Partner number and short name	WP4 effort
Total	30.00

List of deliverables

Deliverable Number [14]	Deliverable Title	Lead beneficiary	Type [15]	Dissemination level [16]	Due Date (in months) [17]
D4.1	Maturity requirements of good practices viable for scaling up	5 - KRONIKGUNE	Report	Public	6

Description of deliverables

Deliverables linked to this work package:

D4.1 Guide on the maturity requirements of good practices viable for scaling up (M6) – This report provides the contextual analysis of the requirements for the adoption of 15 selected good practices in Europe.

D4.1 : Maturity requirements of good practices viable for scaling up [6]

This reports provides the contextual analysis of the requirements for the adoption of 15selected good practices.

Schedule of relevant Milestones

Milestone number [18]	Milestone title	Lead beneficiary	Due Date (in months)	Means of verification
MS17	Good practices work initiated by all partners.	5 - KRONIKGUNE	2	Good practices work initiated by all partners.
MS18	Availability of data for 30 good practices.	5 - KRONIKGUNE	3	Availability of data for 30 good practices.
MS19	Upload of 30 good practices on website and EIP on AHA database of good practices.	5 - KRONIKGUNE	5	Upload of 30 good practices on website and EIP on AHA database of good practices.
MS20	Completed maturity assessment for 15 good practices.	5 - KRONIKGUNE	6	Completed maturity assessment for 15 good practices.

Work package number [9]	WP5	Lead beneficiary [10]	2 - UEDIN
Work package title	Refinement of the B3-MM		
Start month	4	End month	27

Objectives

WP5 has 4 objectives:

1. To refine the B3-MM as a tool enabling multi-dimensional assessment of the capacity of health and care systems for adoption of good practice.

2. To develop a guide on how to use the B3-MM as a self-assessment tool.

3. To further refine the B3-MM as a tool to facilitate knowledge transfer activities(WP6, T6.4).

4. To provide a final, validated and tested B3-MM tool to facilitate scaling-up and knowledge transfer amongst European member states, based on the outcomes of WP6 (T6.4) and WP7 (T7.3).

The outcomes of WP4 will then feed directly to WP5 where the self-assessment process is envisaged. This WP also links to WP3 but focuses mostly on the collection of qualitative data for the validation purposes.

Description of work and role of partners

WP5 - Refinement of the B3-MM [Months: 4-27]
UEDIN, NHS 24, VUB, KRONIKGUNE, Osakidetza , ARES PUGLI, FNOL, NLL
The work will be carried out through the completion of the following tasks:

Task 5.1 First refinement of the B3-MM, M4-M7
Lead partner: UEDIN; Contributors: NHS 24, VUB, Kronikgune, Osakidetza, ARES PUGLI, FNOL, NLL
The B3-MM will be refined using the using the outcomes of WP4 – D4.2 Guide on the maturity requirements of good practices viable for scaling-up. These outcomes will provide some validation for the development of the B3-MM as a tool enabling multidimensional assessment of the capacity of regions for adoption of a good practice. This will involve the validation of domains and maturity indicators of each of the dimensions of the B3-MM. The refined B3-MM will be validated internally with the five European regions.

Task 5.2 Measurement scale, M7-M8
Lead partner: UEDIN; Contributors: NHS 24, VUB, Kronikgune, Osakidetza, ARES PUGLI, FNOL, NLL
Second step in the process of refining the B3-MM is the development of an objective measurement scale for each dimension of the refined B3-MM in Task 5.1. The focus is on the development of series of questions for comparisons along each of the dimensions of the B3-MM and allocation of scores related to position on the dimensions of the B3-MM. The proposed measurement scale will be validated internally with five European regions.

Task 5.3 Self-assessment tool, M8-M10
Lead partner: UEDIN; Contributors: NHS 24, VUB, Kronikgune, Osakidetza, ARES PUGLI, FNOL, NLL
The outcomes of Tasks 5.1 and 5.2 will inform the final consolidation of the B3-MM as a baseline for multidimensional comparison framework to assess the capacity of the region for the adoption of a good practice. An online version of the self-assessment tool will be developed and tested with the five European regions. This will inform the final consolidation of the assessment tool with B3-MM as baseline.

Task 5.4 Methodology for self-assessment, M10-M11
Lead partner: UEDIN; Contributors: NHS 24, VUB, Kronikgune, Osakidetza, ARES PUGLI, FNOL, NLL
The guide for the regions on how to use the B3-MM as a self-assessment tool will be developed. The proposed methodology will be validated and consolidated internally with five European regions. The outcomes of this task will directly inform the WP6 where the self-assessment of European regions is envisaged.

Participation per Partner

Partner number and short name	WP5 effort
1 - NHS 24	1.00
2 - UEDIN	12.00
3 - VUB	2.00
5 - KRONIKGUNE	1.00
6 - Osakidetza	1.00
7 - ARES PUGLI	1.00
8 - FNOL	1.00
9 - NLL	1.00
Total	20.00

List of deliverables

Deliverable Number [14]	Deliverable Title	Lead beneficiary	Type [15]	Dissemination level [16]	Due Date (in months) [17]
D5.1	SCIROCCO online assessment tool	2 - UEDIN	Demonstrator	Public	27

Description of deliverables

D5.1 SCIROCCO online assessment tool (M27) – On-line tool enabling multidimensional assessment to facilitate the implementation of good practices and scaling-up, including the manual for the European regions on how to use the B3-MM in the self-assessment process.

D5.1 : SCIROCCO online assessment tool [27]

On-line tool enabling multi-dimensional assessment to facilitate the implementation of good practices and scaling-up, including the manual for European regions on how to use the B3-MM in the self-assessment process.

Schedule of relevant Milestones

Milestone number [18]	Milestone title	Lead beneficiary	Due Date (in months)	Means of verification
MS21	Refinement of the B3-MM initiated.	2 - UEDIN	4	Refinement of the B3-MM initiated.
MS22	Validation of B3-MM is completed.	2 - UEDIN	8	Validation of B3-MM is completed.
MS23	Access to online self-assessment tool.	2 - UEDIN	9	Access to online self-assessment tool.
MS24	Knowledge of regions on how to use the B3-MM	2 - UEDIN	11	Knowledge of regions on how to use the B3-MM.

Work package number [9]	WP6	Lead beneficiary [10]	9 - NLL
Work package title	Self-assessment		
Start month	11	End month	19

Objectives

WP6 has three objectives:

1. Assess five European regions in terms of their maturity for the adoption of particular good practice in integrated care provision.

2. Identify strengths and weaknesses of the five European regions in the adoption of integrated care interventions (good practices).

3. Test the B3-MM as the tool enabling multi-dimensional comparison.

This WP builds directly on WP5 where the baseline and methodology for self-assessment was developed and tested. The outcomes of this WP will inform the WP7 Knowledge Transfer andWP3, WP5 and WP8 on the experience of five European regions with using the B3-MM in the self-assessment process.

Description of work and role of partners

WP6 - Self-assessment [Months: 11-19]
NLL , NHS 24, UEDIN, VUB, KRONIKGUNE, Osakidetza , ARES PUGLI, FNOL
The work will be carried out through the completion of the following tasks:

T6.1 Self-assessment process in five European regions, M11-M13
Lead: NLL; Contributors: NHS 24, Kronikgune, Osakidetza, ARES PUGLI, FNOL
The objective of this task is to perform self-assessment in five European regions. The regions will be assessed in terms of their maturity for adoption of integrated care interventions (good practices). The regions will use the online self-assessment tool (with the B3-MM as the baseline measurement) developed in WP5 (D5.1). The consistency of the approach and use of the self-assessment tool is ensured through applying commonly agreed methodology developed and validated in WP5 (D5.2).

T6.2 Strengths and weaknesses of the European region in integrated care, M13-M15
Lead: NLL; Contributors: NHS 24, UEDIN, VUB, Kronikgune, Osakidetza, ARES PUGLI, FNOL
The objective of this task is to collect and analyse data from the self-assessment process. The comparison tables, graphs and radar diagrams will be developed for each region. Data will be analysed to identify strengths and weakness in integrated care in of each of the five regions. The analysis will be performed against each of the B3-MM dimensions. The outcomes of this analysis will inform about the maturity gaps of a particular regional health and care system in integrated care. The five European regions will be then clustered in terms of their complementary strengths and weaknesses to test to what extent SCIROCCO's approach of matching the regions with the same level of maturity speeds up the adoption and scaling-up of good practices.

T6.3 Methodology for twinning and coaching, M17-M19
Lead partner: NLL; Contributors: NHS 24, UEDIN, VUB, UVEG, Kronikgune, Osakidetza, ARES PUGLI, FNOL, Norbotten
The objective of this task is to develop the process and methodology for twinning and coaching activities of five European regions. The methodology will specifically guide the regions on how to use the B3-MM to facilitate the process of knowledge transfer and information sharing.
Commonly agreed methodology tailored to the needs of participating regions will allow consistency in the process of information flows across the European regions. Using the outcomes of T6.2 on clustering of regions with complementary strengths and weaknesses, the regions will be paired in such a way that the knowledge transfer will flow between the regions with the same strengths (twinning) as well as between the regions scoring high at particular dimension with the regions scoring low along the same dimension (coaching). The priorities for actions as defined in the Action Plans (D6.2) of five European regions will inform the selection of areas for twinning and coaching. The areas will reflect specific dimensions of the B3-MM

Task 6.4 Second Refinement of the B3-MM – M11-M17
Lead: UEDIN; Contributors: NHS 24, VUB, Kronikgune, Osakidetza, ARES PUGLI, FNOL, NLL

The objective of this task is to refine and consolidate the B3-MM as a tool to assess European health and care regions in terms of their maturity for the adoption of good practices.

Participation per Partner

Partner number and short name	WP6 effort
1 - NHS 24	10.00
2 - UEDIN	2.00
3 - VUB	2.00
5 - KRONIKGUNE	7.00
6 - Osakidetza	10.00
7 - ARES PUGLI	10.00
8 - FNOL	10.00
9 - NLL	12.00
Total	63.00

List of deliverables

Deliverable Number [14]	Deliverable Title	Lead beneficiary	Type [15]	Dissemination level [16]	Due Date (in months) [17]
D6.1	Guidance (process) for twinning and coaching	9 - NLL	Report	Public	19

Description of deliverables

D6.1 Guidance (process) for twinning and coaching (M19) – The manual describing how to use the B3-MM in the process of twinning and coaching to facilitate the knowledge transfer, including the examples of five European regions.

D6.1 : Guidance (process) for twinning and coaching [19]

The manual describing how to use the B3-MM in the process of twinning and coaching to facilitate the knowledge transfer, including the examples of five European regions.

Schedule of relevant Milestones

Milestone number [18]	Milestone title	Lead beneficiary	Due Date (in months)	Means of verification
MS25	Initiation of self-assessment process in all 5 European regions	9 - NLL	11	Initiation of self-assessment process in all five European regions.
MS26	Availability of self-assessment data for five European regions	9 - NLL	13	Availability of self-assessment data for five European regions.
MS27	Completed identification of	9 - NLL	15	Completed identification of maturity gaps in five

Schedule of relevant Milestones

Milestone number [18]	Milestone title	Lead beneficiary	Due Date (in months)	Means of verification
	maturity gaps in five European health and care systems			European health and care systems.
MS28	Second refinement of the B3-MM	2 - UEDIN	17	Second refinement of the B3-MM.

Work package number [9]	WP7	**Lead beneficiary** [10]	7 - ARES PUGLI
Work package title	Knowledge Transfer		
Start month	17	**End month**	27

Objectives

WP7 has two objectives:

1. Facilitate the process of scaling-up using the B3-MM in the twinning and coaching activities of the regions.

2. Test the B3-MM in real life settings to facilitate the process of information sharing and knowledge transfer across five European regions.

This WP builds on the findings of the maturity gaps in integrated care of five European regions (WP6) and will inform the WP3, WP5 and WP8 on the experience of regions with using the B3-MM in the process of twinning and coaching to facilitate information sharing and knowledge transfer.

Description of work and role of partners

WP7 - Knowledge Transfer [Months: 17-27]
ARES PUGLI, NHS 24, UEDIN, VUB, UVEG, KRONIKGUNE, Osakidetza , FNOL, NLL
The work will be carried out through the completion of the following tasks:

T7.1 Coaching and twinning, M17-M24
Lead partner: ARES PUGLIA; Contributors: NHS 24, UEDIN, VUB, UVEG, Kronikgune, Osakidetza, FNOL, NLL
The objective of this task is to facilitate the process of knowledge sharing and information flow among five European regions using the B3-MM to facilitate this process. The guidance (process) for twinning and coaching (D6.2) will apply for this purpose. One twinning and one coaching activity per region are envisaged. The twinning and coaching activities will be organised as face-to-face meetings, webinars and various other online tools.

T7.2 Action Plans – M24-M27
Lead partner: ARES PUGLIA; Contributors: NHS 24, Kronikgune, Osakidetza, FNOL, NLL
The objective of this task is to develop the Action Plans in each of the five European regions. The Action Plans will reflect the findings of the self-assessment process (D6.1) and will specifically focus on addressing the weaknesses in the maturity of particular regional health and care system. The Action Plans will inform the decision-makers about the priority actions necessary for improvement of their health and care systems. Using the good practices and knowing the maturity requirements for their adoption (WP4, D4.1 & D4.2) as well as the level of maturity of particular health and care system (D6.1), regions will be able to identify the solutions that fit into their implementation context and thus achieving adoption and scaling-up of good practices. The implementation of these Action Plans is not considered to be scope for the project.

T7.3 Final refinement of the B3-MM, M17-M27
Lead partner: UEDIN; Contributors: NHS 24, VUB, UVEG, Kronikgune, Osakidetza, ARES PUGLI, FNOL, NLL
The objective of this task is to conduct the final refinement of the B3-MM using the experience of five European regions with the B3-MM in the process of twinning and coaching activities (T7.1). As a result of this second testing, the final B3-MM will be provided as a tool that identifies, analyses and facilitates knowledge transfer of the multidimensional maturity requirements of good practices and health and care systems in order to achieve scaling-up. The tool will become available online for the potential users.

Participation per Partner

Partner number and short name	WP7 effort
1 - NHS 24	10.00
2 - UEDIN	2.00

Partner number and short name	WP7 effort
3 - VUB	2.00
4 - UVEG	4.00
5 - KRONIKGUNE	5.00
6 - Osakidetza	5.00
7 - ARES PUGLI	12.00
8 - FNOL	10.00
9 - NLL	10.00
Total	60.00

List of deliverables

Deliverable Number [14]	Deliverable Title	Lead beneficiary	Type [15]	Dissemination level [16]	Due Date (in months) [17]
D7.1	Five Action Plans	7 - ARES PUGLI	Report	Public	27

Description of deliverables

D7.1 Five Action Plans (M27) – The Action plan describes the concrete solutions in each of the five European regions to address specific weaknesses in their health and care systems.

D7.1 : Five Action Plans [27]

The Action plan describes the concrete solutions in each of the five European regions to address specific weaknesses in their health and care systems.

Schedule of relevant Milestones

Milestone number [18]	Milestone title	Lead beneficiary	Due Date (in months)	Means of verification
MS29	Initiation of twinning and coaching activities in five European regions.	7 - ARES PUGLI	17	Initiation of twinning and coaching activities in five European regions.
MS30	Final refinement of the B3-MM	2 - UEDIN	24	Final refinement of the B3-MM.
MS31	Five regions have completed their Action Plans.	7 - ARES PUGLI	27	Five regions have completed their Action Plans.
MS32	Access to final B3-MM tool online	2 - UEDIN	27	Access to final B3-MM tool online.

Work package number [9]	WP8	Lead beneficiary [10]	4 - UVEG
Work package title	Lessons learned and policy implications		
Start month	6	End month	32

Objectives

WP8 has four main objectives:

1. Collect lessons learned on the process of knowledge transfer using the B3-MM.
2. Inform decision-makers about the potential of the B3-MM to facilitate scaling-up and exchange of good practices in the provision of integrated care in Europe.
3. Analyse the role of policy in facilitating the knowledge transfer.
4. Support the preparation of the exploitation phase of the B3-MM as described in WP2.

The tasks carried out in this WP link closely with WP3, WP5, WP6 and WP7 on using the B3-MM in the process of knowledge transfer to facilitate scaling-up in the five European regions.

Description of work and role of partners

WP8 - Lessons learned and policy implications [Months: 6-32]
UVEG, NHS 24, UEDIN, VUB, KRONIKGUNE, Osakidetza , ARES PUGLI, FNOL, NLL , EHTEL
The work will be carried out through the completion of the following tasks:

T8.1 Analysis of the experience of knowledge transfer, M6-M28
Lead partner: UVEG; Contributors: All
This task will be action-research oriented. The objective of this task is to monitor and analyse activities of WP5, WP6 and WP7 activities, when the B3-MM is used for testing purposes as well as in the process of self-assessment, and twinning and coaching. Its outcomes will inform the subsequent task of this WP and will feed the further refinement of the B3-MM as defined under the WP5, WP6 and WP7.

T 8.2 Main issues of scaling-up, M28-M30
Lead partner: UVEG; Contributors: All
The objective of this task is to identify main issues of scaling-up, using the outcomes of T8.1, and provide policy recommendations on how these issues can be overcome by using the B3-MM in the process of knowledge sharing. This will support the decision-makers interested in the B3-MM about the utility of the tool in facilitating the process of scaling-up and exchange of good practices across Europe.

T8.3 Policy Advisory Group, M16-M32
Lead partner: EHTEL; Contributor: UVEG
The objective of this task is to create a Policy Advisory Group of European NGOs (representing the stakeholder groups that have an interest in innovation in integrated care). It will start from a pre-existing working group of EHTEL, with the support of other European networks such as EIP on AHA, AER, IFIC, ERRIN, ECHA, EUREGHA and CORAL. It will be made up of representatives of regions, at European level; patients and informal carers; health and social care professionals and managers; health insurers. This group will meet two times during the second cycle of SCIROCCO. It will advise the project by developing policy-oriented activities and briefing papers (D8.1 and D8.2).

T8.4 Role of policy in facilitating knowledge-transfer, M7-M32
Lead partner: EHTEL; Contributor: All
The Policy Advisory Group created under Task 8.3 will review the outcome of Tasks 8.1 and 8.2.
The objective of this task is to identify areas where policy support can act as an incentive or an accelerator for knowledge transfer using the B3-MM. Out of this analysis, the Group will derive policy recommendations and will present them to a policy-oriented audience duringSCIROCCO's final conference, as defined under WP2.

Participation per Partner

Partner number and short name	WP8 effort
1 - NHS 24	2.00

Partner number and short name	WP8 effort
2 - UEDIN	2.00
3 - VUB	2.00
4 - UVEG	7.00
5 - KRONIKGUNE	2.00
6 - Osakidetza	2.00
7 - ARES PUGLI	2.00
8 - FNOL	2.00
9 - NLL	2.00
10 - EHTEL	4.00
Total	27.00

List of deliverables

Deliverable Number [14]	Deliverable Title	Lead beneficiary	Type [15]	Dissemination level [16]	Due Date (in months) [17]
D8.1	White Paper on the issues of scaling up	4 - UVEG	Report	Public	30

Description of deliverables

D8.1 White Paper on the issues of scaling up (M30) - This White Paper contains lessons learned and policy recommendations on how to address the issues of scaling, including the role of policy in knowledge transfer, using the experience of five European regions with the B3-MM in the knowledge-sharing process.

D8.1 : White Paper on the issues of scaling up [30]

This White Paper contains lessons learned and policy recommendations on how to address the issues of scaling, including the role of policy in knowledge transfer, using the experience of five European regions with the B3-MM in the knowledge-sharing process.

Schedule of relevant Milestones

Milestone number [18]	Milestone title	Lead beneficiary	Due Date (in months)	Means of verification
MS33	Analysis of the experience of knowledge transfer is initiated by all partners.	4 - UVEG	6	Analysis of the experience of knowledge transfer is initiated by all partners.
MS34	Information on the experience of regions with the B3-MM is available	4 - UVEG	28	Information on the experience of regions with the B3-MM is available
MS35	Establishment of functioning Policy Advisory Board	10 - EHTEL	16	Establishment of functioning Policy Advisory Board.

Schedule of relevant Milestones

Milestone number [18]	Milestone title	Lead beneficiary	Due Date (in months)	Means of verification
MS36	Presentation of lessons learned and policy recommendations at SCIROCCO's final conference	10 - EHTEL	32	Presentation of lessons learned and policy recommendations at the SCIROCCO's final conference.

1.3.4. WT4 List of milestones

Milestone number [18]	Milestone title	WP number [9]	Lead beneficiary	Due Date (in months) [17]	Means of verification
MS1	Project Kick-off Meeting in Luxembourg	WP1	1 - NHS 24	1	Project kick-off meeting in Luxembourg.
MS2	First Project Assembly Meeting	WP1	1 - NHS 24	7	First Project Assembly meeting for consortium partners.
MS3	Second Project Assembly meeting	WP1	1 - NHS 24	14	Second project assembly meeting for consortium partners.
MS4	Acceptance of Interim Report	WP1	1 - NHS 24	16	Acceptance of consortium partners and EC of interim project report.
MS5	Third Project Assembly meeting	WP1	1 - NHS 24	21	Third project assembly meeting for consortium partners.
MS6	Fourth Project Assembly meeting	WP1	1 - NHS 24	28	Fourth project assembly meeting for consortium partners.
MS7	Final Project Assembly meeting, linked to Project Final Conference	WP1	1 - NHS 24	32	Final project assembly and final conference.
MS8	Acceptance of Final Report	WP1	1 - NHS 24	32	Acceptance of Final Report by consortium partners and EC.
MS9	Availability of website	WP2	10 - EHTEL	3	Website set up and accessible to partners and public.
MS10	Availabilty of dissemination materials	WP2	10 - EHTEL	3	Early project information for dissemination purposes available.
MS11	Availability of Disemination Strategy and Action Plan	WP2	10 - EHTEL	6	Dissemination Strategy and Action Plan available to guide and monitor impact of dissemination activities.
MS12	SCIROCCO interim findings presented in public	WP2	10 - EHTEL	19	Interim findings disseminated to public appropriately.
MS13	Final Conference	WP2	10 - EHTEL	32	Final project conference organised.
MS14	Literature review	WP3	3 - VUB	4	Literature review to compare and contrast existing self-assessment tools with the B3-MM.

Milestone number [18]	Milestone title	WP number [9]	Lead beneficiary	Due Date (in months) [17]	Means of verification
MS15	Validated B3-MM through Delphi study	WP3	3 - VUB	4	First refinement of the B3-MM based on the outcomes of Delphi study.
MS16	Assessment level of maturity of integrated care	WP3	3 - VUB	19	Report about the level of maturity of integrated care in five European regions.
MS17	Good practices work initiated by all partners.	WP4	5 - KRONIKGUNE	2	Good practices work initiated by all partners.
MS18	Availability of data for 30 good practices.	WP4	5 - KRONIKGUNE	3	Availability of data for 30 good practices.
MS19	Upload of 30 good practices on website and EIP on AHA database of good practices.	WP4	5 - KRONIKGUNE	5	Upload of 30 good practices on website and EIP on AHA database of good practices.
MS20	Completed maturity assessment for 15 good practices.	WP4	5 - KRONIKGUNE	6	Completed maturity assessment for 15 good practices.
MS21	Refinement of the B3-MM initiated.	WP5	2 - UEDIN	4	Refinement of the B3-MM initiated.
MS22	Validation of B3-MM is completed.	WP5	2 - UEDIN	8	Validation of B3-MM is completed.
MS23	Access to online self-assessment tool.	WP5	2 - UEDIN	9	Access to online self-assessment tool.
MS24	Knowledge of regions on how to use the B3-MM	WP5	2 - UEDIN	11	Knowledge of regions on how to use the B3-MM.
MS25	Initiation of self-assessment process in all 5 European regions	WP6	9 - NLL	11	Initiation of self-assessment process in all five European regions.
MS26	Availability of self-assessment data for five European regions	WP6	9 - NLL	13	Availability of self-assessment data for five European regions.
MS27	Completed identification of maturity gaps in five European health and care systems	WP6	9 - NLL	15	Completed identification of maturity gaps in five European health and care systems.
MS28	Second refinement of the B3-MM	WP6	2 - UEDIN	17	Second refinement of the B3-MM.

Milestone number [18]	Milestone title	WP number [9]	Lead beneficiary	Due Date (in months) [17]	Means of verification
MS29	Initiation of twinning and coaching activities in five European regions.	WP7	7 - ARES PUGLI	17	Initiation of twinning and coaching activities in five European regions.
MS30	Final refinement of the B3-MM	WP7	2 - UEDIN	24	Final refinement of the B3-MM.
MS31	Five regions have completed their Action Plans.	WP7	7 - ARES PUGLI	27	Five regions have completed their Action Plans.
MS32	Access to final B3-MM tool online	WP7	2 - UEDIN	27	Access to final B3-MM tool online.
MS33	Analysis of the experience of knowledge transfer is initiated by all partners.	WP8	4 - UVEG	6	Analysis of the experience of knowledge transfer is initiated by all partners.
MS34	Information on the experience of regions with the B3-MM is available	WP8	4 - UVEG	28	Information on the experience of regions with the B3-MM is available
MS35	Establishment of functioning Policy Advisory Board	WP8	10 - EHTEL	16	Establishment of functioning Policy Advisory Board.
MS36	Presentation of lessons learned and policy recommendations at SCIROCCO's final conference	WP8	10 - EHTEL	32	Presentation of lessons learned and policy recommendations at the SCIROCCO's final conference.

1.3.5. WT5 Critical Implementation risks and mitigation actions

Risk number	Description of risk	WP Number	Proposed risk-mitigation measures
R1	Bankruptcy of one of the beneficiaries.	WP1	The Consortium Agreement mitigates the risk.
R2	Serious underperformance of one of the beneficiaries.	WP1, WP2, WP3, WP4, WP5, WP6, WP7, WP8	The Consortium Agreement mitigates the risk.
R3	Withdrawal of a partner.	WP1	The Consortium Agreement mitigates the risk.
R4	Motivation to scaling-up and exchange of good practices can change in the participating regions.	WP6, WP7	Potential new partner / regions for the collaboration will be identified to mitigate the risk.
R5	The B3-MM does not demonstrate the anticipated benefits.	WP5, WP6	Three refinements of the B3-MM based on the experience of five European regions will mitigate the risk.
R6	Development of the B3-MM tool takes longer than planned.	WP5, WP6, WP7, WP8	Flexibility of the Project Plan mitigates the risk. Tasks that do not directly depend on the tool can be prioritised.
R7	Maturity of regions and good practices too heterogeneous to allow coaching and twinning.	WP4, WP5, WP6, WP7, WP8	Involvement of new collaborating regions to mitigate the risks. A number of regions participating in the EIP on AHA have already expressed an interest to test the B3-MM in the process of twinning and coaching.
R8	Experience from regions too heterogeneous to draw meaningful lessons learned,	WP2, WP7, WP8	Preliminary work of EIP on AHA on collection and analysis of good practices in integrated care and other EU initiatives mitigate the risk.
R9	Target group is harder to reach than foreseen.	WP1, WP3, WP4	Identification of champions at local, regional and European level to canvas the support for SCIROCCO findings at the start of the project mitigate the risk.
R10	Insufficient interest in participating in Final Conference or other SCIROCCO dissemination activities.	WP1, WP2	Advanced, timely planning of the events, stimulating programme, engagement of the partners in the preparation of the dissemination activities mitigate the risks.

1.3.6. WT6 Summary of project effort in person-months

	WP1	WP2	WP3	WP4	WP5	WP6	WP7	WP8	Total Person/Months per Participant
1 - NHS 24	7	2	1	4	1	10	10	2	37
2 - UEDIN	1	1	0	0	12	2	2	2	20
3 - VUB	1	1	20	0	2	2	2	2	30
4 - UVEG	1	1	7	0	0	0	4	7	20
5 - KRONIKGUNE	1	1	1	10	1	7	5	2	28
6 - Osakidetza	0	1	0	4	1	10	5	2	23
7 - ARES PUGLI	1	1	1	4	1	10	12	2	32
8 - FNOL	0	1	1	4	1	10	10	2	29
9 - NLL	1	1	1	4	1	12	10	2	32
10 - EHTEL	1	7	0	0	0	0	0	4	12
Total Person/Months	14	17	32	30	20	63	60	27	263

1.3.7. WT7 Tentative schedule of project reviews

Review number [19]	Tentative timing	Planned venue of review	Comments, if any
RV1	16	Interim Review	
RV2	32	Final	

1.4. Ethics Requirements

No ethics requirements indicated

1. Project number

The project number has been assigned by the Commission as the unique identifier for your project. It cannot be changed. The project number **should appear on each page of the grant agreement preparation documents (part A and part B)** to prevent errors during its handling.

2. Project acronym

Use the project acronym as given in the submitted proposal. It can generally not be changed. The same acronym **should appear on each page of the grant agreement preparation documents (part A and part B)** to prevent errors during its handling.

3. Project title

Use the title (preferably no longer than 200 characters) as indicated in the submitted proposal. Minor corrections are possible if agreed during the preparation of the grant agreement.

4. Starting date

Unless a specific (fixed) starting date is duly justified and agreed upon during the preparation of the Grant Agreement, the project will start on the first day of the month following the entry into force of the Grant Agreement (NB : entry into force = signature by the Commission). Please note that if a fixed starting date is used, you will be required to provide a written justification.

5. Duration

Insert the duration of the project in full months.

6. Call (part) identifier

The Call (part) identifier is the reference number given in the call or part of the call you were addressing, as indicated in the publication of the call in the Official Journal of the European Union. You have to use the identifier given by the Commission in the letter inviting to prepare the grant agreement.

7. Abstract

8. Project Entry Month

The month at which the participant joined the consortium, month 1 marking the start date of the project, and all other start dates being relative to this start date.

9. Work Package number

Work package number: WP1, WP2, WP3, ..., WPn

10. Lead beneficiary

This must be one of the beneficiaries in the grant (not a third party) - Number of the beneficiary leading the work in this work package

11. Person-months per work package

The total number of person-months allocated to each work package.

12. Start month

Relative start date for the work in the specific work packages, month 1 marking the start date of the project, and all other start dates being relative to this start date.

13. End month

Relative end date, month 1 marking the start date of the project, and all end dates being relative to this start date.

14. Deliverable number

Deliverable numbers: D1 - Dn

15. Type

Please indicate the type of the deliverable using one of the following codes:

R	Document, report
DEM	Demonstrator, pilot, prototype
DEC	Websites, patent fillings, videos, etc.
OTHER	

16. Dissemination level

Please indicate the dissemination level using one of the following codes:

PU	Public

CO	Confidential, only for members of the consortium (including the Commission Services)
EU-RES	Classified Information: RESTREINT UE (Commission Decision 2005/444/EC)
EU-CON	Classified Information: CONFIDENTIEL UE (Commission Decision 2005/444/EC)
EU-SEC	Classified Information: SECRET UE (Commission Decision 2005/444/EC)

17. Delivery date for Deliverable

Month in which the deliverables will be available, month 1 marking the start date of the project, and all delivery dates being relative to this start date.

18. Milestone number

Milestone number:MS1, MS2, ..., MSn

19. Review number

Review number: RV1, RV2, ..., RVn

20. Installation Number

Number progressively the installations of a same infrastructure. An installation is a part of an infrastructure that could be used independently from the rest.

21. Installation country

Code of the country where the installation is located or IO if the access provider (the beneficiary or linked third party) is an international organization, an ERIC or a similar legal entity.

22. Type of access

VA	if virtual access,
TA-uc	if trans-national access with access costs declared on the basis of unit cost,
TA-ac	if trans-national access with access costs declared as actual costs, and
TA-cb	if trans-national access with access costs declared as a combination of actual costs and costs on the basis of unit cost.

23. Access costs

Cost of the access provided under the project. For virtual access fill only the second column. For trans-national access fill one of the two columns or both according to the way access costs are declared. Trans-national access costs on the basis of unit cost will result from the unit cost by the quantity of access to be provided.

History of changes

Version	Date	Changes
1.0	26.01.2016	Changes compared with the original proposal: • Part 5 Methods and Means - Elaboration on how the targets/output indicator of 180 will be reached; pp.32 • Part 5 Methods and Means – Explanation of the content and aim of the logbooks, including the targeted participants; pp.35 • Part 5 Methods and Means – Elaboration on missing elements of the evaluation strategy (operational and mid-term evaluation); pp. 34 • Part 7.1 Overview on work packages - Justification of duration of SCIROCCO activities; pp.37-38 • Part 7.2 Work packages – Update of deliverables in WP1-WP8 and elaboration on evaluation strategy; pp. 39-52 • Part 7.3 Timetable – Update of the Timetable; pp. 53 • Part 8 Milestones and deliverables – Update of the Table; pp.55-56 • Part 9.3 External and internal risk analysis and contingency planning updated; pp.69 • Part 10.1 Content description and Budget – Justification of allocation of 13% of funding for travel; pp.71 • Part 10.1 Content description and Budget – Justification of allocation of 50% of total costs to WP6/WP7 and 12% of budget for evaluation; pp. 70 • Part Correction of mistake in calculation of staff efforts for partner 5 and 6; pp. 75-76 • Table of contents is updated; pp.3

EUROPEAN COMMISSION
CONSUMERS, HEALTH, AGRICULTURE AND FOOD EXECUTIVE AGENCY
Health Unit

Project Grants (HP-PJ)

3rd EU Health Programme

COVER PAGE

SCIROCCO – SCALING INTEGRATED CARE IN CONTEXT

LIST OF APPLICANTS

Applicant No	Applicant organisation name	Country
1 NHS 24 (Coordinator)	NHS 24	UK
2 UEDIN	University of Edinburgh	UK
3 VUB	Vrije Universiteit Brussel	BE
4 UVEG	Universitat de Valencia	ES
5 Kronikgune	Asociación Centro de Excelencia Internacional en Investigación sobre Cronicidad	ES
6 Osakidetza	Servicio Vasco de Salud Osakidetza	ES
7 ARES PUGLI	Agenzia Regionale Sanitaria Pugliese	IT
8 FNOL	Fakultni Nemocnice Olomouc	CZ
9 NLL	NORBOTTENS LANS LANDSTING	SE
10 EHTEL	European Health Telematics Association	BE

TABLE OF CONTENTS

1. PROBLEM ANALYSIS INCLUDING EVIDENCE

This problem analysis outlines a number of specific challenges affecting health care delivery models, and the ways in which to transform challenge into opportunity. It is therefore important to commit to opportunities to increase healthy life years throughout Europe. In this, the European Innovation Partnership on Active and Healthy Ageing (EIP on AHA), and its database of good practices, plays a very important role. It is vital therefore to determine, and act on, how precisely to expand these practices throughout Europe and speed up adoption and scaling-up of good practices in Europe. The challenges in scaling-up and the role of the context are analysed.

Challenges to health and care delivery models in Europe

European countries have achieved major improvements in public health over recent decades. One of these is the growth in life expectancy. Life expectancy at birth in the European Union (EU)-28 has increased over the last 50 years by about 10 years[1]. In contrast, the gradual increase in life expectancy at birth is one of the contributing factors to the **ageing of the EU-28's population**. According to recent projections, the share of population aged 65 years and over is increasing in every EU Member State. Within the last decade, an overall increase of 2.1 percentage points was observed for the EU-28 as a whole. Another aspect of population ageing is the progressive ageing of the older population itself, as the relative importance of the very old is growing at a faster pace than any other age segment of the EU's population. The share of those aged 80 years or above in the EU-28's population is projected to more than double between 2014 and 2080[2]. As well as leading to huge advantages for Europeans, this growth in life expectancy is placing pressures on Europe's health systems.

Another core challenge facing health systems in Europe and beyond is **the rapid rise in the number of people with multiple health and care needs**. These tend to be more common among older people and an estimated two-thirds of those who have reached pensionable age have at least two chronic conditions[3]. However, evidence from studies of primary care also shows that a sizable number of younger people also experience multiple diseases[4]. Understanding of the burden of multi-morbidity remains patchy, with prevalence estimates ranging widely depending on the setting and assessment method[5]. At the same time the available evidence points to increased mortality and reduced physical functioning among people with multiple morbidities, along with higher use of health and social care services and associated costs[6].

[1]Eurostat. Mortality and life expectancy statistics. Data extracted in June 2015. http://ec.europa.eu/eurostat/statistics-explained/index.php/Mortality_and_life_expectancy_statistics (Accessed 6 September 2015)

[2]Eurostat. Population structure and ageing. Data extracted in June 2015. http://ec.europa.eu/eurostat/statistics-explained/index.php/Population_structure_and_ageing (Accessed 6 September 2015)

[3] Violan C, Foguet-Boreu Q, Flores-Mateo G, Salisbury C, Blom J, Freitag M, Glynn L, Muth C, Valderas JM. Prevalence, determinants and patterns of multimorbidity in primary care: a systematic review of observational studies. PLoS One 2014;9(7):e102149.

[4] Barnett K, Mercer S, Norbury M, Watt G, Wyke S, Guthrie B. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. Lancet 2012;380:37-43.

[5] Diederichs C, Berger K, Bartels D. The measurement of multiple chronic diseases - a systematic review on existing multimorbidity indices. J Gerontol A Biol Sci Med Sci 2011;66:301-11.

[6] France E, Wyke S, Gunn J, Mair F, McLean G, Mercer S. Multimorbidity in primary care: a systematic review of prospective cohort studies. Br J Gen Pract 2012;62:e297-307.

Urgent changes required to European care delivery models

The complexity of needs arising from having multiple chronic conditions - in combination with ageing population – requires urgent changes to models of care in Europe that drive:

- **A shift in focus from extension of life to quality of life, in particular the very slow growth in healthy life expectancy.**
- **A shift towards an environment where health and social care are treated as a single unit bringing together a range of professionals and skills from both the cure (healthcare) and care (long-term and social care) sectors[7].**
- **A shift towards community based health and social care[8] and the need for people to coproduce a healthier population that has less need for acute services and takes more responsibility for its care[9].**
- **The priority towards prevention and support for self-management of health[10].**
- **The need for partnership and cross-sectoral approach to innovation that has significant potential to increase choice and control for European citizens and support a necessary transformation in health and social care services.[11]**

From challenges to opportunities

Countries in Europe and elsewhere are varied in their attempts to drive transformation of their health and social care systems, with many implementing some form of integrated care – for example working together of health and care systems, public health agencies, community based organisations, and many other entities to improve health outcomes in the communities they serve - even though the nature and scope of the related approaches differ[12]. These attempts are driven by recognition that the ageing of European population and its consequences can be turned from a societal challenge to a major opportunity for Europe. This requires a pro-active care, involvement and empowerment of users, implementation of community-based integrated care models but more importantly a **partnership approach to unlock the potential of innovation** in the transformation of healthcare systems in Europe. The pilot European Innovation Partnership on Active and Healthy Ageing (EIP on AHA) is a unique example of such a partnership, bringing together a wide range of stakeholders across Europe into close cooperation. The EIP on AHA considers **ageing an opportunity rather than a burden,** valuing older people and their contributions to society; and seeking to empower them and their communities through user-centred innovation and service delivery[13].

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[7]Nolte E, McKee M, eds. Caring for people with chronic conditions. A health system perspective. Maidenhead: Open University Press/McGraw Hill Education, 2008.

[8]Plochg T, Klazinga N.S. Community-based integrated care: myth or must? International Journal for Quality in Health Care.2002:91-99

[9]"Co-production recognizes that people have assets such as knowledge, skills, characteristics, experience friends, family, colleagues and communities." McColl-Kennedy, Janet R., et al. "Health care customer value co-creation practice styles." Journal of Service Research (2012): 1094670512442806.

[10]Steering Group Working Document. Strategic Implementation Plan for the European Innovation Partnership on Active and Healthy Ageing. 2011 http://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/steering-group/implementation_plan.pdf#view=fit&pagemode=none (Accessed 6 September 2015)

[11] Scottish Government. A National Telehealth and Telecare Delivery Plan for Scotland to 2015.The Scottish Government, 2012

[12] Nolte E, Knai C, McKee M, eds. Managing chronic conditions - experience in eight countries. Observatory Studies Series No. 15. Copenhagen: World Health Organization, on behalf of the European Observatory on Health Systems and Policies, 2008.

[13]Steering Group Working Document. Strategic Implementation Plan for the European Innovation Partnership on Active and Healthy Ageing. 2011 http://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/steering-group/implementation_plan.pdf#view=fit&pagemode=none (Accessed 6 September 2015)

The European Innovation Partnership on Active and Healthy Ageing (EIP on AHA)

The EIP on AHA is a **voluntary collaboration** of regions, companies, research institutions, and healthcare professionals committed to find innovations that meet older people's needs by addressing a triple win: health and quality of life of European citizens; sustainable and efficient care systems and growth and expansion of EU industry in line with the Commission priority "Jobs, Growth and Investment"[14].

The overarching objective of the EIP on AHA is **to increase the average healthy lifespan by two years by 2020**. This has been realised in **six Action groups** reflecting six specific actions of the work – adherence, falls prevention, frailty, integrated care, independent living and age-friendly communities[15]. The SCIROCCO consortium's partners are active members across all six Action Groups. The key objective of the EIP on AHA is to focus on sharing information and solutions on how to overcome bottlenecks, pooling knowledge and resources and acting towards shared goals[16].

In addition to the Action Groups, there are also **Reference Sites** working towards the objectives of the EIP on AHA. The Reference Sites are 32 regions (including three consortium partners - Basque Country, Scotland and University Hospital Olomouc), cities or integrated hospitals/care organisations that implement a comprehensive, innovation-based approach to active and healthy ageing and can give concrete evidence and illustrations of their impact on the ground. They are rewarded by the European Commission with a number of stars (one to three) depending on their readiness for replication and coaching[17].

Database of EIP on AHA good practices

The EIP on AHA aims to maximise the use of existing knowledge and encourages exchange of good practices and knowledge transfer in Europe. This has been achieved through **comprehensive mapping of innovative solutions and collection of good practices** over the last three years that have resulted in the compilation of over 300 good practices in the areas of prescription and adherence action at regional level, prevention of functional decline and frailty, integrated care, independent living and age-friendly environments[18]. A brief overview of compiled good practices is illustrated in the Table 1 below. The full collection of good practices is available at EIP on AHA website[19].

[14] http://ec.europa.eu/priorities/jobs-growth-investment/index_en.htm (Accessed 20 August 2015)

[15]About the European Innovation Partnership on Active and Healthy Ageing. http://ec.europa.eu/research/innovation-union/index_en.cfm?section=active-healthy-ageing&pg=about (Accessed 22 August 2015)

[16]European Commission. European Scaling Up Strategy in Active & Healthy Ageing. European Commission,2015:7

[17]The Reference Sites. http://ec.europa.eu/research/innovation-union/index_en.cfm?section=active-healthy-ageing&pg=sites (Accessed 7 September 2015.)

[18]About the European Innovation Partnership on Active and Healthy Ageing. http://ec.europa.eu/research/innovation-union/index_en.cfm?section=active-healthy-ageing&pg=documents (Accessed 6 September 2015)

[19]http://ec.europa.eu/research/innovation-union/index_en.cfm?section=active-healthy-ageing&pg=documents (Accessed 6 September 2015)

Table 1: Overview of EIP on AHA good practices per Action Group (2013)

ACTION GROUP	TOTAL NUMBER
Prescription and adherence action at regional level	**62**
Prevention of functional decline and frailty	**98**
Integrated care	**86**
Independent living	**22**
Age-friendly environments	**61**

The identification of good practices across different areas of interest is assumed to be a useful activity across the different Action Groups. **The catalogue of good practices has significantly contributed to a better understanding of the existing solutions, resources and expertise** that can be pooled towards the shared goals of the EIP on AHA, its partners and wider objectives of EU policy in this area. In addition, there is the hypothesis that sharing of experience of the good practices should lead to their "easier and faster" adaptation and implementation in other regions, and the catalogue of good practices helps to facilitate these "short cuts".

However, the challenge remains **how to best leverage this existing body of evidence** and utilise the good practice catalogue **to make the learning embedded in the practices more readily and accessible to potential adopters.** The good practices are often limited to a particular pilot, project or region but **achieving the ambitions of the EIP on AHA requires scaling up** of these local innovative solutions across Europe.

Challenges of scaling up

"Nearly every problem has been solved by someone, somewhere. The challenge of the 21st century is to find out what works and scale it up." (Bill Clinton, 2015)[20]

Radical innovations emerge in niches, where pioneers and entrepreneurs nurture their development on multiple dimensions, such as social organisation, business models and technological artifacts. The impact of these innovations on broader audiences or populations **requires a process of scaling up.** The term 'scaling up' has been applied in the literature in several distinct ways, including describing the following initiatives[21]:

- The dissemination of a new technique, a prototype product, or process innovation;
- Epidemiological and economic forecasting;
- 'Growing' an organisational or system capacity to implement to a new level;
- Translating a small-scale initiative into a government policy.

Scaling up in the context of the EIP on AHA covers most of these four meanings but it is used primarily to describe **the ambition or process of expanding the coverage of health**

[20] http://www.citymart.com/blog/2013/05/10/when-inertia-is-not-sustainable-facilitating-social-innovation-in-barcelona (Accessed 7 September 2015)

[21] Milat A, Bauman A, Redman S Narrative review of models and success factors for scaling up public health interventions. Implementation Science (2015) 10:113 DOI 10.1186/s13012-015-0301-6

interventions, but can also refer to increasing the financial, human and capital resources required to expand coverage[22].

Key success factors for scaling up include the importance of establishing monitoring and evaluation systems, costing and economic modelling of intervention approaches, active engagement of a range of implementers and the target community, tailoring the scaled-up approach to the local context, the use of participatory approaches, the systematic use of evidence, infrastructure to support implementation, strong leadership and champions, political will, well defined scale-up strategy and strong advocacy.[23]

Effective scale-up requires the systematic use of different types of evidence[24]. The process of scaling up has to be rigorously tested so as to benefit more people and to foster policy and programme development on a lasting basis[25]. The imperative to gather robust benefits evidence is sometimes the intention but this is not always aligned with the need and demands for evolution.[26]

The implementation of a complex innovation, such as most good practices in EIP on AHA are, needs organic evolution, responsiveness and adaptability to the local health and social care system, driven by support from front-line staff and management**. Scaling-up good practices or innovations requires changes in existing systems**, which are not easy to achieve. They are stabilised by various lock-in processes that lead to path-dependent developments and 'entrapment'. A variety of highly institutionalised processes tends to perpetuate existing systems: the knowledge, capabilities and employment of various actors relevant to their maintenance; the technical infrastructures and institutions that have developed over time to service them the economies of scale and markets of incumbent systems; their social significance, and their links to political power; the mutually reliant clusters of technologies used by these systems; and, the everyday practices and lifestyle values that have come to rely on these systems[27].

Context of scaling-up

Technical actors, such as professionals, managers, firms and governments that are introducing new practices, models or technologies tend to exclude certain other (more social, organizational or citizen) actors; they focus on optimising the technical side of initiatives first while neglecting other social aspects[28]. **The practices and systems are shaped by the context and features of the intervention need to "fit" into the context appropriately.**

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[22] Mangham LJ, Hanson K. Scaling up in international health: what are the key issues? Health Policy Plan. 2010;25(2):85–96.

[23] Milat A J, King L, Bauman AE, Redman S. The concept of scalability: increasing the scale and potential adoption of health promotion interventions into policy and practice. Health Promot. Int. (2013) 28 (3): 285-298. doi: 10.1093/heapro/dar097

[24] Simmons R, Shiffman J. Scaling up health service innovations: a framework for action. In: Simmons RFP, Ghiron L, editors. Scaling up health service delivery. Geneva: World Health Organization; 2007 en http://www.who.int/immunization/hpv/deliver/scalingup_health_service_delivery_who_2007.pdf (Accessed 27 August 2015)

[25] World Health Organization. ExpandNet: nine steps for developing a scaling-up strategy. Geneva: WHO; 2010.

[26] Hendy J, Chriysanthaki T, Barlow J, KnappM, Rogers A, Sanders C, et al. An organizational analysis of the implementation of telecare and telehealth: the whole systems demonstrator. BMC Health Services Research 2012;1:2, http://dx.doi.org/10.1186/1472-6963-12-403

[27]Sustainability Transitions Research Network (STRN). http://www. transitionsnetwork.org/files/STRN research agenda 20 August 2010%20V1.1.pdf

[28] Schot J, Geels FW. Strategic niche management and sustainable innovation journeys: theory, findings, research agenda, and policy. Technology Analysis & Strategic Management 2008;20(5): 537–54

These features can be found for example in the outcomes of the Momentum Thematic Network's project on the 18 critical success factors for the scaling-up of telemedicine solutions – *Personalised Blueprint for Telemedicine Deployment*[29] [30]. For example, the *KSYOS tele-referral intervention in Netherlands,* which is one of the Momentum's case studies, fits well within a traditional referral structure and the intervention does have measurable benefits for its users. These characteristics arise out of the combination of the intervention and context but some are primarily part of the intervention. For example, in the case of KSYOS the dramatic improvement in average time to respond is part of the design of the intervention[31].

However, there are also many aspects of the context that can result in failure. For example: failure to align the intervention with the financial context of the system; failure to ensure political commitment that can span multiple governments over the time period necessary to build systems to scale. For example, using another Momentum case study, the *Home monitoring service for diabetic patients provided by the municipal hospital in Estonia* was discontinued and the main reason was the lack of a reimbursement scheme. The service was too expensive for out-of-pocket payment and the reimbursement by the Health Insurance Fund was not in place[32]. Drawing on the Momentum's examples above, it is obvious that there is **the potential for several aspects or dimensions of the context to play an important role in the failure or success** of the projects or interventions.

One may argue that there are different categories of good practices in terms of their demands on the implementation context. For example, there is a class of **structural (or top-down)** good practices that place requirements on many dimensions of the context. A good example of this is the **ARCHOS model and associated processes and practices**[33] where the dimensions cover, for examples, policies, resource allocation, change management, clinical interventions and organisational aspects. In contrast there is a class of **component (or bottom-up)** good practices that place requirements on only a few of dimensions of the context. These good practices can be adopted into a wider range of contexts and have the potential to play different roles in different contexts. A good example of a component good practice is the **Anticipatory Care Planning**[34] intervention in Scotland where the dimensions such a risk stratification strategies, financial incentives, training programmes could be more easily adaptable/implemented in many different contexts.

The importance of the context or the environment in which the good practice or innovation will be scaled up are underlined by several authors. The strategic niche management (SNM) research (SNM) approach suggests that sustainable innovation journeys can be facilitated by creating niches, for example protected spaces that allow the experimentation with the co-

[29]Momentum. Personalised Blueprint for telemedicine deployment. http://telemedicine-momentum.eu/wp-content/uploads/2015/02/D3.4_v1.0_ValidatedBlueprint.pdf (Accessed 6 September 2015)

[30]Note: Although many of the interventions considered in the empirical work of Momentum can contribute to integrated care there is no specific emphasis on integrated care, nor is there an emphasis on the transfer of interventions from one region to another. Momentum does provide a very strong launching off point for an analysis of the problem of transferring and scaling good practice in integrated care.

[31]Momentum. Personalised Blueprint for telemedicine deployment. http://telemedicine-momentum.eu/wp-content/uploads/2015/02/D3.4_v1.0_ValidatedBlueprint.pdf (Accessed 6 September 2015)

[32]Momentum. Personalised Blueprint for telemedicine deployment. http://telemedicine-momentum.eu/wp-content/uploads/2015/02/D3.4_v1.0_ValidatedBlueprint.pdf (Accessed 6 September 2015)

[33] http://www.iemac.es/data/docs/Formulario_IEMAC_english_version.pdf (Accessed 30 August 2015)

[34] http://www.gov.scot/Resource/Doc/309277/0097422.pdf (Accessed 30 August 2015)

evolution of technology, user practices, and regulatory structures, but that it has to be complemented with attention to niche external processes.[35]

These niche-innovations or good practices may break through more widely if external landscape developments create pressures on the regime that lead to cracks, tensions and windows of opportunity. Subsequent interaction between niches and regimes occur on multiple dimensions (e.g. markets, regulations, cultural meanings, infrastructure) and are enacted by interpretive actors that fight, negotiate, search, learn, and build coalitions as they navigate transitions.[36]

Other authors argue that transitions (to some extent similar to scaling up of EIP on AHA good practices that have a systemic impact on healthcare) come about through interacting processes within and between three levels:

- Niches, the locus for radical innovations/
- Socio-technical regimes, which are locked in and stabilized on several dimensions, but which nevertheless, exhibit incremental innovations: and
- An exogenous socio-technical landscape[37].

Hence, the main research question of SCIROCCO is: **how, and under what circumstances, is the successful emergence of a good practice possible?**

The challenge is to develop tools that can help us to understand how to unlock processes, and stimulate path-breaking changes towards more sustainable health and care systems. We need to provide multi-dimensional answers that are more comprehensive and synthetic to understand.

Framework models for scaling up

There is a growing body of literature describing frameworks for scaling health interventions, the majority of which have an explicit focus on scaling up health action in low and middle income country contexts[38], but not so much on long-term care innovations that have been scaled-up in developed healthcare systems.[39] Examples of such frameworks are:

1.The Scaling Up Management Framework[40]

The framework has three steps with tasks under each step:

- Step 1 develops a scaling up plan and creates a vision of what scaling up will look like;
- Step 2 involves establishing the preconditions for scaling up, with key tasks including building the legitimacy of the intervention and the proposed approach, constituency building and realigning and mobilising resources;
- Step 3, the scaling up process is implemented based on the identification of factors that can promote extension and sustainability. Key tasks involve modifying organisational structures, coordinating action and performance monitoring.

[35] Schot J et al. Strategic niche management and sustainable innovation journeys: theory, findings, research agenda and policy. 2008: 537-554

[36]Markard et al 2008. Technological innovation systems and the multi-level perspective: Towards an integrated framework. Research policy 2008: 596-615

[37]Markard, J., Truffer, B., 2008. Technological innovation systems and the multi-level perspective: towards an integrated framework. Research Policy, 37 (4), 596-615.

[38]Milat et al. The concept of scalability: increasing the scale and potential adoption of health promotion interventions into policy and practice. Public Health Journals. 2015

[39] Cramer H, Dewulf G, Voordijk H The barriers to govern long-term care innovations: The paradoxical role of subsidies in a transition program Health Policy 116 (2014) 71–83

[40]Kohl, R.: Scaling up – A conceptual operational framework. Management System International. 2003 http://tamarackcommunity.ca/downloads/SSI_downloads/kohl_scaleup.pdf (Accessed 15 August 2015)

2. The WHO Framework[41]

The framework is guided by four key principles which are based on systems thinking; a focus on sustainability; the need to determine scalability; and respect for gender, equity and human rights principles. The framework proposes nine steps for developing a scaling-up strategy that involve the following:

- Planning actions to increase the scalability of the innovation;
- Increasing the capacity of the user organisation to implement scaling up;
- Assessing the environment and planning actions to increase the potential for scaling-up success;
- Increasing the capacity of the resource team to support scaling up;
- Making strategic choices to support vertical scaling up (policy, political, regulatory, resourcing or other health systems changes needed to institutionalise the innovation);
- Making strategic choices to support horizontal scaling up (replicating innovations in different geographic sites or extending them to serve larger or different population groups);
- Determining the role of diversification;
- Planning actions to address spontaneous scaling up;
- Finalising the scaling-up strategy and identifying next steps.

3. Framework and key success factors for scaling up global health initiatives[42]

This framework is based on a literature review and interviews with "thought leaders". The framework divides the scaling up process into six categories:

- Attributes of the specific tool or service being scaled up;
- Attributes of the implementers;
- The chosen delivery strategy;
- Attributes of the "adopting" community;
- The socio-political context;
- Research.

4. The EIP on AHA B3 Maturity Model (B3-MM)[43]

The rationale for the development of B3 –MM has been driven by a notion that integrated care in Europe is being adopted at different rates and in diverse ways across regions of Europe. The model has been derived from interviews that took place in 12 regions[44] within European countries responsible for health and care delivery. The many activities that need to be managed in order to deliver integrated care were grouped into 12 'dimensions', each of which addresses

[41] WHO. Nine steps for developing a scaling-up strategy. 2010 http://www.expandnet.net/PDFs/ExpandNet-WHO%20Nine%20Step%20Guide%20published.pdf (Accessed 20 August 2015)

[42] Yamey, G. Scaling up global health interventions: A proposed framework for success. Plos. 2011 http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001049 (Accessed 15 August 2015)

[43] Pavlickova A. B3 Maturity Model: Readiness for integrated care. http://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/pavlickova.pdf (accessed 11 August 2015).

[44] Attica (Greece), Basque, Catalonia, Delta (Netherlands), Olomouc region (Czech republic), Galicia, Northern Ireland, Puglia (Italy), Saxony (Germany), Scotland, Skane (Sweden), South Denmark

a part of the overall process:

- Readiness to Change
- Structure & Governance
- Information & eHealth services
- Standardisation and Simplification
- Finance & Funding
- Removal of Inhibitors
- Population Approach
- Citizen Empowerment
- Evaluation Methods
- Breadth of Ambition
- Innovation Management
- Capacity Building

Challenges to transfer of good practices

A critical challenge is **how to best leverage the existing body of evidence** and utilise the existing EIP on AHA good practice catalogues **to ensure the learning embedded in the practices is readily available to potential adopters in other regions.**

Policymakers and organisations have to change their short-term focus on immediate evaluations and their illusion of empowering successful pilot projects by copying them elsewhere. Instead, they have to consider a more diversified and dynamic process of utilizing niche-innovations, putting greater emphasis on spreading ideas and providing freedom to adjust for contextual differences.[45]

Knowledge transfer influences scaling up processes in three different ways:

- The articulation of expectations and visions, that provide direction to learning processes, attract attention, and legitimate (continuing) protection and nurturing;
- The building of social networks that creates a constituency behind the new good practice, facilitate interactions between relevant stakeholders, and provide the necessary resources (such as money, people, expertise);
- Learning processes at multiple dimensions: (a) technical aspects and design specifications (b) market and user preferences (c) cultural and symbolic meaning (d) infrastructure and maintenance networks (e) industry and production networks (f) regulations and government policy (g) societal and environmental effects[46].

These challenges and the process of knowledge transfer raise the issue of **how to ensure the flow of appropriate information and knowledge flow between an adopting and the transferring entities as a precondition to successful transfer and scaling up of good practices.** It includes the:

- **Identification of transferable elements of good practice for scaling up.** These elements are likely to vary from good practice to good practice and the needs of the potential adopter of the good practice. Depending on what is being transferred the method of transfer might vary considerably, (ranging for example from primarily educational activities to the transfer of people and ICT components).
- **Basis on which to transfer good practice.** There is usually some evidence of success from the originating health and care system but the challenge remains if it is

[45]Cramer et al. The barriers to empowering niche-innovations in long-term care. 2014. http://doc.utwente.nl/91109/1/thesis_H_Cramer.pdf (Accessed 20 August 2015)

[46] Schot J et al. Schot J et al. Strategic niche management and sustainable innovation journeys: theory, findings, research agenda and policy. 2008: 537-554

transferable and what constitutes adequate evidence to inform the decision to attempt a transfer of good practice to a new health and care system.

- **Understanding the context of good practice:** (a) the *originating context* that has allowed the good practice to develop; this captures the requirements of the good practice on the environment; (b) the *receiving context,* that defines the situation into which the good practice will be transferred, characterising what the new context can supply to support the transferred good practice[47].

A key notion in the B3-MM is that of context and transferability. In particular, the B3-MM considered the context in which a good practice has developed, or into which a good practice will be transferred. The main goal of the B3-MM is to provide **a multi-dimensional benchmark of the maturity of a context** (the regional delivery system and political and organisational environment) in which a good practice operates or is proposed to transfer into.

The B3-MM now needs to be further tested and validated to demonstrate its full potential as a tool for helping regions to understand the preconditions for successful scaling-up. It will help regions to identify:

- **The context requirements of a good practice that is considered for adoption;**
- **The level of maturity required for the health and social care system to adopt a particular practice;**
- **The actions that more progressive regions have taken in order to be successful;**
- **Lessons learned from these pioneers to overcome barriers and accelerate results;**
- **The process of information sharing on lessons learned to help other aspiring regions to speed up their own adoption.**

[47] B3 Maturity Model: Readiness for integrated care. http://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/pavlickova.pdf (Accessed 15 August 2015)

2. AIMS AND OBJECTIVES OF THE PROJECT

2.1. General objective of the project

SCIROCCO aims to facilitate the implementation of good practices at local, regional or country level by **recognising the maturity requirements of good practices and health and care systems in order to achieve scaling-up and knowledge transfer amongst European Member States.**

SCIROCCO goals **build on the preliminary achievements of the EIP on AHA[48], and specifically the Database of Good Practices and the B3 Maturity Model (B3-MM)** with its ambition to:

1. To improve the **evaluation and benchmark of good practices** in order to filter and identify potentially adoptable good practices for health and care systems;

2. To assess the health and care delivery system of a region in terms of its **maturity to adopt good practice** in the provision of integrated care;

3. To **facilitate the process of information sharing** between regions to shared lessons learned, thereby speeding up adoption and scaling-up;

4. To provide a **refined and tested tool that identifies, analyses and facilitates knowledge transfer of the multidimensional maturity requirements of good practices and health and care systems.**

SCIROCCO focuses specifically on EIP on AHA good practices in the area of integrated health and social care. It will **develop, test and validate the B3-MM to become a key tool in facilitating exchange of good practices and scaling-up of processes in Europe.**

The results of this project should demonstrate the benefits of moving towards community based health and care which enables older people to remain active and healthy for longer as well as providing efficient care and treatment when needed. The results will also contribute to informed strategic decision-making at a European level.

2.2. Specific objective(s) of the project

Specific Objective Number	**1**
Specific Objective	**Face validity of B3-MM assessed**
Process Indicator(s)	**Target**
Number of databases reviewed for comparison of B3-MM with other tools and their properties	3
Number of experts consulted for their opinion about face validity of B3-MM	10

[48]European Innovation Partnership on Active and Healthy Ageing: Action Groups 2014 Achievements. http://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/achievements_2014.pdf#view=fit&pagemode=none (Accessed 5 September 2015)

Output Indicator(s)	**Target**
Number of tools identified and assesses as comparator for B3-MM	≥ 10
Number of items of B3-MM assessed by experts	12
Outcome/Impact Indicator(s)	**Target**
Face validation of B3-MM executed (by review of literature and Delphi method).	Conceptual underpinning of tool from existing knowledge as derived from literature review. Consensus among experts about appropriateness of the tool.

Specific Objective Number	**2**
Specific Objective	**Local integrated care interventions with the maturity requirements for scaling-up are identified**
Process Indicator(s)	**Target**
Number of interventions (good practices) with viability assessment done in participating regions	30
Number of good practices selected for maturity assessment	15
Output Indicator(s)	**Target**
Number of maturity dimensions assessed	180
Outcome/Impact Indicator(s)	**Target**
Number of interventions (good practices) considered as transferable and scalable after the application of the B3-MM and level of maturity required assessed	13

Specific Objective Number	**3**
Specific Objective	**The B3-MM applied as a tool to assess the readiness of a regional health and care system to adopt a particular good practice**
Process Indicator(s)	**Target**
Number of dimensions of the B3-MM assessed	12
Number of interventions tested	Min 60 and max 120
Output Indicator(s)	**Target**
Number of completed and documented assessments	Min 60 and max 120
Outcome/Impact Indicator(s)	**Target**

Tested underlying structure and internal consistency of B3-MM	Factor loading >0.35; Cronbach's alpha ≥ 0.70

Specific Objective Number	**4**
Specific Objective	**European regions[49] evaluated to assess their readiness to adopt integrated care interventions at scale**
Process Indicator(s)	**Target**
Number of regions evaluated	5
Output Indicator(s)	**Target**
Number of completed and documented assessments	5
Outcome/Impact Indicator(s)	**Target**
Level of readiness assessed for regions	5

Specific Objective Number	**5**
Specific Objective	**Complete transfer and scaling up process using B3 –MM (twinning and coaching to facilitate knowledge transfer)**
Process Indicator(s)	**Target**
Number of twinning/coaching processes implemented	≥5
Output Indicator(s)	**Target**
Agreed Action Plans to transfer and/or scale up interventions	≥5
Outcome/Impact Indicator(s)	**Target**
Number of successful twinning/coaching processes implemented	≥5
Administered B3-MM tool and think-aloud sessions with respondents who were invited to administer B3-MM	≥5

Specific Objective Number	**6**
Specific Objective	**Decision-makers informed about the potential and benefits of B3-MM to facilitate process of scaling-up**
Process Indicator(s)	**Target**
Number of stakeholders reached	>30
Use of the website	350-500 unique users

[49] For the purpose of SCIROCCO, the region is defined as national, regional or local health and care delivery organisations. From SCIROCCO partners, these are: NHS 24, Osakidetza, ARES PUGLI, FNOL and NLL.

Scientific communications	>10
Participation in international expert events	>20
Output Indicator(s)	**Target**
Number of regions expressing interest in the tool	>30
Outcome/Impact Indicator(s)	**Target**
Numbers of regions engaged	>30
Numbers of regions applying the tool (from outside the consortium)	>5

Specific Objective Number	**7**
Specific Objective	**Knowledge transfer process evaluated**
Process Indicator(s)	**Target**
Number of processes evaluated	≥5
Output Indicator(s)	**Target**
Number of transfer/scaling-up documented	≥5
Outcome/Impact Indicator(s)	**Target**
Number of transfer/scaling-up documented	≥5

3. TARGET GROUPS

There is no single primary target group for the SCIROCCO project. Rather, the intention is to involve a primary target group that consists of all the potential stakeholders involved in integrated care who are united by single common objective, which is to achieve the transformation of the health and care system(s) in a particular European region or country.

SCIROCCO will also seek to influence policy change and inform decision-makers at European, national and local levels. SCIROCCO will therefore target **multiple stakeholders at both policy level and health and social care system level**. At the policy level, those stakeholders are namely politicians at European, national and regional levels, including national and regional governments, city councils, CEOs of healthcare organisations, finance directors, operations directors/managers, implementation bodies and health and social care commissioners. At the health and social care system level, those are hospitals, primary and secondary care doctors, nurses, pharmacists, social workers, other social care workers and voluntary sector providers. As the regions in Europe vary in terms of the organisation of their health and care systems, this short list of categories of stakeholders should not be considered to be exhaustive.

SCIROCCO targets the multi-stakeholders at policy and health and social care system levels for two reasons:

- They are most likely to be involved in the validation and testing of the B3-MM as a tool for facilitating the process of scaling up of and exchange of good practices.
- The transformation and change of health and care system structure requires both; the bottom-up initiatives, combined with top-down support. Therefore there is a strong need to bring together stakeholders from both levels.

Carefully targeted and comprehensive dissemination and engagement activities will be undertaken to reach these multiple stakeholders at both policy and health and care level systems. Stakeholder mapping will take place at European, national and regional levels. The SCIROCCO web site will be set up to provide easy access to information on the background of the project, its progress and its outcomes. The site will provide an interactive and dynamic learning experience with multiple resources for all of its stakeholder target groups. Visitors will be enticed to explore the site and make connections with SCIROCCO through comments or direct contact. In addition, a Policy Advisory Group will be established as part of SCIROCCO to explore initiative's findings and formulate evidence-based policy recommendations. As a result, the policy and health and social care policy decision-makers at European, national and regional levels will be fully informed of SCIROCCO's achievements.

4. POLITICAL RELEVANCE

4.1. Contribution to meeting the objectives and priorities defined in the annual work programme

This proposal addresses 2.1.3 Actions under Thematic Objective 3 – *Contributing to innovative, efficient and sustainable health systems,* and specifically, *2.1.3.1 Support for the implementation and scaling up of good practices in the areas of integrated care, frailty prevention, adherence to medical plans and age-friendly communities* (Thematic Priority 3.5 of Annex to the Programme Regulation).

The European Commission launched the European Innovation Partnerships within the Innovation Union, one of the seven flagship initiatives[50] of the *Europe 2020 Strategy: Europe's Growth Strategy*, with the objective of accelerating innovation to address a well-defined target within a grand societal challenge[51]. The EIP on AHA was selected as a pilot initiative to tackle the challenge of an ageing population in Europe. The aim of this action is to mobilise actors across the innovation sector in order to speed up innovative solutions to the societal challenge of healthy ageing. Its goals are also to achieve sustainability and efficiency of health systems (by supporting the knowledge transfer, exchange of expertise and implementation, and scaling-up of good practices across Europe). SCIROCCO aims to accelerate these actions by building on the achievements of the EIP on AHA. It specifically addresses the challenge of scaling-up - a critical step in the achievement of the EIP on AHA objectives.

SCIROCCO will contribute to the annual Work Programme in four ways, through:

- Six specific contributions to the EIP on AHA (see Table 2 below);
- Five specific contributions to the *European Scaling Up Strategy in Active and Healthy Ageing* (see Table 3 below);
- Compatibility with a three (or more) complementary activities and existing actions;
- Liaison with six (or more) existing European networks involved in scaling-up.

Specific contribution to the EIP on AHA

SCIROCCO's six proposed activities will contribute to achieving the objectives of 2.1.3.1. *Support for the implementation and scaling up of good practices in the areas of integrated care, frailty prevention, adherence to medical plans and age-friendly communities* in the following ways (see Table 2):

[50] Other flagship initiatives include: "Youth on the move"; "A Digital agenda for Europe"; "Resource-efficient Europe"; "An industrial policy for the globalization era"; "An agenda for new skills and jobs"; "European platform against poverty"

[51] European Commission. Director General for Communication. Europe 2020: Europe's growth strategy. 2012. http://ec.europa.eu/europe2020/pdf/europe_2020_explained.pdf (Accessed 7 September 2015)

Table 2: SIROCCO's six proposed activities

EXPECTED ACTIVITIES	SCIROCCO's PROPOSED ACTIVITIES
Building on the **preliminary achievements** of the EIP on AHA.	The activities build directly on the achievements and priorities of the EIP on AHA, in particular those of the B3 Action Group on Integrated Care. Specifically, SCIROCCO will utilise: • The rich **collection of over 100 good practices;** • The **B3-MM** developed by the B3 Action Group, which describes the key dimensions relevant for implementing integrated care and can function as a self-assessment tool that provides valid and reliable measurement(s) and guides regions on how to improve their capacity to deploy services.[52]
Benchmarking local interventions with high potential for transferability.	SCIROCCO will test the **B3-MM so that it becomes a validated tool that facilitates a multi-dimensional benchmark** to assess the health and care delivery system, in terms of its maturity to adopt a particular good practice.
Support to the **twinning and coaching** and/or scaling up of identified good practices.	SCIROCCO will test the **B3-MM as a tool for facilitating the scaling-up process,** supporting the process of twinning and coaching to achieve knowledge transfer and sharing of information.
Support the potential of innovation in health and social care by **encouraging the integration of health and care** and highlighting independent living and participation in the community.	Local implementation is both the foundation and aspiration of the B3 Action Group. The B3 members are implementing chronic disease programmes and **integrated care programmes in 44 regions**; they are now beginning to focus on the **scaling-up and replication** of their practices to the target of 50 regions so as to cover 10% of the target population[53]. SCIROCCO will directly contribute to the on-going implementation process in the B3 Action Group by providing the regions with a tool to facilitate the process of scaling-up and potentially to speed-up the exchange of good practices in Europe.
Demonstrates the **benefits of moving towards community-based health and social care**.	**Knowledge sharing** about the delivery of services for chronic conditions management in an integrated way is one of the key objectives of the B3 Action Group[54], as well as of

[52] Action Groups 2014 Achievements. 2014. http://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/achievements_2014.pdf#view=fit&pagemode=none pp.23 (Accessed 7 September 2015)

[53] Action Groups 2014 Achievements. 2014. http://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/achievements_2014.pdf#view=fit&pagemode=none pp.22 (Accessed 7 September 2015)

[54] Action Groups 2014 Achievements. 2014. http://ec.europa.eu/research/innovation-union/pdf/active-healthy-ageing/achievements_2014.pdf#view=fit&pagemode=none pp.23 (Accessed 7 September 2015)

EXPECTED ACTIVITIES	SCIROCCO's PROPOSED ACTIVITIES
	SCIROCCO. Through the collection of successful local integrated interventions that have potential for scaling-up, and twinning and coaching activities, SCIROCCO will directly identify and promote the benefits of the integration of health and care, highlighting the importance of engagement of individuals and communities in care delivery.
Contribute to an **informed decision-making** at European level.	SCIROCCO will contribute to an informed decision-making at European level through a comprehensive evaluation of the process of scaling-up and exchange of good practices using the B3-MM to facilitate knowledge transfer. The outcomes of this evaluation will be formulated in the form of **lessons learned** and **evidence-based policy recommendations** developed by SCIROCCO's Policy Advisory Group. The policy recommendations will be disseminated through SCIROCCO's "champions" networks, social media and awareness-raising events.

Contribution to the European Scaling Up Strategy in Active and Healthy Ageing

SCIROCCO specifically aims to support the objectives and implementation of the *European Scaling Up Strategy in Active and Healthy Ageing* of the EIP on AHA[55]. The multiple examples of good practices developed throughout the EU has led to a realisation that a comprehensive scaling-up strategy is needed at European level. The EIP on AHA scaling-up ambition can be defined as follows:

"To mobilise sufficient resources and expertise which, combined with the collection of good practices and Reference sites experiences, will ensure implementation of innovative solutions for active and healthy ageing on European scale."[56]

The Strategy presents five steps for effective scaling-up. The first three steps constitute a *"what to scale up"* element, while the remaining two constitute the *"how to scale up"* part[57]. The outline of the European Scaling Up Strategy is contained in the following figure:

[55]European Commission. European Scaling Up Strategy in Active & Healthy Ageing. European Commission, 2015.

[56]European Commission. European Scaling Up Strategy in Active & Healthy Ageing. European Commission,2015:8

[57]European Commission. European Scaling Up Strategy in Active & Healthy Ageing. European Commission,2015:6

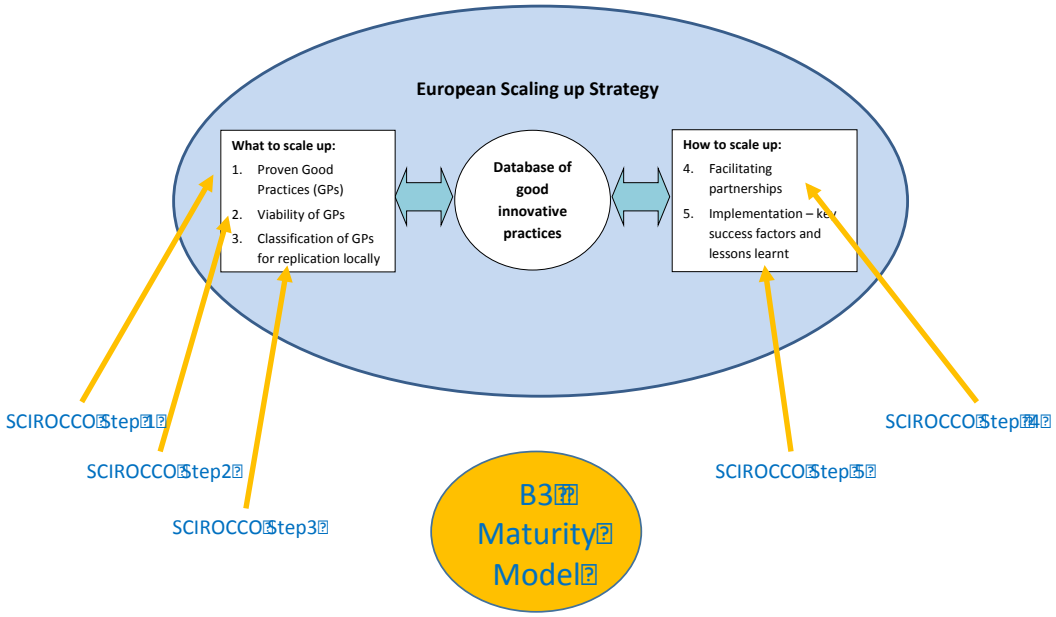

Figure 1: The 5-step model of scaling-up and SCIROCCO's contribution

SCIROCCO will make the following contributions to each step of the European Scaling Up Strategy. In each case the contribution will be rooted in the B3-MM as illustrated in the figure below:

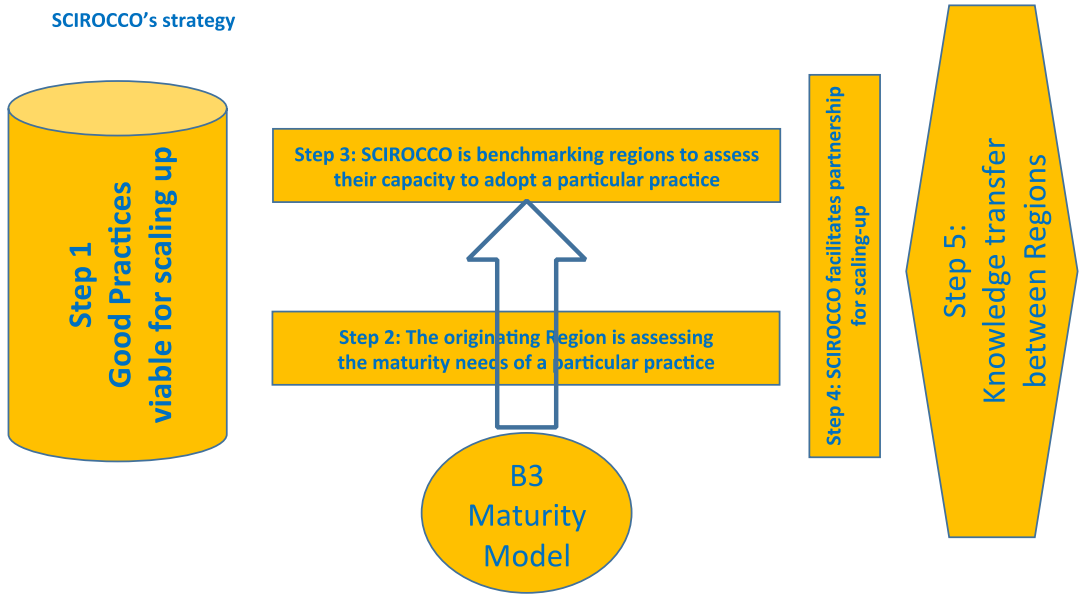

Figure 2: SCIROCCO's contribution to the European Scaling Up Strategy

A detailed contribution of SCIROCCO to the European Scaling Up Strategy is illustrated in Table 3 below:

Table 3: SCIROCCO's contribution

5-STEP MODEL OF SCALING UP	SCIROCCO's CONTRUBUTION
1. **Proven good practices**	**SCIROCCO's step 1:** SCIROCCO will identify in each region **successful evidence-based local integrated care interventions with a potential for scaling-up.** These good practices will contribute to an online database (that is currently in the preparation phase and should serve as a toolkit for successful scaling-up[58]). The objective is to enrich the existing collection of good practices compiled by the Action Groups and Reference Sites to showcase additional inspiring bottom-up innovation in active and healthy ageing and benefits of moving towards community based health and care.
2. Viability of good practices	**SCIROCCO's step 2:** SCIROCCO will **refine the B3-MM as one of the assessment tools** for innovation in active and healthy ageing with the objective to enable an understanding of **regional capacity to adopt a particular practice,** and identify potential commonalities and gaps between regions and good practices as the basis for a potential scaling up.
3. Classification of good practices for replication locally	**SCIROCCO's step 3:** SCIROCCO will test **the B3-MM as a tool to assess contextual requirements for scale-up** of a good practice, hence to verify the feasibility of scaling it up or identifying its transferable elements.
4. Facilitating partnership	**SCIROCCO's step 4:** SCIROCCO will use the B3-MM **to benchmark local integrated care interventions** (good practices) and to identify specific areas of strengths and weaknesses of five regions in the consortium. SCIROCCO will use the results of this work for **matching together regions that have complementary strengths and weaknesses** in order to organise twinning and coaching activities to facilitate the scale-up of innovative solutions.
5. Implementation – key success factors and lessons learned	SCIROCCO will capture **the lessons learned** from the use of the B3-MM and the process of knowledge sharing about the implementation and scaling-up of local integrated care interventions.

[58]European Commission. European Scaling Up Strategy in Active & Healthy Ageing. European Commission, 2015:10

Compatibility with existing and future actions

SCIROCCO will complement and build on the existing actions within EIP on AHA to address the issues of knowledge transfer and scaling-up of innovative solutions in Europe. SCIROCCO is entirely compatible with these existing actions, without in any way duplicating or overlapping with them. It demonstrates innovation in its approach through its focus on context and maturity requirements to facilitate the process of scaling-up. The specific existing actions that SCIROCCO seeks to implement are:

- ***Joint Actions addressing chronic diseases and promoting healthy ageing across the life cycle (CHRODIS-JA) -*** the objective is to promote and facilitate a process of exchange and transfer of good practices between European countries and regions addressing chronic conditions, multi-morbidity and diabetes specifically[59]. SCIROCCO will seek to contribute to the process of exchange and transfer of CHRODIS-JA Good Practices.
- ***EIP on AHA*** – SCIROCCO will aim to contribute to the implementation of EIP on AHA Action Plans for 2016-2017, in particular the B3 Action Plan on Integrated Care and relevant synergy actions between the Action Groups.
- ***PROEIPAHA 2015-2016*** – PROEIPAHA's objective is to support the EIP on AHA Action Groups to deliver their Action Plans, to increase their impact at systematic level across Europe and to hep the EIP on AHA to innovate itself[60]. SCIROCCO will seek to support these activities, wherever appropriate.
- ***Project Integrate –*** the project's objective is to define what constitutes good quality integrated care provision, how integrated care systems can most effectively be built, and to consider cross-cutting themes (for example process design, service delivery, skill mix, patient involvement, financial flows, regulatory conditions, and enabling information technologies) in order to create connectivity, alignment and collaboration within and between the cure and care sectors[61]. SCIROCCO's benchmarking of good practices on integrated care will build on and complement the work of this project.
- ***Study on support to scaling-up of innovation in active and healthy ageing – SMART*** – the objective of this project is to support sharing of experience and skills regarding scaling-up strategies and experiences, also addressing problems due to diversity of health and care systems, including social protection paradigms. In this way, it will support the success of the deployment efforts of the EIP on AHA partners, the Reference Sites, and other targeted regions and organisations[62]. Once again, SCIROCCO's activities that aim to support knowledge transfer and sharing of lessons learned that support scaling-up will complement the work of SMART.

In the near future, SCIROCCO will also seek the collaboration with other initiatives and activities through the evaluation of the call addressing the challenge of active and healthy ageing. SCIROCCO will also target successfully and seek synergies with projects under Horizon 2020 and Interreg Europe[63] funding programmes. By its focus on scaling-up of innovative solutions to address the challenge of ageing population, SCIROCCO fits very well into health priorities defined in Horizon 2020's[64] objective which is to support the actions to keep older people active and independent for longer and supports the development of new, safer and more effective interventions. Interreg Europe emphasis on interregional learning and exchange of good practices is fully in line with SCIROCCO objective to provide a tool to facilitate the process of knowledge transfer in order to achieve implementation and scaling-up of good practices.

[59] http://www.chrodis.eu/ (Accessed 7 September 2015)
[60] http://www.proeipaha.eu (Accessed 5 September 2015)
[61] http://projectintegrate.eu/ (Accessed 7 September 2015)
[62] https://ec.europa.eu/digital-agenda/en/news/study-support-scaling-innovations-active-and-healthy-ageing-smart-20150039 (Accessed 7 September 2015)
[63] http://ec.europa.eu/programmes/horizon2020/ (Accessed 7 September 20150
[64] http://www.interreg4c.eu/interreg-europe/ (Accessed 7 September 2015)

SCIROCCO partners are already working together in many of these initiatives and these synergies are explained in details in Part 9.1 of the proposal.

Engagement in European networks

SCIROCCO will engage with at least six existing European networks working towards scaling-up and uptake of innovative solutions in the area of active and healthy ageing. SCIROCCO intends to arrange to follow the relevant coordination meetings of these networks and associations. In addition to the EIP on AHA as the primarily targeted network, the other networks are:

- ***Community of Regions for Assisted Living (CORAL) -*** a European network of regions collaborating in the field of Ambient Assisted Living and Active and Healthy Ageing through a process of open innovation to solve the barriers implementing active and health ageing solutions[65].
- ***The International Foundation for Integrated Care (IFIC)*** – a non-for-profit educational network that crosses organisational and professional boundaries to bring people together to advance the science, knowledge and adoption of integrated care policy and practice[66].
- ***The Assembly of European Regions (AER)*** - the largest independent network of regional authorities in wider Europe with the objective to raise the voice of regions at national and international level. AER has the influence in terms of capacity-building, and exchange of experiences and success stories as well as failures[67].
- ***European Regional and Local Health Authorities (EUREGHA)*** – a network of 13 European Regional and Local Health authorities focused on public health policy.[68]
- ***European Connected Health Alliance (ECHA)*** – the Alliance brings together the whole range of health, wellbeing and social care stakeholders interested in developing a joint health and care agenda across a specific country or region[69].
- ***European Regions for Research and Network Innovation (ERRIN) –*** this network has a specific focus on influencing research and innovation policy at a European level and maximising the benefits of regional collaboration in the field[70].

Some of these networks are also listed in Part 14 of the proposal as their representatives have confirmed the interest to contribute to increased value of SCIROCCO's project. Many SCIROCCO partners are active members of these networks and their detailed affiliation is explained in Part 9.1 of the proposal.

4.2. Added value at EU level in the field of public health

SCIROCCO will aim to achieve EU-added value in the following areas:

A. Impact on target groups

SCIROCCO targets multiple stakeholders at both policy and health and care system levels.

Impact on multiple stakeholders at policy level

SCIROCCO will provide evidence-based policy recommendations addressing the issues of scaling-up. These will inform decision-makers about the lessons learned from the process of scaling-up using the B3-MM to facilitate knowledge transfer. SCIROCCO will also investigate the role of policy in facilitating the process of knowledge transfer. The outcomes of the SCIROCCO's project are expected to bring added value to the limited knowledge and evidence on the

[65] http://www.coral-europe.eu/ (Accessed 7 September 2015)
[66] http://integratedcarefoundation.org/ (Accessed 7 September 2015)
[67] http://www.aer.eu/what-is-aer/aer/ (Accessed 7 September 2015)
[68] http://www.euregha.net/2012-11-28-12-46-27 (Accessed 7 September 2015)
[69] http://www.echalliance.com/ecosystems/ (Accessed 7 September 2015)
[70] http://www.errin.eu (Accessed 7 September 2015)

difficulties of scaling-up in Europe.

Additionally, using the B3-MM to identify the strengths and weaknesses of a region in adoption of particular integrated care intervention (good practice) contributes to informed decision-making about the priorities and actions in European regions. This allows systematic improvement of the weaknesses rather than random actions.

Impact on multiple stakeholders at health and care system levels

SCIROCCO will facilitate the exchange of good practices highlighting the potential of innovation in health and social care, in the areas of health and social care integration, independent living and participation in the community. As a result, SCIROCCO will contribute to the existing European evidence on the benefits of moving towards community based health and social care.

B. Long-term effect and potential multiplier effects, such as replicable, transferable and sustainable activities

SCIROCCO aspires to provide a tool, validated and tested in real-life settings, to facilitate implementation and scaling-up of successful local integrated care interventions in Europe. It is expected that such a tool will be widely used by regions and organisations interested in the self-assessment of their capacity to adopt a particular practice. The development of methodology for self-assessment, twinning and coaching activities using the validated tool will enable replication and transferability of these activities across EU regions. An exploitation plan will be developed during the project to address the sustainability of proposed activities.

C. Contribution to complementarity, synergy and compatibility with relevant EU and EU Member States policies and programmes.

Contribution to EU policies

SCIROCCO complements, supports and adds value to the overarching policy ambitions of the European Commission – Jobs, Growth, Investment and Competitiveness agenda by providing a tool to accelerate the uptake and replication of innovative solutions in Europe and boost opportunities of integrated care for European citizens.

By working on the development of an assessment framework (B3-MM), SCIROCCO also builds on the priorities of the Commission in health and food safety, of Commissioner Vytenis P. Andriukaitis, Commissioner for Health and Food Safety, specifically on Priority 4 of the Mission Letter[71]:

"Developing expertise on performance assessments of health systems, drawing lessons from recent experience, and from EU-funded research projects to build up country-specific and cross-country knowledge which can inform policies at national and European level. To the extent that it relates to the quality and productivity of the EU workforce, to the modernisation of social protection systems and to the quality and effectiveness of public expenditure, this expertise can also usefully inform the work of the European semester of economic policy coordination" (Mission Letter, pp4)."

SCIROCCO will also complement the following EU policies:

- **Europe 2020: Europe's growth strategy**[72]- the EU has set 5 targets relating to employment, innovation, education, social inclusion and climate energy. In supporting

[71] http://ec.europa.eu/commission/sites/cwt/files/commissioner_mission_letters/andriukaitis_en.pdf (Accessed 5 September 2015)

[72] http://ec.europa.eu/europe2020/pdf/europe_2020_explained.pdf (Accessed 8 September 2015)

the scaling-up of active and healthy ageing initiatives, SCIROCCO will seek to contribute to the achievement of the specific targets relating to employment (of older people) and reducing poverty and social exclusion, through the scaling up of good practices that address these issues.

- **Innovation Union**[73] **-** is the European Union strategy to create an innovation-friendly environment that makes it easier for great ideas to be turned into products and services that will deliver economic growth and jobs. SCIROCCO will seek to speed-up the implementation of innovative solutions by facilitating their transferability across regions.
- **Digital Agenda for Europe – eHealth and Ageing (2014-2020)**[74] **–** the Agenda has seven specific priority areas for action relating to the best use of information and communication technologies (ICT) to support foundations of a sustainable digital future. SCIROCCO will seek to contribute to this Agenda by showcasing and exchanging good practices illustrating the application of ICT solutions to address societal challenge of the ageing population and rising healthcare costs.
- **2013 Staff Working Document – Investing in Health**[75]- This document forms a key part of the Commission's 2013 Social Investment Package, recognizing the contribution of health for a job-rich economic recovery, as well as a precondition for economic prosperity and considers health spending as "growth friendly" expenditure. SCIROCCO will seek to influence the policy and system reform agenda through the sharing of lessons learned with key policy level stakeholders across Europe.
- **European Innovation Partnership on Active and Healthy Ageing**[76]**-** SCIROCCO will aim to contribute to the implementation of EIP on AHA Action Plans for 2016-2019, in particular the B3 Action Plan on Integrated Care and relevant synergy actions between the Action Groups. SCIROCCO will do so by providing a tool that helps to facilitate the process of scaling-up and exchange of good practices in support of the next phase of development of the EIP on AHA and the implementation of the European Scaling up Strategy in Active & Healthy Ageing[77].
- **eHealth Action Plan 2012-2020: Innovative healthcare for the 21st century**[78]**-** the eHealth Action Plan provides a roadmap to empower patients and healthcare workers, to link up devices and technologies, and to invest in research towards the personalised medicine of the future. SCIROCCO will contribute to this policy initiatives by sharing the good practices on the potential of ICT to empower European citizens as well as health and social care professionals.

D. Contribution to complementarity, synergy and compatibility with relevant EU and EU Member States policies and programmes

SCIROCCO complements, supports and adds values to the policies of Member States aimed at improving the health of EU citizens and reducing health inequalities by promoting health, encouraging innovation in health and increasing the sustainability of European health systems. From the regions in consortium, these are for example:

[73] http://ec.europa.eu/research/innovation-union/index_en.cfm?pg=home (Accessed 8 September 2015)
[74] http://ec.europa.eu/digital-agenda/en/ehealth-and-ageing (Accessed 8 September 2015)
[75] http://ec.europa.eu/social/main.jsp?catId=89&langId=en&newsId=1807&moreDocuments=yes&tableName=news (Accessed 15 August 2015)
[76] http://ec.europa.eu/research/innovation-union/index_en.cfm?section=active-healthy-ageing&pg=home (Accessed 8 September 2015)
[77] European Commission. European Scaling Up Strategy in Active & Healthy Ageing. European Commission, 2015.
[78] http://ec.europa.eu/digital-agenda/en/news/ehealth-action-plan-2012-2020-innovative-healthcare-21st-century (Accessed 8 September 2015)

- **Basque Country -** Basque Country Strategic Guidelines of the Health Department 2013-2016[79], Basque Country Health Plan 2013-2020[80]
- **Czech Republic –** National Action Plan for Active and Healthy Ageing 2013-2017[81]; National Strategy for eHealth, 2015[82].
- **Norrbotten Lans Landsting (NLL)** – Strategy for Patient and User Participation[83]; Improved Life for Sick Elderly in Norrbotten 2015-2018[84]; Strategy for Distance Spanning Healthcare in Norrbotten County Council 2014-2016[85].
- **Puglia** - Strategic Implementation Plan of Puglia (2013-2015)[86] highlighting the following programmes: Programme 13.3 Disease and care management of chronic patients; Programme 14.2 Converted hospitals to support to serve reinforcement of the delivery of care on the territory; Programme 4.1/4.2 ICT services to use this U-turn towards reduction of hospitalisation and empowerment of primary care settings.
- **Scotland –** Public Bodies (Joint Working) Act 2014[87]; Reshaping Care for Older People[88], 2020 Vision[89], The Quality Strategy[90].

Ways how to achieve EU- added value

The SCIROCCO will achieve EU-added value in the following ways:

Table 4: SCIROCCO's contribution to achieving EU-added value

WAYS OF ACHIEVING EU ADDED VALUE	SCIROCCO's CONTRIBUTION
Promoting best practice	SCIROCCO will identify and promote successful local interventions highlighting benefits of moving towards community based health and social care. These good practices will be promoted in a close cooperation with the existing European and national and regional initiatives as identified in Part 4 of the proposal.

[79] https://www.google.es/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0CCEQFjAAahUKEwjl7PKFzenHAhVMvBoKHYNxC_I&url=https%3A%2F%2Fwww.euskadi.eus%2Fr85-pkpubl01%2Fes%2Fcontenidos%2Finformacion%2Fpublicaciones_informes_estudio%2Fes_pub%2Fadjuntos%2Flineas_estrategicas_%2520castellano.pdf&usg=AFQjCNF02icy5M4e-gv0-Mcl1JQ-V_dwEw (Accessed 9 September 2015)

[80] https://www.google.es/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0CCEQFjAAahUKEwig_vrVzenHAhUKMNsKHQnAALw&url=http%3A%2F%2Fwww.osakidetza.euskadi.eus%2Fcontenidos%2Finformacion%2Fpublicaciones_informes_estudio%2Fes_pub%2Fadjuntos%2Fplan_salud_2013_2020.pdf&usg=AFQjCNGL-ygV4A9Nh8D7lryF4K8m8vt0PA (Accessed 9 September 2015)

[81] http://www.mpsv.cz/cs/14540 (Accessed 8 September 2015)

[82] http://www.mzcr.cz/dokumenty/narodni-strategie-elektronickeho-zdravotnictvi_9813_3216_1.html http://www.mzcr.cz/dokumenty/narodni-strategie-elektronickeho-zdravotnictvi_9813_3216_1.html (Accessed 8 September 2015)

[83] http://www.bd.komforb.se/download/18.7c2c67e214b32ad57e72828d/1423668287268/Strategipatient_brukarmedverkan.pdf (Accessed 8 September 2015)

[84] http://www.bd.komforb.se/download/18.7c2c67e214b32ad57e7dd4b5/1428657660664/Strategi+B%C3%A4ttre+liv+f%C3%B6r+sjuka+%C3%A4ldre+i+Norrbottens+l%C3%A4n+2015-2018.pdf (Accessed 8 September 2015)

[85] http://www.nll.se/publika/lg/verk/Kansli/Lst/2014/Bilagor/140527/L%c3%a4nsstrategi%20distansv%c3%a5rd.pdf (Accessed 8 September 2015)

[86] http://www.sanita.puglia.it/portal/pls/portal/docs/1/2185510.PDF (Accessed 8 September 2015)

[87] http://www.legislation.gov.uk/asp/2014/9/contents/enacted (Accessed 8 September 2015)

[88] http://www.gov.scot/Topics/Health/Support-Social-Care/Support/Older-People/ReshapingCare (Accessed 8 September 2015)

[89] http://www.gov.scot/Topics/Health/Policy/2020-Vision (Accessed 8 September 2015)

[90] http://www.gov.scot/Topics/Health/Policy/Quality-Strategy (Accessed 8 September 2015)

Benchmarking for decision-making	SCIROCCO will undertake benchmarking of local integrated care interventions (good practices) using B3-MM as the baseline measurement. The outcomes of self-assessment will indicate the capacity of regions for the adoption of a particular good practice. The self-assessment process will also enable the identification of strengths and weaknesses of European regions in the development and implementation of that particular integrated care intervention (good practice). This will inform the direction of decision-making towards the areas that require an attention to address a challenge of active and healthy ageing.
Strengthening networking activities	To maximise the impact of the project's activities, SCIROCCO will build on the participation of its partners in existing European networks. These include EIP on AHA (both Action Groups and Reference Sites), CORAL, AER, EUREGHA, IFIC, ECHA and ERRIN. Some of these networks are also listed in Part 14 of the proposal as their representatives have confirmed their interest in contributing to increased value of SCIROCCO's project outcomes. The affiliation of partners with these networks is explained in Part 9.1 of the proposal.

Expected impact of the coordinated work at European level

In summary, SCIROCCO builds on the remit of the EIP on AHA and the need for a partnership approach to address the issues of ageing population and its consequences in Europe. Pooling resources, knowledge and expertise towards the achievement of commonly shared goals and objectives will be key to success, thereby unlocking the potential of innovation in health and social care in Europe. Working in partnership a coordinated way with partners at a European level will help to maximise the impact of innovative solutions in Europe in two ways: it avoids duplication of efforts and resources – i.e. by working on the same solutions twice or reinventing wheel; and it allows learning from both successes and failures which helps to speed up the implementation process and prevent the system from repeating the same mistakes as others. SCIROCCO's ambition is to provide tools and methodologies on how to improve this process of learning from each other and maximize the scaling-up and exchange of good practices to achieve the triple win and expected impact of the EIP on AHA on quality of life of European citizens, sustainability of healthcare systems and growth of European market.

4.3. Pertinence of geographical coverage

The EU countries selected to participate in SCIROCCO's activities represent different geographic areas of Europe - namely, those of North (Scotland, Sweden), West (Belgium), South (Italy, Spain) and East (Czech Republic) Europe. SCIROCCO does covers countries with **different organisational models, maturity of health and care systems providing a unique spectrum of public health practices** in Europe. They also represent a variety of stakeholders at policy and health and care system levels which are SCIROCCO's primary targeted groups.

The diversity of the partnership will benefit SCIROCCO's objectives in the following ways:

- The gathering of diverse good practices highlighting successful local interventions working towards community-based health and social care in different health and care systems as well as in different political, cultural, social and economic contexts.

- A better understanding of the issues and importance of context in transferring and adopting successful local integrated interventions and the extent to which maturity of a particular healthcare system influences the adoption and scaling-up of good practices in Europe.
- The richness of expertise and knowledge in sharing and scaling-up good practices in Europe.
- The self-assessment process of local integrated care interventions (good practices) in different healthcare systems and richness of data collected on strengths and weaknesses in development and implementation of these interventions.
- The testing of the B3-MM in the real life settings with different maturity, political, cultural, social and economic contexts.
- The richness of lessons learned on the issues of scaling up and implementation of good practices in Europe captured from different healthcare settings.
- Access to and influence upon a diverse spectrum of stakeholders at policy and health and care system levels of selected countries.

The participating regions inputs will be complemented by support from numerous networks and membership organisations to facilitate and maximise knowledge exchange and dissemination of SCIROCCO's findings achieving wider geographic reach and system impact. These are namely IFIC, CORAL, AER, EUREGHA, ERRIN, ECHA and European Public Health Association (EUPHA)[91].

4.4. Consideration of the social, cultural and political context

SCIROCCO acknowledges the heterogeneity of healthcare systems. It encourages the potential for knowledge-sharing and scaling-up of different innovative solutions in Europe. This is because the issues, aims and objectives are in fact very similar across the SCIROCCO partnership. SCIROCCO is primarily process oriented and thus pays attention to the unique features of sites in line with their distinct social, cultural and political contexts.

Social, political and cultural context

A preliminary assessment of the social, political and cultural context of each of the five regions has been undertaken by the consortium. It confirms that despite the diversity in organisation and maturity of health and care systems, the consortium partners face common challenges to their systems including for examples, those of ageing population, multi-system nature of chronic diseases, hospital-based healthcare systems, insufficient provision of community care services, lack of cooperation among health and social care, fragmentation of the health and social care systems and rurality. These challenges are regarded as a stimulus to the integration of care across all SCIROCCO partners[92]. It is widely recognised by SCIROCCO partners that the reorientation of health and care services from hospital-based to 'community-based' care requires integration between social and health care institutions and organisations. However, despite integration models having a similar background, it cannot be argued that there is European consensus about the concept and implementation of integrated care. These differences are often rooted in the culture, social norms or customs of a particular country. For some, it means the whole system restructuring; for others, the improvement of relationships between parts of the system (health and social care, or acute and primary care, etc.); and for others, it means a partnership between providers, organisations and professionals.

This is also reflected in current policies and strategies of consortium partners as listed in details in part 4.2. They clearly demonstrate that regions have a political commitment to address the

[91] http://www.eupha.org (Accessed 8 September 2015)

[92] Antunes V., Moreira J.P. Approaches to developing integrated care in Europe: a systematic literature review. Journal of Management & Marketing in Healthcare 2011: Vol4, pp.129-135

challenge of chronicity and ageing population through integration of the systems. These are among the most complex and interdependent institutions and as such they have remained separated for several reasons: different rules and jurisdictions, distinct budgets, different institutional and professional cultures and different approaches in the provision of care. This demonstrates that there is a need and interest across the consortium partners to look for the innovative solutions in other European regions or countries and thus benefit from shared learning.

The social, political and cultural context of participating counties is thus compatible with SCIROCCO's objectives to facilitate the scaling up of integrated care solutions in Europe, although the regions and countries vary in the types of legislation or regulations implemented and the way in which regions define and organise health and social care delivery.

Ethical, confidentiality and protection of personal data considerations

Ethical aspects, confidentiality and protection of personal data are not considered directly in SCIROCCO, as the proposed initiative does not include studies involving specific human beings.

5. METHODS AND MEANS

SCIROCCO's overarching objective is to **facilitate the scaling-up of good practices at local, regional or country level by recognising the maturity requirements of good practices and health systems in order to achieve scaling-up and knowledge transfer among European Member States.** To achieve this objective, SCIROCCO will use a step-based approach, with each of the steps reflecting SCIROCCO's specific objectives. The process is illustrated in details in the following figure and each step is described in details below:

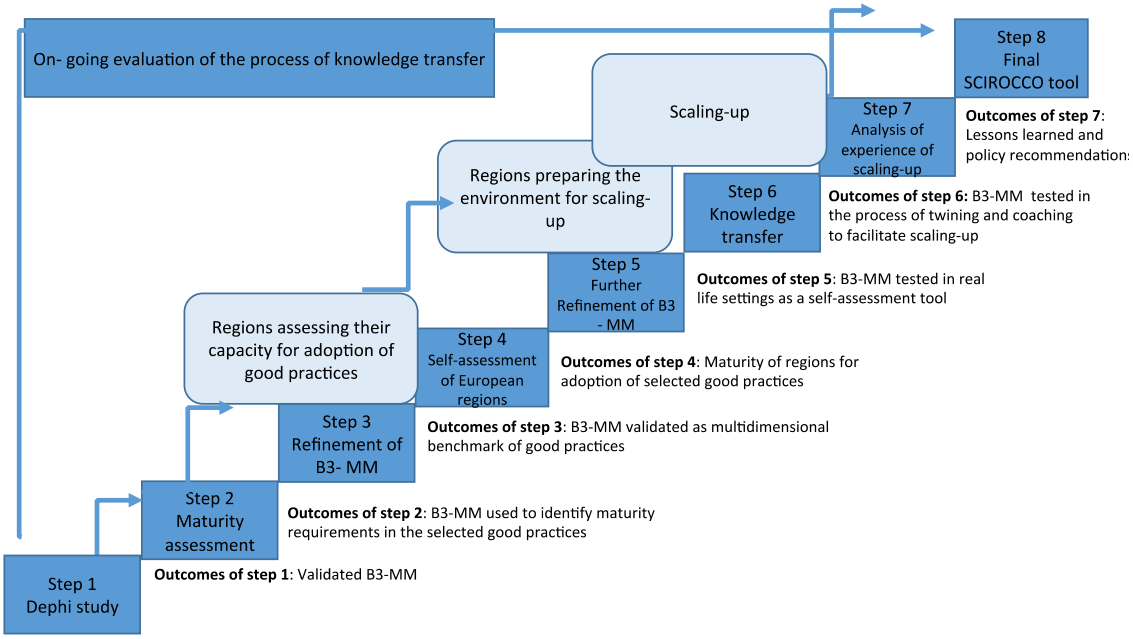

Figure 3: SCIROCCO's strategy to implement the project

Step 1: Validity assessment of the B3-MM

In this step, SCIROCCO will seek the validation of the B3-MM. First, a review literature will be undertaken to compare B3-MM with other instruments developed to measure the level of maturity of integrated care. For this three databases will be used, snowballing and inventory among 10 experts in the field of integrated care and its evaluation and measurement. The review should provide a conceptual underpinning of the dimensions of B3-MM, its items, and answering categories. Following from this, an international Delphi study will be performed

among 20 experts, including 10 experts consulted for literature review, to test the appropriateness of B3-MM to measure maturity of integrated care. In round 1, experts will receive a link to an online version of B3-MM and asked to rate the appropriateness of each feature to assess maturity of integrate care on a nine-point Likert-scale, ranging from 1 (completely irrelevant) to 9 (extremely relevant). Experts will be asked to comment on any of the features, to suggest possible rephrasing, and to highlight any features that may have been missed in the initial list. In round 2, experts will be invited to participate in a call conference to discuss the results of Round 1 and, after the discussion, to reassess the appropriateness of features of B3-MM. Round 1 and 2 together will provide information about the face validity of B3-MM and enable us to optimise the instrument.

Specific objective SO1	Methods	Means
SO1: Face validity of B3-MM assessed	Literature review Delphi study	3 databases (PubMed, Cochrane and the internet) Snowballing Purposive sampling Call conference

Step 2: Maturity assessment

In this step, SCIROCCO will select a minimum of 15 local integrated care interventions (good practices) in five participating EU regions[93]. For the purpose of SCIROCCO's objectives, the good practices will showcase the potential of innovation in health and social care and the benefits of moving towards community-based care. The precondition for the selection of these good practices is that they are strategic initiatives that can contribute to the transformation of health and care systems and that there is an existing commitment to the practice. This commitment is required to ensure that during the lifetime of the project some progress will be made with the scaling-up of the good practices. These good practices will possibly be at different stages of development and levels of maturity. In this phase, the viability assessment will be performed to identify the potential of good practices for scaling-up. The criteria defined in the "Accessibility Template[94]" which was developed in the EIP on AHA will be applied to understand the potential of good practices for scaling up. These criteria are:

- Level of time needed for the good practice to be deployed (from the baseline to current situation);
- Level of investment costs (from the baseline to current situation);
- Level of scientific evidence behind the good practice;
- Level of maturity of the good practice;
- Level of proven societal impact of the good practice;
- Level of tested transferability;
- Level of proven economic impact of the good practice[95].

In the next stage, the maturity requirements for successful implementation of the selected good practices will be defined using the B3-MM. The objective is to test the B3-MM as a tool for evaluation and benchmarking of good practices and to filter and identify potentially adoptable good practices for health and care system. By considering each dimension, and allocating a measure of maturity to that domain, it is possible to assess the maturity requirements for the transfer of the practice by developing a "radar diagram". This will result in the clusters of good practices that represent different levels of maturity across the different domains of the B3-MM.

[93] These are Basque Country, Norbotten Lans Landsting (Sweden), Puglia region (Italy), Olomouc region (Czech Republic) and Scotland.

[94] To our knowledge, the Accessibility Template – Good practices has not yet been published therefore the reference is not provided.

[95] To our knowledge, the Accessibility Template – Good practices has not yet been published therefore the reference is not provided.

The cluster will inform potential adopters of the good practice of any preconditions regarding the context in which the good practice has arisen to maximise the chances of successful transfer and scaling-up.

The initial B3-MM developed in the B3 Action Group on Integrated Care consists of 12 dimensions (see pp.11) and it is foreseen to test and validate the B3-MM in 15 good practices. The testing of 12 dimensions in 15 different good practices results in the target of 180 maturity dimensions assessed as indicated in description of SO2 (see pp. 15). This number is required for the statistical testing of the psychometric characteristics of B3-MM.

Specific objective SO2	Methods	Means
SO2: Local integrated care interventions with the maturity requirements for scaling-up identified	Literature review Interviews Viability Assessment Maturity assessment	Validated B3-MM Radar diagrams

Step 3: Refinement of the B3-MM

In this step, SCIROCCO will refine the B3-MM using the findings of step 1 and 2 where B3-MM is validated and applied to assess the maturity requirements of identified good practices in five European regions. This will be used to provide validation for the development of the B3-MM as a tool that enables self-assessment and comparison between regions. This will include:

- Refinement of the dimensions and maturity indicators of the B3-MM based on the outcomes of step 2. This might include splitting or merging of the dimensions depending on the clarity of the distinctions and salience for maturity.
- Development of the approach to provide a rating for each dimension of the B3-MM. This will involve the development of a series of questions that provide a score that relates to a position on the dimension. Currently, the assessment using the B3-MM depends on the subjective judgment of the assessor to decide on the maturity level.
- Development of the methodology on how to carry out the self-assessment process (comparison of the regions) using the B3-MM as a baseline measurement.

Specific objective SO3	Methods	Means
SO3: The B3-MM applied as a useful tool to assess the readiness of regional health and care system to adopt a particular good practice	Literature review Methodological triangulation	Validated B3-MM

Step 4: Self-assessment of European regions

Step 5: Further refinement of the B3-MM

In Step 4, SCIROCCO will assess five European regions in terms of their capacity and readiness for adoption of good practices. For the purpose of the SCIROCCO project, the validated B3-MM as an outcome of Step 3 will apply as the baseline for self-assessment process in five European regions.

Similarly as in Step 1, by considering each dimension, assessing its current situation, and allocating a measure of maturity to that domain, it is possible for a country or region to measure its maturity in relation to readiness to adopt a good practice. This is done by developing a 'radar diagram' which will reveal areas of strengths and weakness in each dimension of the B3-MM, thereby identifying any gaps between the maturity required to implement a practice (as

identified in Step 2) and the maturity status of the potential adopting region (Step 4). This provides a measure of the capacity of the system to accommodate the new practices.

In addition, using these insights, and comparing the "radar diagram" with those of other regions/countries that have conducted the same exercise, the B3-MM facilitates two activities: the capacity to offer others the knowledge and experience from the regions' areas of strengths, and the opportunity to find learning/share expertise to fill any gaps in capabilities.

The SCIROCCO project will, during its lifespan, see the development of Action Plans to address the gaps, however the actual implementation of the Plans and monitoring of their progress (on-going self-assessment) is not within the scope of the project due to the limited duration of the project.

Further refinement of the B3-MM is also envisaged (Step 5) based on the experience of regions using the B3-MM as a self-assessment tool during Step 4.

Specific objective SO4	**Methods**	**Means**
SO4: European regions evaluated to assess their readiness to adopt integrated care interventions at scale	Internal self-assessment using B3-MM as the baseline measurement	Comparison tables Graphs Radar web diagram

Step 6: Knowledge transfer

In this phase, SCIROCCO will explore the extent to which an approach of matching together regions that have complementary strengths and weaknesses (as a result of Steps 4 and 5) can provide both a strong basis for twinning and coaching activities and be useful in facilitating the process of information-sharing between the regions to speed up adoption and scaling up of good practices. The goal of this step is to support the creation of teaming and coaching relationships on a sound basis that uses evidence to construct these relationships utilising evidence to construct a solid basis for these relationships. (Steps 1-4 of SCIROCCO's strategy). SCIROCCO will consider if this approach can help regions improve on their weaknesses and consolidate their strengths by being required to both reflect and communicate how they achieved strength in a particular dimension. The outcomes of Step 6 will also inform whether the benchmarking of good practices in terms of their maturity can be used to promote more short-term relationships between regions where there is a need to "fix" a particular part of the context, and other regions that are deemed to have demonstrated strengths in those areas. The outcomes of step 6 will results in the final refinement of the B3-MM as a tool facilitating the knowledge transfer and flow of appropriate information to achieve scaling-up and implementation of good practices.

Specific objective SO5	**Methods**	**Means**
SO5: Complete transfer and scaling-up process using B3-MM (twinning and coaching to facilitate the knowledge transfer)	Twinning Coaching	Workshops Study visits Webinars

Step 7: Analysis of experience of scaling-up

In this step, SCIROCCO will capture lessons learned from using the B3-MM to facilitate the process of knowledge transfer of the multidimensional maturity requirements of good practices and health and care systems. The lessons learned will inform the development of evidence-

based policy recommendations on the challenges of scaling up, the volume and relevance of knowledge gained from other partners progressing towards implementation and on how policy can facilitate this process of knowledge transfer. In addition, the experience and satisfaction of the B3-MM users will be captured in order to understand the usefulness of the B3-MM as a tool for facilitating the scaling up and exchange of good practices in Europe. The outcomes of this step will inform the final development of the SCIROCCO tool.

Specific objective SO6	Methods	Means
SO6: Influence policy change and inform decision-makers about the potential and benefits of B3-MM to facilitate the process of scaling-up.	Meetings Conference calls Interviews Briefings documents White Paper Report	SCIROCCO Policy Advisory Group

Step 8: Final SCIROCCO tool and exploitation of its findings

In this step, final SCIROCCO tool will be provided in its online version. The tool will be publicly available for the use of interested countries, regions or organisations in Europe.

SCIROCCO will also identify some support actions to promote and accelerate the actual use of the tool, and implicitly, the implementation or scaling-up of good practices in and across Europe. The B3-MM will at this stage be a refined, validated and tested tool that will be publicly available at the end of the project for regions across Europe to use for their own self-assessment and comparison purposes.

Among the supportive actions that could be considered are: education and training workshops on the B3-MM for local stakeholders in regions and match-making activities to facilitate knowledge transfer through twinning and coaching to transfer or scale-up good practices. However, these types of supportive actions (in regions that are not partners in the SCIROCCO project) are considered to be out of the scope of the SCIROCCO project due to project timescale and resource restrictions.

On-going evaluation of the process of knowledge transfer

And finally, the experience of regions using B3-MM in the process of knowledge transfer to facilitate the scaling-up and implementation of good practices will be evaluated. Evaluation activities are part of all specific objectives:

- *SO1* – assessment of face validity of B3-MM, including literature review and expert interviews
- *SO2* – identification of practices, including assessment of maturity dimensions;
- *SO3* – application of validated B3-MM, including data collection and analysis;
- *SO4* – assessment of readiness for adoption of integrated care, including data collection in five European regions;
- *SO5* – evaluation of scaling-up process, including providing inputs for the process;
- *SO6* – informing decision-makers, including translation of evaluation results;
- *SO7* – measurement of the extent of knowledge transfer.

Every phase captures an important evaluation process, starting from expert validation (step 1), over psychometric testing (step 2&3), “in-vivo” assessment (step 4&5), all the way through reporting on scores and evaluation of their interpretation by stakeholders (step 6&7). To measure the extent of knowledge transfer, use will be made of a survey based on the

Development Model for Integrated Care (DMIC) by Minkman in step 4&5[96].

Specific objective S07	Methods	Means
SO7: Knowledge transfer process evaluated	DMIC Survey Key informant interviews Non-participant observations Questionnaires studies Analysis of participants' logbooks[97] Other project documented analysis	Descriptive statistics Frequency analysis Chi Square ANOVA and Kruskal-Wallis H, using SPSS software, version 22.0

6. EXPECTED OUTCOMES

Table 6 below summarises the expected outcomes and anticipated changes following the achievements of SCIROCCO's objectives.

Table 5: SCIROCCO expected outcomes

SCIROCCO OBJECTIVES	SCIROCCO EXPECTED OUTCOMES
Improve the evaluation and benchmark of good practices in order to filter and identify potentially adaptable good practices for health and care system.	***Improved access to learning embedded in good practices.*** SCIROCCO will validate the B3-MM as the tool for the maturity assessment of good practices. The intention is to contribute to an improved understanding of the contextual requirements of good practices as preconditions for their successful scaling-up and replication in Europe. This will classify good practices in terms of their maturity and demands on the implementation context. As a result, SCIROCCO aims to make embedded learning more readily accessible to potential adopters to stimulate and accelerate the implementation process of good practices in the provision of integrated care in Europe.
Assess the health and care delivery system of European regions in terms of their maturity to adopt good practices in the provision of integrated care.	***Improved capacity of regions for adoption of good practices.*** The health and care systems are shaped/defined by their context, and features of particular interventions (good practices) need to fit into the context appropriately in order to be adopted successfully. Using the B3-MM, SCIROCCO will assess the maturity of the context of the health and care system to understand its readiness and capacity for the

[96] http://www.vilans.nl/docs/vilans/over_vilans/pdf/Proefschrift_Mirella_Minkman_Developing_Integrated_Care.pdf (Accessed 4 September 2015)

[97] The content of the logbooks is descriptive in nature and aims to capture barriers and/or facilitators of the activities for scaling-up, including the use of B3-MM tool. These logbooks have been tested and applied in previous projects concerning the scaling-up of new care models. For the purpose of SCIROCCO's project, multiple stakeholders at both policy level and health and social care system level are targeted participants.

	adoption of a particular good practice. By comparing maturity requirements of good practices with the maturity of the context of the health and care system, SCIROCCO will facilitate an understanding of how, and under which circumstances, is the successful scaling-up and adoption of good practice possible. The identification of maturity gaps has the potential to unlock processes to address these gaps and stimulate actions for improvements and changes in health and social care systems. It also allows the clustering of regions with complementary strengths and weaknesses which can facilitate the potential partnerships-building and knowledge-transfer activities.
Facilitate the process of information sharing between regions to speed up adoption and scaling-up.	***Faster adoption and scaling-up of good practices in the provision of integrated care.*** SCIROCCO will seek to test the B3-MM in the process of twinning and coaching to facilitate knowledge transfer among participated participating regions. The ambition is to provide a tool that can facilitate the flow of appropriate information between adopting and transferring regions which can speed-up adoption and scaling-up of good practices in the provision of integrated care in Europe.
To provide a refined and tested tool that identifies, analyses and facilitates knowledge transfer of the multidimensional maturity requirements of good practices and health and care systems.	***Increased use of the B3-MM in the process of scaling-up*** SCIROCCO will provide a refined and tested B3-MM to assist regions with scaling-up and adoption of good practices. SCIROCCO tool and methodologies on how to improve the process of learning from each other can helps to maximise the scaling-up and replication of integrated care solutions and thus achieve the triple win and expected impact of the EIP on AHA on quality of life of European citizens, sustainability of healthcare systems and growth of the EU market.
To inform the decision-makers about the potential of the B3-MM in facilitating the knowledge transfer in order to achieve implementation and scaling-up of good practices in Europe.	***Improved informed decision-making on European, national and local level*** Based on the experience of five European regions with using the B3-MM, SCIROCCO will seek to inform its primary target group (multi-stakeholders at policy and healthcare system levels) about how to scale-up integrated care by making use of existing knowledge as well as to accelerate the spread and development of knowledge by those involved in the development, implementation and/or evaluation of integrated care initiatives in Europe. This can result in the potential changes in policies to facilitate this process of

	knowledge transfer and information sharing in Europe.

7. WORK PACKAGES

SCIROCCO's work packages (WPs) have been designed to implement its overarching objective - that is to provide a refined and tested tool to facilitate the scaling-up and transfer of good practices in European health and care systems.

7.1. Overview on work packages

WP number	Title	Description
1	Coordination of the project	Actions undertaken to manage the project and to make sure that it is implemented as planned.
2	Dissemination of the project	Actions undertaken to ensure that the results and deliverables of the project will be made available to the target groups.
3	Evaluation of the project	Actions undertaken to verify the extent to which the project is being implemented as planned and reaches the objectives.
4	Maturity requirements in selected good practices	Actions undertaken to identify maturity requirements of selected local integrated care interventions (good practices) which have the potential for scaling-up.
5	Refinement of the B3-MM	Actions undertaken to refine the B3-MM as a tool that enables multi-dimensional comparison framework to assess the capacity of health and care systems to adopt a good practice.
6	Self-assessment	Actions undertaken to compare five European regions to assess their strengths and weaknesses to adopt good practices, using the B3-MM as the baseline.
7	Knowledge transfer	Actions undertaken to facilitate knowledge transfer and scaling-up using B3-MM in the process of twinning and coaching activities.
8	Lessons learned and policy implications	Actions undertaken to collect lessons learned on the process of scaling-up to inform decision-makers about the potential of B3-MM and to positively influence regional integrated health and care policies.

There are three horizontal and five vertical work packages. A total duration of 32 months has been envisaged for the implementation of the project. The project will start with the identification of good practices and the maturity requirements for scaling-up of a minimum of 15 good practices in Europe (M2-M6). The majority of total duration of the project (M11-M24) will be dedicated to the actual facilitation of the process of scaling-up and exchange of good practices in five EU regions. The self-assessment process is envisaged for 6 months (M11-M17) particularly due to potential difficulties with collection and analysis of self-assessment data which may delay the progress of the project. Another 10 months are planned for the organisation of twining and coaching activities (mostly face-to-face meetings) and facilitation of knowledge transfer that are highly resource demanding in addition to the development of regional Action Plans with concrete solutions on how to overcome specific barriers in

implementing integrated care in 5 European regions. The refinement and development of SCIROCCO self-assessment tool is considered as cross-cutting activity, the results of which directly feed to WP3, WP4, WP6 and WP7 (M4-M27). The coordination, dissemination and evaluation activities are envisaged for the whole duration of the project.

The organisation of WPs is illustrated in the following figure:

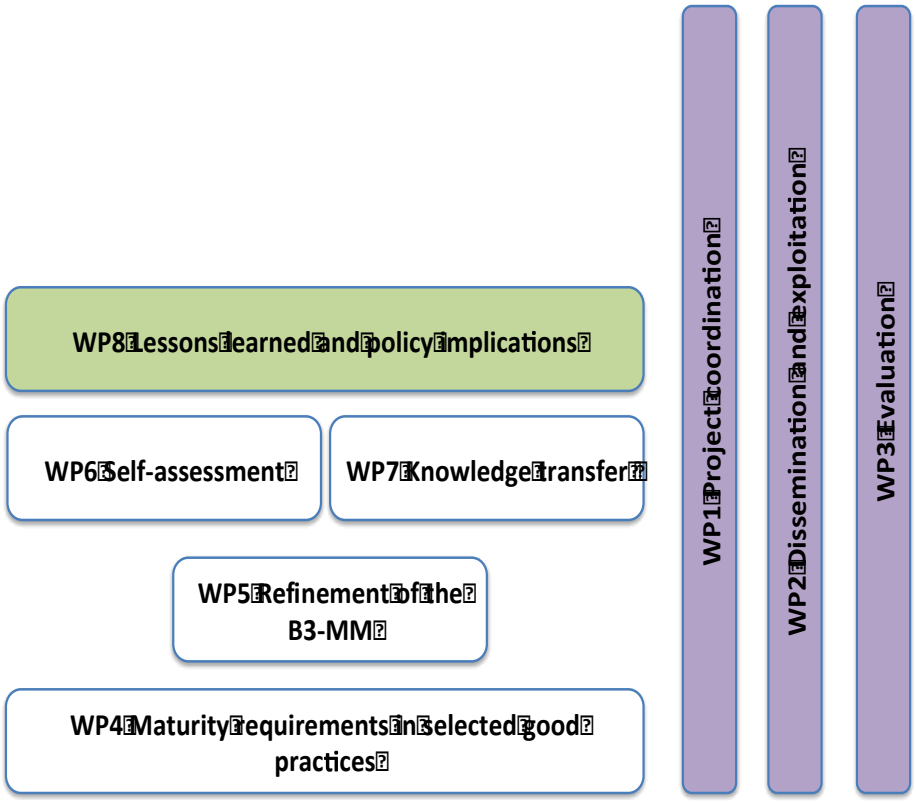

Figure 4: Overview of SCIROCCO's work packages

7.2. Work packages

Work package number	**1**									
Work package title	**Coordination of the project**									
Starting month	M1			**Ending month**			M32			
Leading applicant	**NHS 24 (NHS 24)**									
Applicants Number	**1**	2	3	4	5	6	7	8	9	10
Applicants Acronym	**NHS 24**	UEDIN	VUB	UVEG	Kronikgune	Osakidetza	ARES PUGLI	FNOL	NLL	EHTEL
Person month per applicant	**7**	1	1	1	1	0	1	0	1	1

Objectives

WP1 aims to manage the project effectively, making sure that it is implemented on time and as planned, through the establishment of regular communication processes and channels for and between the consortium partners.

Description of work

The work will be carried out through the completion of the following tasks:

Task 1.1 Coordinator responsibilities, M1-M32
Lead partner: NHS 24
Acting as the point of contact between the EC and the consortium, distribution of the financial contribution, reviewing and approval of all reports and deliverables including financial claims will be performed by the coordinator. The coordinator will support the consortium partners in delivery of the project with respect to their obligations defined in the CHAFEA Grant Agreement.

Task 1.2 Establishment of consortium bodies, planning, organisation and administration of consortium meetings, M1 – M32
Lead partner: NHS 24; Contributors: All
The coordinator will implement and record meetings of the consortium. Advanced planning and communication to all partners will ensure that meetings are arranged to meet the needs of the project and partners. The location of consortium meetings will be at the partners' offices or another mutually convenient location. Efficient and effective use of the project budget will be considered when making arrangements. Agendas and minutes of all consortium meetings will be circulated in a timely manner to ensure all partners are allowed sufficient time to prepare for meetings.

Task 1.3 Management of the consolidation of technical and financial partner reports and communications with CHAFEA, M1 – M32
Lead partner: NHS 24; Contributing partners: UEDIN, VUB, UVEG, Kronikgune, ARES PUGLI, NLL, EHTEL
Management of the consolidation of technical and financial partner reports in a timely and professional manners as required, meeting the needs of the Commission. Latest communications tools and techniques will be utilised including web portal services, common

document areas and integrated financial data recording systems.

Task 1.4 Financial management, M1 – M32
Lead partner: NHS 24;
Working closely with the Finance Departments of the participating organisations to ensure that all budget related actions are performed correctly and within the rules and regulations set out by the CHAFEA Grant Agreement. This includes the establishment of efficient good operating procedures for financial management, adapted for the financial system of each partner, to ensure that received funds are correctly distributed and accounted for that cost statements are received and appropriate, regular audits undertaken. Facilitation of decisions regarding any re-allocation of budgets between beneficiaries.

Deliverables linked to this work package

MD1. Interim report (M18) - This report describes the activities carried out, milestones and results achieved in the first half of the project. The project deliverables will be annexed.
MD2. Final Report (M32) - This report describes the project implementation and the results achieved. The project deliverables will be annexed.

Milestones to be reached by this work package

M1.1 Project Kick-off Meeting in Luxembourg (M1)
M1.2 First Project Assembly meeting (M7)
M1.3 Second Project Assembly meeting (M14)
M1.4 Acceptance of Interim Report (M16)
M1.5 Third Project Assembly meeting (M21)
M1.6 Fourth Project Assembly meeting (M28)
M1.7 Final project Assembly meeting linked to SCIROCCO final conference (M32)
M1.8 Acceptance of Final Report (M32)

Work package number	**2**									
Work package title	**Dissemination and Exploitation**									
Starting month	M1			**Ending month**			M32			
Leading applicant	**European Health Telematics Association (EHTEL)**									
Applicants Number	1	2	3	4	5	6	7	8	9	**10**
Applicants Acronym	NHS 24	UEDIN	VUB	UVEG	Kronikgune	Osakidetza	ARESPUGLI	FNOL	NLL	**EHTEL**
Person month per applicant	2	1	1	1	1	1	1	1	1	**7**

Objectives

WP2 has two main objectives:

1. Dissemination: raising awareness at European and national/regional level about the project's ambitions, lessons learned during the testing and validation phase of the B3-MM tool and finally the project end results/outcomes.
2. Exploitation: creating the necessary organisational elements to enable the use of the B3-MM beyond the project's end by regions seeking to scale-up services or benefit from

relevant good practices identified in other regions.

Description of work

The work will be carried out through the completion of the following tasks:

T2.1: Project web site and branding, M1-M3

Lead partner: EHTEL; Contributors: All

The objective of this task is to create SCIROCCO's website and other dissemination materials. The project web site will work as a project-related repository of information. Its purpose will be to create a reference point for all future dissemination activities. This task will also include the preparation of a preliminary Dissemination Plan, outlining key tasks, including the organisation of Editorial Committee for the project, web site, on-going management of the Committee and regular updating of the web site to share lessons learned and progress on an on-going basis throughout the project lifespan.

For branding of the project, the consortium will develop a unique visual identity for the project based on the project values (logo, presentation templates, graphical charter for the web site and other dissemination material). The branding will also be used during the exploitation of the results of the project, i.e. beyond the duration of the project.

T2.2: Project leaflets, M1-M32

Lead partner EHTEL; Contributors: All

The objective of this task is to promote the use of SCIROCCO's web site. Social media activities and paper-based material (to be distributed during workshops and conferences), will be used to incentivise stakeholders to visit the web site. There will be two generations of paper-based materials produced: the first one will be aimed at presenting an overview of the project's ambition, values and objectives; and the second one will be a lay version of the Project Final Report and will present testimonials from those who have used the B3 -MM.

T2.3: Dissemination Strategy and Action Plan, M6

Lead partner: EHTEL; Contributors: All

The objective of this task is to develop a targeted Dissemination Strategy and Action Plan. This Dissemination Plan will be organised combining several axes of activities such as regional and European dissemination as well as operational and policy-oriented dissemination. It will, furthermore, include liaison with other EU projects and the EIP on AHA community e.g. to organise joint focus groups or workshops.

To ensure high visibility of the project its whole lifecycle, the Dissemination Strategy will furthermore be organised into three phases:

- Phase One: A focus on the development of the project branding / graphical identity and its web site.
- Phase Two: A focus on gathering and disseminating the lessons learned by the consortium during the testing phase of the model and its use for twining / coaching.
- Phase Three: Promotion of the results of the project and organisation of the exploitation arrangements for after the end of the project.

All project dissemination activities will seek to take advantage of the well-established networks of each member of the consortium. EHTEL will also take a lead role in working with other identified pan-European and multi-stakeholder network – EIP on AHA, CORAL, IFIC, AER, EUREGHA, ECHA and ERRIN – to further disseminate the work and impact of the project. This will enable the project's Dissemination Strategy to work as an "impact multiplier". This Strategy will also aim to create synergies with already planned key local, national and European stakeholder engagement activities (conference, workshops, etc.) to organise the exploitation of the project results.

T2.4: Project presentations to conferences, workshops and other meetings, M6-M32
Lead partner: EHTEL; Contributors: All
The objective of this task is to raise awareness and validate the findings of the SCRIOCCO project. Under this task, the participation of all the project representatives will be actively promoted in relevant regional, national or European dissemination activities to present lessons learned and interim results of the project.

T2.5: Final conference, M32
Lead partner: EHTEL; Contributors: All
The objective of this task is to organise the final conference as a final milestone for presenting lessons learned, and final results of the project. The final conference will be designed to attract an audience of 100 participants.

T2.6: Exploitation organisation, M30 and M32
Lead partner: EHTEL; Contributors: All
The objective of this task is to develop the Exploitation Plan for the use of B3-MM - SCIROCCO's final deliverable beyond the duration of the project. The B3-MM deliverable is a tool that will be publicly available at the end of the project. Support actions will be required to accelerate the actual use of the tool and implicitly, the implementation or scaling-up of good practices in and across Europe.

The supportive actions that will be considered are: education and training workshops on the B3-MM for local stakeholders in regions and match-making activities to facilitate knowledge transfer through twinning and coaching to transfer or scale-up good practices. Self-funded mechanisms will be required to be identified as these supportive actions will run after the end of the project.

Deliverables linked to this work package

D2.1 Dissemination Strategy and Action Plan (M6-M12) - The document that describes the Dissemination Plan and Strategy for SCIROCCO, including project branding, participation of all the project representatives in any regional, national or European dissemination activities and organisation of SCIROCCO final conference.
MD3 Project Leaflet (M3)
MD4 Project Flyer v02 (layman version of the final report) (M32)
MD5 Project Web Site (M3)

Milestones to be reached by this work package

M.2.1 Availability of website (M3)
M.2.2 Availability of dissemination materials (M3)
M.2.3 Availability of Dissemination Strategy and Action Plan (M6)
M.2.4 SCIROCCO interim findings presented in public (M19)
M.2.5 Final Conference (M32)

Work package number	**3**									
Work package title	**Evaluation**									
Starting month	M1		**Ending month**			M32				
Leading applicant	**Vrije Universitet Brussels (VUB)**									
Applicants Number	1	2	**3**	4	5	6	7	8	9	10
Applicants Acronym	NHS 24	UEDIN	**VUB**	UVEG	Kronikgune	Osakidetza	ARES PUGLI	FNOL	NLL	EHTEL
Person month per applicant	1	0	**20**	7	1	0	1	1	1	0

Objectives

WP3 has four objectives:

1. To test the validity and reliability of B3-MM as instrument to measure the level of maturity of integrated care;
2. To measure the level of maturity of integrated care in selected sites at baseline and after scaling up activities;
3. To measure the level of knowledge translation in selected sites at baseline and after scaling up activities
4. To assess to what extent SCIROCCO adheres to program fidelity i.e. is implemented as intended and according to the goals that underlie its conception.

Description of work

The work will be carried out through completion of the following tasks:

T3.1. Testing of validity and reliability of B3-MM M1-M4
Lead partner VUB; Contributing partners: UVEG;

First, a review literature will be undertaken to compare B3-MM with other instruments developed to measure the level of maturity of integrated care. For this, three databases will be used (PubMed, Cochrane and the Internet), snowballing and an inventory of 10 experts in the field of integrated care, and its evaluation and measurement (purposive sampling). The review should provide a conceptual underpinning of the dimensions of B3-MM, its components and results categories.

Following on from the review, an international Delphi Study will be performed with 20 experts to test the appropriateness of B3-MM to measure maturity of integrated care. In Round 1, experts will receive a link to an online version of B3-MM and asked to rate the appropriateness of each dimension to assess the maturity of integrated care on a nine-point Likert-Scale. Experts will be asked to comment on any of the features, to suggest possible rephrasing, and to highlight any features that may have been missed in the initial list. In Round 2, experts will be invited to discuss the results of Round 1 and to reassess the appropriateness of features of the B3-MM. Rounds 1 and 2 together will provide information about the face validity of B3-MM and enable the instrument to be optimised.

By applying B3-MM to measure the level of maturity of integrated care (see T3.2) at baseline and 2 follow-up measurements, quantitative data-analysis will be performed to assess the underlying structure, test-retest reliability and internal consistency of B3-MM. For this, factor analysis and Cronbach's Alpha will be calculated using SPSS software, version 22.0. It is envisaged for Task 3.1 to be technical activities for underpinning the psychometric properties of

the B3-MM (mid-term evaluation).

T3.2. Measuring of knowledge transfer M11-M27
Lead partner: VUB; Contributors: NHS 24, UVEG, Kronikgune, ARES PUGLI, FNOL, NLL

To measure knowledge translation, use will be made of a survey based on the Development Model for Integrated Care (DMIC) by Minkman[98]. This survey has been developed and validated to assess the relevance and implementation of elements of integrated care. It consists of 89 items grouped in 9 clusters. The clusters are: 'patient-centeredness', 'delivery system', 'performance management', 'quality of care', 'result-focused learning', 'inter-professional teamwork', 'roles and tasks', 'commitment', and 'transparent entrepreneurship'. As with B3-MM, stakeholders identified from the participating sites will be invited to fill out the DMIC survey at baseline and 2 follow-up measurements. Data analyses will be executed per site and for all sites by means of descriptive statistics, frequency analyses, Chi Square, ANOVA and Kruskal-Wallis H, using SPSS software, version 22.0. It is envisaged for Task 3.2 to be functional activities for underpinning the applicability of the B3-MM (final-term evaluation).

T3.3 Assessing implementation fidelity of SCIROCCO M1-M32
Lead partner: VUB; Contributors: UVEG

The most complete conceptual framework for implementation fidelity (Carroll et al. [99]) will be used for evaluation of implementation fidelity of SCIROCCO. This framework includes components of implementation fidelity and factors that may influence the degree of fidelity, referred to as moderating factors. The measurement of implementation fidelity is a measurement of adherence, with its subcategories: content, frequency, duration, and coverage (dose). Moderating factors are: intervention complexity, facilitation strategies, quality of delivery, and participant responsiveness.

Data will be collected for each of the participating sites during the entire intervention period and a multi-method approach will be used. Data collection methods will include key informant interviews, non-participant observations, questionnaire studies (including B3-MM, DMIC) analysis of participants' logbooks and other project document analysis.

Deliverables linked to this work package

D3.1 Assessment level of knowledge transfer (M30) - The document that describes the evaluation outcomes of the B3-MM as a tool facilitating knowledge transfer.

Milestones to be reached by this work package

M3.1 Literature review (M4)
M3.2 Validated B3-MM through Delphi study (M4)
M3.3 Assessment level of maturity of integrated care (M19)
M3.3 Final evaluation - Assessment fidelity of SCIROCCO (M32)

[98] http://www.vilans.nl/docs/vilans/over_vilans/pdf/Proefschrift_Mirella_Minkman_Developing_Integrated_Care.pdf (Accessed 5 September 2015)

[99] Carroll C, Patterson M, Wood S, Booth A, Rick J, Balain S. A conceptual framework for implementation fidelity. 2007 Nov 30; 2:40.

Work package number	**4**									
Work package title	**Maturity requirements in selected good practices**									
Starting month	M2			**Ending month**		M6				
Leading applicant	**Asociación Centro de Excelencia Internacional en Investigación sobre Cronicidad (Kronikgune)**									
Applicants Number	1	2	3	4	**5**	6	7	8	9	10
Applicants Acronym	NHS 24	UEDIN	VUB	UVEG	**Kronikgune**	Osakidetza	ARES PUGLI	FNOL	NLL	EHTEL
Person month per applicant	4	0	0	0	**10**	4	4	4	4	0

Objectives

WP4 has two objectives:

1. Identify 30 good practices with a potential for scaling-up in five European regions by means of viability assessment.
2. Define the maturity requirements of a minimum of 15 selected good practices for their adoption in Europe.

The work of this WP will contribute to the dissemination of the selected good practices amongst EIP on AHA network and in the selected communication channel in collaboration with WP2. The outcomes of this WP will feed directly to WP5 as the inputs for the refinement of the B3-MM.

Description of work

The work will be carried out through the completion of the following tasks:

Task 4.1 Viability assessment of good practices, M2-M3
Lead partner: KRONIKGUNE; Contributors: NHS 24, Osakidetza, ARES PUGLI, FNOL, NLL
The objective of this task is to map and select good practices in five European regions for the purpose of the viability assessment. These good practices will address the issues of active and healthy ageing and highlight the benefits of integration of health and social care and of benefits of moving towards community based health and care. The viability criteria will be applied to assess the potential of these good practices for scaling-up across European health and care systems. Minimum 30 good practices in five European regions will be identified.

Task 4.2 Data collection, M2-M4
Lead partner: KRONIKGUNE; Contributors: NHS 24, Osakidetza, ARES PUGLI, FNOL, NLL
The objective of this task is to collect data on 30 good practices selected in Task 4.1. The template for the data collection will be developed using potentially, the existing templates for the description of good practices, to ensure the consistence of data collection in five European regions. Data on 30 good practices will be collected.

Task 4.3 Maturity requirements of identified good practices, M4-M6

Lead partner: KRONIKGUNE; Contributors: NHS 24, Osakidetza, ARES PUGLI, FNOL, NLL

The objective of this task is to define the maturity requirements for 15 good practices selected from the collection of good practices in Task 4.1. These good practices are identified as those with a potential for scaling-up and adoption across European regions. The B3-MM will be applied to each of these good practices to assess their maturity requirements for the potential adoption across Europe along each of the dimension of the B3-MM. This will result in a guide to potential adopters of the context in which the good practice has arisen. The outcomes of this task will also directly inform the WP3 which will seek the refinement of the B3-MM.

Deliverables linked to this work package

D4.1 Guide on the maturity requirements of good practices viable for scaling up (M6) – This reports provides the contextual analysis of the requirements for the adoption of 15 selected good practices in Europe.

Milestones to be reached by this work package

M4.1 Good practices work initiated by all partners (M2)
M4.2 Availability of data for 30 good practices (M3)
M4.3 Upload of 30 good practices on website and EIP on AHA database of good practices (M5)
M4.4 Completed maturity assessment for 15 good practices (M6)

Work package number	**5**									
Work package title	**Refinement of the B3-MM**									
Starting month	M4			**Ending month**			M27			
Leading applicant	**University of Edinburgh (UEDIN)**									
Applicants Number	1	**2**	3	4	5	6	7	8	9	10
Applicants Acronym	NHS 24	**UEDIN**	VUB	UVEG	Kronikgune	Osakidetza	ARES PUGLI	FNOL	NLL	EHTEL
Person month per applicant	1	**12**	2	0	1	1	1	1	1	0

Objectives

WP5 has 4 objectives:

1. To refine the B3-MM as a tool enabling multi-dimensional assessment of the capacity of health and care systems for adoption of good practice.
2. To develop a guide on how to use the B3-MM as a self-assessment tool.
3. To further refine the B3-MM as a tool to facilitate knowledge transfer activities (WP6, T6.4).
4. To provide a final, validated and tested B3-MM tool to facilitate scaling-up and knowledge transfer amongst European member states, based on the outcomes of WP6 (T6.4) and WP7 (T7.3).

The outcomes of WP4 will then feed directly to WP5 where the self-assessment process is envisaged. This WP also links to WP3 but focuses mostly on the collection of qualitative data for the validation purposes.

Description of work

The work will be carried out through the completion of the following tasks:

Task 5.1 First refinement of the B3-MM, M4-M7
Lead partner: UEDIN; Contributors: NHS 24, VUB, Kronikgune, Osakidetza, ARES PUGLI, FNOL, NLL
The B3-MM will be refined using the using the outcomes of WP4 – D4.2 Guide on the maturity requirements of good practices viable for scaling-up. These outcomes will provide some validation for the development of the B3-MM as a tool enabling multidimensional assessment of the capacity of regions for adoption of a good practice. This will involve the validation of domains and maturity indicators of each of the dimensions of the B3-MM. The refined B3-MM will be validated internally with the five European regions.

Task 5.2 Measurement scale, M7-M8
Lead partner: UEDIN; Contributors: NHS 24, VUB, Kronikgune, Osakidetza, ARES PUGLI, FNOL, NLL
Second step in the process of refining the B3-MM is the development of an objective measurement scale for each dimension of the refined B3-MM in Task 5.1. The focus is on the development of series of questions for comparisons along each of the dimensions of the B3-MM and allocation of scores related to position on the dimensions of the B3-MM. The proposed measurement scale will be validated internally with five European regions.

Task 5.3 Self-assessment tool, M8-M10
Lead partner: UEDIN; Contributors: NHS 24, VUB, Kronikgune, Osakidetza, ARES PUGLI, FNOL, NLL
The outcomes of Tasks 5.1 and 5.2 will inform the final consolidation of the B3-MM as a baseline for multidimensional comparison framework to assess the capacity of the region for the adoption of a good practice. An online version of the self-assessment tool will be developed and tested with the five European regions. This will inform the final consolidation of the assessment tool with B3-MM as baseline.

Task 5.4 Methodology for self-assessment, M10-M11
Lead partner: UEDIN; Contributors: NHS 24, VUB, Kronikgune, Osakidetza, ARES PUGLI, FNOL, NLL
The guide for the regions on how to use the B3-MM as a self-assessment tool will be developed. The proposed methodology will be validated and consolidated internally with five European regions. The outcomes of this task will directly inform the WP6 where the self-assessment of European regions is envisaged.

Deliverables linked to this work package

D5.1 SCIROCCO online assessment tool (M27) – Online tool enabling multidimensional assessment to facilitate the implementation of good practices and scaling-up, including the manual for the European regions on how to use the B3-MM in the self-assessment process

Milestones to be reached by this work package

M5.1 Refinement of the B3-MM initiated (M4)
M5.2 Validation of B3-MM is completed (M8)
M5.3 Access to online self-assessment tool (M9)
M5.4 Knowledge of regions on how to use the B3-MM (M11)

Work package number	**6**
Work package	**Self-assessment**

title										
Starting month	M11			**Ending month**			M17			
Leading applicant	**Norbotten Lans Landsting (NLL)**									
Applicants Number	1	2	3	4	5	6	7	8	**9**	10
Applicants Acronym	NHS 24	UEDIN	VUB	UVEG	Kronikgune	Osakidetza	ARES PUGLI	FNOL	**NLL**	EHTEL
Person month per applicant	10	2	2	0	7	10	10	10	**12**	0

Objectives

WP6 has three objectives:

1. Assess five European regions in terms of their maturity for the adoption of particular good practice in integrated care provision.
2. Identify strengths and weaknesses of the five European regions in the adoption of integrated care interventions (good practices).
3. Test the B3-MM as the tool enabling multi-dimensional comparison.

This WP builds directly on WP5 where the baseline and methodology for self-assessment was developed and tested. The outcomes of this WP will inform the WP7 Knowledge Transfer and WP3, WP5 and WP8 on the experience of five European regions with using the B3-MM in the self-assessment process.

Description of work

The work will be carried out through the completion of the following tasks:

T6.1 Self-assessment process in five European regions, M11-M13

Lead: NLL; Contributors: NHS 24, Kronikgune, Osakidetza, ARES PUGLI, FNOL

The objective of this task is to perform self-assessment in five European regions. The regions will be assessed in terms of their maturity for adoption of integrated care interventions (good practices). The regions will use the online self-assessment tool (with the B3-MM as the baseline measurement) developed in WP5 (D5.1). The consistency of the approach and use of the self-assessment tool is ensured through applying commonly agreed methodology developed and validated in WP5 (D5.2).

T6.2 Strengths and weaknesses of the European region in integrated care, M13-M15

Lead: NLL; Contributors: NHS 24, UEDIN, VUB, Kronikgune, Osakidetza, ARES PUGLI, FNOL

The objective of this task is to collect and analyse data from the self-assessment process. The comparison tables, graphs and radar diagrams will be developed for each region. Data will be analysed to identify strengths and weakness in integrated care in of each of the five regions. The analysis will be performed against each of the B3-MM dimensions. The outcomes of this analysis will inform about the maturity gaps of a particular regional health and care system in integrated care. The five European regions will be then clustered in terms of their complementary strengths and weaknesses to test to what extent SCIROCCO's approach of matching the regions with the same level of maturity speeds up the adoption and scaling-up of good practices.

T6.3 Methodology for twinning and coaching, M17-M19

Lead partner: NLL; Contributors: NHS 24, UEDIN, VUB, UVEG, Kronikgune, Osakidetza, ARES PUGLI, FNOL, Norbotten

The objective of this task is to develop the process and methodology for twinning and coaching activities of five European regions. The methodology will specifically guide the regions on how to use the B3-MM to facilitate the process of knowledge transfer and information sharing. Commonly agreed methodology tailored to the needs of participating regions will allow

consistency in the process of information flows across the European regions. Using the outcomes of T6.2 on clustering of regions with complementary strengths and weaknesses, the regions will be paired in such a way that the knowledge transfer will flow between the regions with the same strengths (twinning) as well as between the regions scoring high at particular dimension with the regions scoring low along the same dimension (coaching). The priorities for actions as defined in the Action Plans (D6.2) of five European regions will inform the selection of areas for twinning and coaching. The areas will reflect specific dimensions of the B3-MM

Task 6.4 Second Refinement of the B3-MM – M11-M17
Lead: UEDIN; Contributors: NHS 24, VUB, Kronikgune, Osakidetza, ARES PUGLI, FNOL, NLL
The objective of this task is to refine and consolidate the B3-MM as a tool to assess European health and care regions in terms of their maturity for the adoption of good practices.

Deliverables linked to this work package

D6.1 Guidance (process) for twinning and coaching (M19) – The manual describing how to use the B3-MM in the process of twinning and coaching to facilitate the knowledge transfer, including the examples of five European regions.

Milestones to be reached by this work package
M6.1 Initiation of self-assessment process in all five European regions (M11)
M6.2 Availability of self-assessment data for five European regions (M13)
M6.3 Completed identification of maturity gaps in five European health and care systems (M15)
M6.4 Second refinement of the B3-MM (M17)

Work package number	**7**									
Work package title	**Knowledge transfer**									
Starting month	M17			**Ending month**			M27			
Leading applicant	**Agenzia Regionale Sanitaria Pugliese (ARES PUGLI)**									
Applicants Number	1	2	3	4	5	6	**7**	8	9	10
Applicants Acronym	NHS 24	UEDIN	VUB	UVEG	Kronikgune	Osakidetza	**ARES PUGLI**	FNOL	NLL	EHTEL
Person month per applicant	10	2	2	4	5	5	**12**	10	10	0

Objectives
WP7 has two objectives:

1. Facilitate the process of scaling-up using the B3-MM in the twinning and coaching activities of the regions.
2. Test the B3-MM in real life settings to facilitate the process of information sharing and knowledge transfer across five European regions.

This WP builds on the findings of the maturity gaps in integrated care of five European regions (WP6) and will inform the WP3, WP5 and WP8 on the experience of regions with using the B3-

MM in the process of twinning and coaching to facilitate information sharing and knowledge transfer.

Description of work

The work will be carried out through the completion of the following tasks:

T7.1 Coaching and twinning, M17-M24
Lead partner: ARES PUGLIA; Contributors: NHS 24, UEDIN, VUB, UVEG, Kronikgune, Osakidetza, FNOL, NLL
The objective of this task is to facilitate the process of knowledge sharing and information flow among five European regions using the B3-MM to facilitate this process. The guidance (process) for twinning and coaching (D6.2) will apply for this purpose. One twinning and one coaching activity per region are envisaged. The twinning and coaching activities will be organised as face-to-face meetings, webinars and various other online tools.

T7.2 Action Plans – M24-M27
Lead partner: ARES PUGLIA; Contributors: NHS 24, Kronikgune, Osakidetza, FNOL, NLL
The objective of this task is to develop the Action Plans in each of the five European regions. The Action Plans will reflect the findings of the self-assessment process (D6.1) and will specifically focus on addressing the weaknesses in the maturity of particular regional health and care system. The Action Plans will inform the decision-makers about the priority actions necessary for improvement of their health and care systems. Using the good practices and knowing the maturity requirements for their adoption (WP4, D4.1 & D4.2) as well as the level of maturity of particular health and care system (D6.1), regions will be able to identify the solutions that fit into their implementation context and thus achieving adoption and scaling-up of good practices. The implementation of these Action Plans is not considered to be scope for the project.

T7.3 Final refinement of the B3-MM, M17-M27
Lead partner: UEDIN; Contributors: NHS 24, VUB, UVEG, Kronikgune, Osakidetza, ARES PUGLI, FNOL, NLL
The objective of this task is to conduct the final refinement of the B3-MM using the experience of five European regions with the B3-MM in the process of twinning and coaching activities (T7.1). As a result of this second testing, the final B3-MM will be provided as a tool that identifies, analyses and facilitates knowledge transfer of the multidimensional maturity requirements of good practices and health and care systems in order to achieve scaling-up. The tool will become available online for the potential users.

Deliverables linked to this work package

D7.1 Five Action Plans (M27) – The Action plan describes the concrete solutions in each of the five European regions to address specific weaknesses in their health and care systems.

Milestones to be reached by this work package

M7.1 Initiation of twinning and coaching activities in five European regions (M17)
M7.2 Final refinement of the B3-MM (M24)
M7.3 Five regions have completed their Action Plans (M27)
M7.4 Access to final B3-MM tool online (M27)

Work package number	**8**
Work package title	**Lessons learned and policy implications**

Starting month	M6			**Ending month**			M32			
Leading applicant	**University of Valencia (UVEG)**									
Applicants Number	1	2	3	**4**	5	6	7	8	9	10
Applicants Acronym	NHS 24	UEDIN	VUB	**UVEG**	Kronikgune	Osakidetza	ARES PUGLI	FNOL	NLL	EHTEL
Person month per applicant	2	2	2	**7**	2	2	2	2	2	4

Objectives

WP8 has four main objectives:

1. Collect lessons learned on the process of knowledge transfer using the B3-MM.
2. Inform decision-makers about the potential of the B3-MM to facilitate scaling-up and exchange of good practices in the provision of integrated care in Europe.
3. Analyse the role of policy in facilitating the knowledge transfer.
4. Support the preparation of the exploitation phase of the B3-MM as described in WP2.

The tasks carried out in this WP link closely with WP3, WP5, WP6 and WP7 on using the B3-MM in the process of knowledge transfer to facilitate scaling-up in the five European regions.

Description of work

The work will be carried out through the completion of the following tasks:

T8.1 Analysis of the experience of knowledge transfer, M6-M28
Lead partner: UVEG; Contributors: All

This task will be action-research oriented. The objective of this task is to monitor and analyse activities of WP5, WP6 and WP7 activities, when the B3-MM is used for testing purposes as well as in the process of self-assessment, and twinning and coaching. Its outcomes will inform the subsequent task of this WP and will feed the further refinement of the B3-MM as defined under the WP5, WP6 and WP7.

T 8.2 Main issues of scaling-up, M28-M30
Lead partner: UVEG; Contributors: All

The objective of this task is to identify main issues of scaling-up, using the outcomes of T8.1, and provide policy recommendations on how these issues can be overcome by using the B3-MM in the process of knowledge sharing. This will support the decision-makers interested in the B3-MM about the utility of the tool in facilitating the process of scaling-up and exchange of good practices across Europe.

T8.3 Policy Advisory Group, M16-M32
Lead partner: EHTEL; Contributor: UVEG

The objective of this task is to create a Policy Advisory Group of European NGOs (representing the stakeholder groups that have an interest in innovation in integrated care). It will start from a pre-existing working group of EHTEL, with the support of other European networks such as EIP on AHA, AER, IFIC, ERRIN, ECHA, EUREGHA and CORAL. It will be made up of representatives of regions, at European level; patients and informal carers; health and social care professionals and managers; health insurers. This group will meet two times during the second cycle of SCIROCCO. It will advise the project by developing policy-oriented activities and briefing papers (D8.1 and D8.2).

T8.4 Role of policy in facilitating knowledge-transfer, M7-M32
Lead partner: EHTEL; Contributor: All
The Policy Advisory Group created under Task 8.3 will review the outcome of Tasks 8.1 and 8.2. The objective of this task is to identify areas where policy support can act as an incentive or an accelerator for knowledge transfer using the B3-MM. Out of this analysis, the Group will derive policy recommendations and will present them to a policy-oriented audience during SCIROCCO's final conference, as defined under WP2.

Deliverables linked to this work package

D8.1 White Paper on the issues of scaling up (M30) - This White Paper contains lessons learned and policy recommendations on how to address the issues of scaling, including the role of policy in knowledge transfer, using the experience of five European regions with the B3-MM in the knowledge-sharing process.

Milestones to be reached by this work package

M8.1 Analysis of the experience of knowledge transfer is initiated by all partners (M6)
M8.2 Information on the experience of regions with the B3-MM is available (M28)
M8.3 Establishment of functioning Policy Advisory Group (M16)
M8.4 Presentation of lessons learned and policy recommendations at the SCIROCCO's final conference (M32)

Associated with document Ref. Ares(2016)1266959 - 14/03/2016

7.3. Timetable

Year	1												2												3							
Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32
WP1 Coordination of project																																
T1.1 Coordinator responsibilities																																
T1.2 Establishment of Consortium																																
T1.3 Consolidation of reports																																
T1.4 Financial management																																
Deliverables																		D														D
Milestones	M						M							M			M				M								M			M
WP 2 Dissemination and Exploitation																																
T2.1 Project website and branding																																
T2.2 Project leaflets																																
T2.3 Dissemination Strategy																																
T2.4 Project presentations																																
T2.5 Final conference																																
T2.6 Exploitation organisation																																
Deliverables			D			D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D	D
Milestones			M			M													M												M
WP3 Evaluation																																
T3.1 Validity & reliability of B3-MM																																
T3.2 Measuring of knowledge transfer																																
T3.3 Assessing implementation fidelity																																
Deliverables																														D		
Milestones				M															M													M
WP4 Maturity requirements																																
T4.1 Viability assessment of GP																																
T4.2 Data collection																																
T4.3 Maturity requirements																																
Deliverables						D																										

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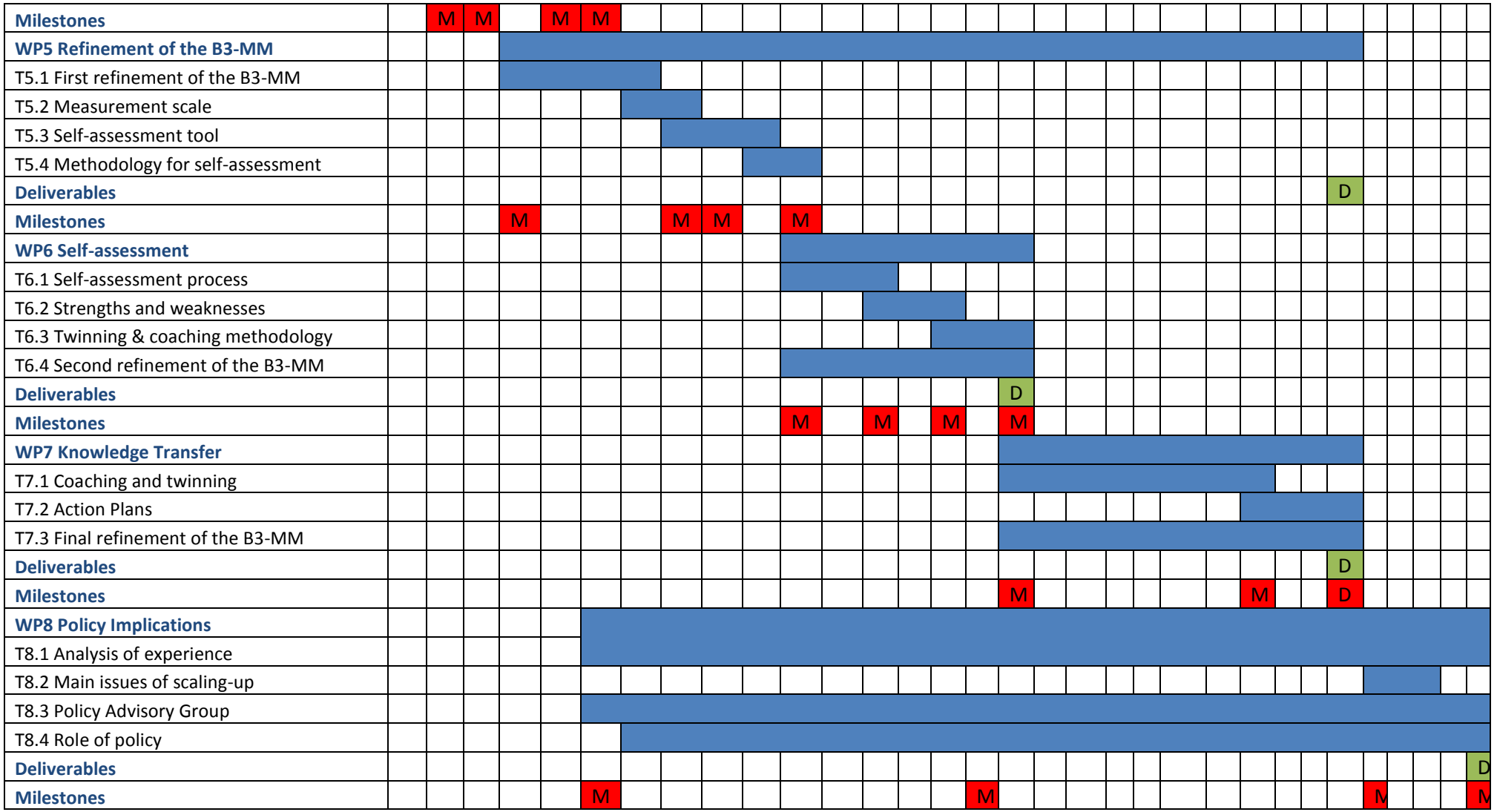

8. MILESTONES AND DELIVERABLES

Deliverable Number	Deliverable Name	Work package number	Leading applicant acronym	Content specification	Dissemination level	Delivery month
D2.1	Dissemination Strategy and Action Plan	WP2	EHTEL	The document that describes the Dissemination Plan and Strategy for SCIROCCO, including project branding, participation of all the project representatives in any regional, national or European dissemination activities and organisation of SCIROCCO final conference.	P	M6-M32
D3.1	Assessment level of knowledge transfer	WP3	VUB	The document that describes evaluation outcomes of the B3-MM as a tool to facilitate knowledge transfer.	P	M30
D4.1	Maturity requirements of good practices viable for scaling up	WP4	Kronikgune	This reports provides the contextual analysis of the requirements for the adoption of selected good practices.	P	M6
D5.1	SCIROCCO online assessment Tool	WP5	UEDIN	Online tool enabling multidimensional assessment to facilitate the implementation of good practices and scaling-up, including the manual for the European regions on how to use the B3-MM in the self-assessment process.	P	M27
D6.1	Methodology for twinning and coaching	WP6	NLL	The manual describing how to use the B3-MM in the process of twinning and coaching to facilitate the knowledge transfer, including the examples of 5 European regions.	P	M19
D7.1	Five Action Plans	WP7	ARES PUGLI	The Action plan describes the concrete solutions in each of the five European regions to address specific weaknesses in their health and care systems.	P	M27
D8.1	White Paper	WP8	UVEG	This White Paper	P	M30

Deliverable Number	Deliverable Name	Work package number	Leading applicant acronym	Content specification	Dissemination level	Delivery month
	on the issues of scaling up			contains lessons learned and policy recommendations on how to address the issues of scaling, including the role of policy in knowledge transfer, using the experience of five European regions.		
Mandatory Deliverables (MD)						
MD.1	Interim report	WP1	NHS 24	This report describes the activities carried out, milestones and results achieved in the first half of the project. The other project deliverables are annexed.	P	M16
MD.2	Final report	WP1	NHS 24	This report describes the project implementation and the results achieved. The other project deliverables are annexed.	P	M32
MD.3	Leaflet	WP2	EHTEL	A leaflet to promote the project will be produced at the beginning of the project.	P	M3
MD.4	Layman version of the final report	WP2	EHTEL	This is short report is a condensed version of the project final report, written for the interested public as a target group.	P	M32
MD.5	Website	WP2	EHTEL	This will be the project's website and will feature information about the project's vision, values and objectives, on-going progress updates and final outcomes / deliverables.	P	M3

9. PROJECT MANAGEMENT STRUCTURE

9.1. Organisational structure

SCIROCCO's project management structure is designed to create the optimum environment for the partners to efficiently carry out the project and meet the requirements of the CHAFEA Consortium Agreement. Proactive communications, early establishment of procedures and protocols, and prompt resolutions of issues will be the guiding principles of the project management and implementation. The SCIROCCO partners recognise the importance of good governance in delivering a successful project, and the need for a robust decision-making framework. There is a need to balance scientific and technical efforts with appropriate management capability in support of the project objectives, while maintaining performance in line with agreed Milestones and Deliverables. SCIROCCO implies a two-level management structure, which addresses the need for both consistency at project level and flexibility in the field. The upper level of management is responsible for the overall supervision of the project, while the lower level has the mandate to carry out the individual work packages and activities in the countries / regions. This in line with SCIROCCO's overarching objective as the majority of activities related to the facilitation of knowledge transfer, scaling-up and exchange of good practices will be carried out in the participating countries and regions. The following project management structure has been determined by the partners as providing the ideal framework for achieving rigour project performance and SCIROCCO objectives:

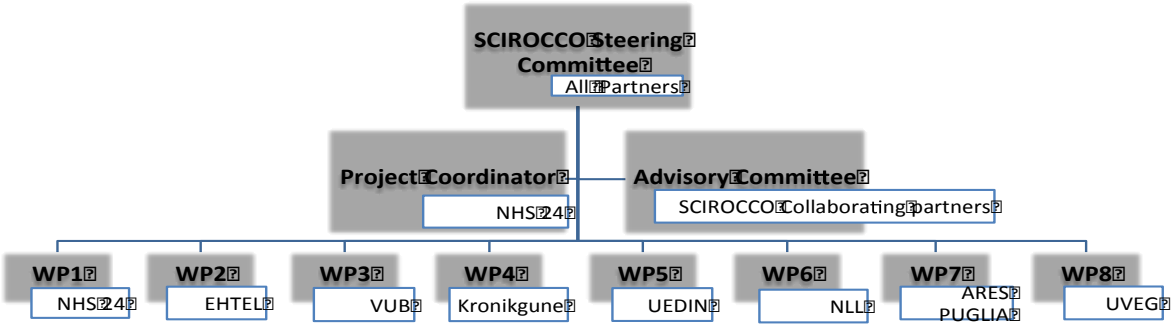

Figure 5: SCIROCCO's project management structure

Decision-making, monitoring and supervision of SCIROCCO project

The SCIROCCO Committee Group (SCG) will be the ultimate decision-making body comprising senior personnel from each partner creating a highly experienced and powerful leadership team. The SCG gives strategic guidelines to the Project Co-ordinator (NHS 24) and other members of the Project Management Team and steers the SCIROCCO project on the agreed achievement of its agreed objectives. The SCG will also address legal and financial issues emerging during the life-cycle of the project. It will evaluate and approve when appropriate, the candidature of additional collaborating partners of SCIROCCO consortium, scientific journals,

posters, presentations and other potential dissemination materials and activities. The SCG will meet bi-annually at the SCIROCCO Project Assembly meetings to discuss any emerging issues in the project. Alternatively conference calls will be arranged if urgent matters arise so that any problems are promptly and effectively resolved.

The SCG is chaired by the Project Co-ordinator (NHS 24) who represents the Consortium and communicates on its behalf with the European Commission. The Project Co-ordinator (NHS 24) will be directly responsible for communication with the European Commission including the submission of all technical, financial and commercial reports, contractual or any other issues. The Project Co-ordinator reports to SCG on the progress of the project and keeps the direct control of the project performance. The Project Co-ordinator (NHS 24) will be supported by the NHS 24 team for administrative and financial responsibilities and by SCIROCCO Evaluation Team (VUB) to provide the Quality Assurance of the overall project.

In addition, decision-making is supported by Work Package Leaders who are responsible for the detailed management of the work packages. This includes monitoring and control of work packages, production of work packages deliverables and contribution to other cross-cutting activities such as preparation of SCIROCCO meetings, presentations and other awareness-raising and dissemination activities.

Finally, a Project Advisory Committee (PAC) will be established at the project kick-off. The Committee will consist of experts and representatives of SCIROCCO collaborating organisations and networks (Part 11 of the proposal) to provide advice on the direction of the project and to validate, disseminate and promote SCIROCCO findings to increase its potential impact.

Communication Strategy

Effective internal communication will be central to monitoring SCIROCCO's progress, and has additional significance as a function of effective team building. All appropriate techniques for promoting good internal communication will be employed, including regular contact between the SCG, Work Package leaders and contributors, including:

- Weekly Project Management Team meetings via tele/video-conferences.
- Bi-weekly Work Package Team meetings via tele/video conferences.
- Bi-monthly SCG meetings via tele/video conferences.
- Face-to-face and/or teleconference meetings of all partners every 6 / 7 months.
- Circulation of agenda items, discussions and agreements at virtual and face-to face meetings.

In addition, the principle partner of each institution will produce a brief monthly report based on an agreed template, detailing general progress and any problems or risks arising with respect to the Project Work Plan (D1.1). These reports will be sent to the Project Co-ordinator at the end of each month. The partner reports will be consolidated and distributed to the partners by the Co-ordinator and stored a shared, digital storage place for download. Activity reports will contain (1) a management overview; (2) a description of the progress towards the project objectives; (3) identification of challenges and suggested corrective actions to be taken. In the case of notable divergence from the objectives of a WP, a detailed plan of action will be established between the Project Co-ordinator, the WP Leader, and the contributors of the WP concerned. If important scientific, technical or financial re-orientations are required, decisions will be made during the SCG meeting by consensus whenever possible, or if where necessary, and as a final resort, by a simple majority vote. All participants will be notified in advance of any proposed modifications to the work plan or budget allocations that are to be decided upon. Further conflict resolution measures will be defined and agreed in the SCIROCCO Consortium Agreement that will describe in details the rights and obligations of SCIROCCO partners.

9.2. Quality of the partnership

SCIROCCO builds on a sound partnership of stakeholders who share the project's common goals, are complementary to each other and are committed to deliver on SCIROCCO objectives. The quality of the SCIROCCO consortium rests upon:

Expertise of the partners

SCIROCCO's overall objective is to facilitate the implementation of good practices at local, regional or country level by recognising the maturity requirements of good practices and health and care systems in order to achieve scaling-up and knowledge transfer amongst European member states. The SCIROCCO consortium covers the entire value chain in underpinning this objective, including regional, technical, research and industry expertise. The consortium comprises four different types of players:

- *Regional health and social care authorities (NHS 24, Osakidetza, ARES PUGLI, FNOL, NLL)* – They provide SCIROCCO with rich expertise in the delivery of health and social care services in an integrated way to benefit citizens and wider communities. These authorities represent the "natural owners" of the good practices that are going to be exchanged and assessed for their potential adoption and scaling-up across Europe. In addition, these authorities are users of the B3-MM; and as such will be involved in testing and validation of the process of self-assessment of regional health and care systems and in knowledge transfer during the process of twinning and coaching. They are also key players in the process of scaling-up and implementation of good practices and solutions identified by SCIROCCO.
- *Research institutions and excellence centres (UEDIN, VUB, UVEG, Kronikgune)* – They provide SCIROCCO with a rich platform for academic excellence and innovation. SCIROCCO will benefit from the technical support of UEDIN in the process of testing and developing online B3-MM as a key tool to facilitate the scaling up and exchange of good practices in Europe. SCIROCCO will also benefit from the extensive expertise on different approaches to evaluation of VUB and UVEG to ensure a high quality evaluation of the process of knowledge transfer and utility of the B3-MM to facilitate the exchange of good practices and scaling-up. Kronikgune is an international excellence centre in research in chronicity and is one of the specialised regional entities in the design, implementation and assessment of regional policies and strategies in chronic care. SCIROCCO will benefit from Kronikgune expertise, specifically in relation to viability assessment and maturity assessment of local integrated care interventions and health and care systems that will be carry on as part of the project.
- *Industry (IBM)* – Through participation of IBM as SCIROCCO collaborating partner, project will benefit from in-kind support and expertise of IBM in the testing and development of the B3-MM tool. The IBM can add significant expertise in this process as the initial B3-MM was based on the findings from interviews with 12 European regions that were led by IBM as part of its commitment to the EIP on AHA's B3 Action Group on Integrated Care.
- *Membership organisation (EHTEL)* – SCIROCCO will benefit from EHTEL's extensive experience in dissemination and communication activities to secure the outreach of SCIROCCO's findings to its primary target groups but also a wide range of collaborating partners, including networks, end user organisations, NGOs, academia, industry and others. EHTEL will also contribute to SCIROCCO objectives to provide evidence-based policy recommendations on addressing the challenges of scaling-up and the role of policy in facilitating the knowledge transfer between regions. For this purpose, SCIROCCO will envisage the engagement with EHTEL's Policy Advisory Group. EHTEL will also contribute to SCIROCCO with its expertise in providing support services to exploit

the potential and sustainability of SCIROCCO deliverables beyond the timeline of the project.

In addition to the specific expertise of each of SCIROCCO;s partners as described above, the quality of the partnership is enhanced by common expertise and competences of SCIROCCO partners in integrated care and the scaling up local interventions through their active participation and commitment to the EIP on AHA. As an example, the partners' involvement in the B3 Action Group on Integrated Care is highlighted:

- NHS 24 - Professor George Crooks is the Chair of the B3 Action Group Co-ordination Group. Donna Henderson is lead co-ordinator of the Group. Andrea Pavlickova leads the specific work stream –Action Area 7 (AA7) on ICT and Teleservices where the concept of the B3-MM was initiated and developed.
- UVEG are active participants across various work streams of the B3 Action Group.
- Kronikgune is a member of the B3 Co-ordination Group and leads the specific work stream - Action Area 4 (AA4) on Risk Stratification.
- ARES PUGLI is a member of the B3 Co-ordination Group and leads specific work stream – Action Area 6 (AA6) Citizen Empowerment.
- UEDIN, EHTEL, and FNOL are the members of the AA7 ICT Co-ordinator group leading the work on the B3-MM.

The described expertise and contribution of SCIROCCO partners demonstrates the complementarity, commitment and shared goals of the participating stakeholders towards integrated care, scaling-up of innovative solutions and exchange of knowledge and expertise which is strongly in line with European Commission ambitions and objectives. The partners reflect SCIROCCO's ethos of working with multi-stakeholders to achieve transformational and change in European health and care systems by bringing together regional health and social care authorities, research and excellence centres, industry and membership organisations.

Previous working experiences and existing collaborations

There is a considerable level of existing collaborations and experiences already established between SCIROCCO partners. This underlines that the composition of the consortium is a result of solid relationships rather than coincidental inks. The existing relationships and interactions also help to secure the effectiveness of the consortium as partners know each other and can better understand and utilise the different assets, skills and expertise of other partners from all over Europe. Table 7 below illustrates some examples of previous and existing collaborations of SCIROCCO partners:

Table 6: Overview of previous and existing collaborations of SCIROCCO partners

PREVIOUS AND EXISTING COLLABORATIONS	SCIROCCO PARTNERS
ACT (Advancing Care Coordination and Telehealth Deployment) project[100]	NHS 24, Kronikgune
ASSEHS (Activation of Stratification Strategies and Results of the interventions on frail patients of Healthcare Services)[101]	Kronikgune, Osakidetza, UVEG, ARES PUGLI
CORAL	NHS 24, Kronikgune, ARES PUGLI, NLL, FNOL
EIP on AHA	NHS 24, UEDIN, UVEG, Kronikgune, ARES PUGLI, FNOL, NLL (via AER commitment), EHTEL

[100] http://www.act-programme.eu (Accessed 5 September 2015)
[101] http://assehs.eu (Accessed 5 September 2015)

PREVIOUS AND EXISTING COLLABORATIONS	SCIROCCO PARTNERS
ENGAGED Thematic network[102]	NHS 24, Kronikgune, EHTEL, ARES PUGLI
MasterMind[103]	NHS 24, Kronikgune, Osakidetza
MOMENTUM Thematic Network project	NHS 24, EHTEL, NLL
United4Health[104]	NHS 24, Kronikgune, Osakidetza, FNOL, EHTEL
CareWell[105] project (Delivery integrated care to frail patients through ICT)	Kronikgune, ARES PUGLI
Project Integrate	VUB

9.3. Capacity of the staff

A concise profile of the key staff involved in each partner is presented below.

Coordinator institution (1) – NHS 24

Competence, experience and leadership

NHS 24 is a Special Health Board providing and facilitating the development of national telehealth and telecare services across Scotland. The Scottish Centre for Telehealth and Telecare (SCTT) is part of NHS 24, and has been established to provide practical support and advice to Health Boards, Local Authorities and other key stakeholders across Scotland. NHS 24/SCTT act on behalf of the Scottish government to represent Scotland in Europe in digital health and care. NHS 24 has significant experience with the management and coordination of the European projects. To date, NHS 24 has been partner in several EU funded projects: United4Health, SmartCare MasterMind, UNWIRED Health, eSMART, ACT, CASA and MOMENTUM. NHS 24 is also currently the lead coordinator of the United4Health project. NHS 24 has successfully positioned Scotland at the centre of key stakeholder organisations and partnerships that shape the health, ICT and innovation agenda in Europe. NHS 24 is member of the following multi-stakeholder organisations: ECHA, EHTEL, EUREGHA, CORAL, HIMSS Europe, IFIC, European mHealth Task Force and EIP on AHA. The leadership capabilities of NHS 24 are demonstrated by its lead coordination role in the B3 Action Group on Integrated Care, a partnership of over 300 stakeholders across Europe. It also facilitated the award of 2 x 3-star EIP on AHA Reference Sites status for 2 Scottish active and healthy ageing good practice initiatives.

Key staff of coordinator

Professor George Crooks OBE, NHS 24 and SCTT Medical Director, is responsible for the delivery of all NHS 24 clinical services and the development of new services in partnership with other NHS organisations. Since April 2010, Professor Crooks has also been accountable for the Scottish Centre for Telehealth and Telecare. He was a General Practitioner in Aberdeen, Scotland for 22 years and his past appointments include Director of Primary Care with NHS Grampian with responsibility for all community-based independent contractor services. Professor Crooks' responsibilities include the use of technology to support the delivery of high quality patient care to the population of Scotland. Professor Crooks is the President of EHTEL and Chair of Board of the Digital Health Institute in Scotland. George will oversee the strategic direction of SCIROCCO project.

Donna Henderson, SCTT Interim European Engagement Manager, has over 25 years' experience in project / programme management, strategy and policy development in health and social care. She currently leads the NHS 24/SCTT European engagement activities and manages the SCTT European portfolio, which includes taking the role of lead coordinator of the

[102] http://engaged-innovation.eu (Accessed 5 September 2015)
[103] http://mastermind-project.eu/partners/kronikgune-spain/ (Accessed 5 September 2015)
[104] http://united4health.eu (Accessed 5 September 2015)
[105] http://www.carewell-project.eu/home/ (Accessed 5 September 2015)

United4Health project. Donna also leads the Telecare work stream of the new £30m Scottish Government Technology Enabled Care Programme which aims to increase the number of people using telecare in Scotland. At a European level, she co-ordinates the EIP on AHA B3 Action Group on Integrated Care. Donna will oversee the management of SCIROCCO project, including chairing of SCIROCCO Project Advisory Committee and will represent the project to the European Commission.

Dr Andrea Pavlickova, SCTT European Engagement Manager, has over 4 years' experience in the management and coordination of the European projects focusing on the deployment of teleservices and integrated care in Europe. She is a coordinator of the B3 Action Group on Integrated Care, leading the specific work stream AA7 on ICT and Teleservices. Andrea is also experienced in the management of EU projects: Self-Care project, Momentum and ACT. She studied at the University of Matej Bel in Slovakia where she was awarded MA and PhD in International Relations and Diplomacy. Andrea also continued her studies at the University of Northern British Columbia (UNBC) in Canada focusing on International Development. Andrea will be responsible for the day-to-day management of SCIROCCO project.

Morag Keith, NHS 24 European Finance Manager, is an experienced senior manager with more than 20 years' experience in operational and financial management of European funded projects, covering a variety of funding streams. Morag holds a Masters in the Management of EU Funds from the Academy for Taxes, Economics and Law in Berlin. Morag will oversee all aspects of the financial management of the SCIROCCO project.

Victoria Hunter, SCTT European Project Coordinator, is an **e**xperienced project coordinator with over two years' experience in coordinating European funding projects, proven experience in financial management of EC funded projects and coordination of partners. Victoria will facilitate effective communication and co-ordination between SCIROCCO partners and NHS 24, as project coordinator, to ensure the effective management of the project.

Participant organisation (2) – UEDIN

Competence, experience and leadership

The University of Edinburgh (UEDIN), School of Informatics contributes 10% of the UK's world-leading research in Computer Science and Informatics. It delivers more internationally-excellent or world-leading research than any other UK University. In the last UK Research Assessment Exercise it led the tables in terms of numbers of world-leading and internationally competitive researchers by a substantial margin. The University of Edinburgh also supports one of the UK's most thriving technology transfer organisations which provides dedicated support for commercialisation, entrepreneurialism and technology transfer. Over the last year, the Scottish Funding Council has established four new Innovation Centres with relevance to health and care. University of Edinburgh is involved in all four and leads on two: Sensors (with a focus area in medical sensors) and Stratified Medicine, Data Science (with a focus on health date). University of Edinburgh also engages in various European networks and projects, most notably the EIP on AHA and B3 Action Group on Integrated Care where UEDIN is member of the coordinators group of the AA7 ICT and Teleservices Action Area.

Key staff of participant

Stuart Anderson, is Deputy Head of School of Informatics at the University of Edinburgh. His research is in the area of safety, trust and the dependability of socio-technical systems with a particular focus on health and care delivery systems and the role of social computation in transforming the nature of work in health and care delivery systems to systems based on co-production. This is a highly interdisciplinary area and he works extensively with social and organisational scientists. Recent projects focussed on supporting training activities in radiology, the role of trust on health settings and joint work with the World Health Organisation on disease control systems. Current projects focus on social computation and on innovation in the delivery of health and care.

Participant organisation (3) – VUB

Competence, experience and leadership

Vrije Universiteit Brussel (VUB) is one of the leading universities in Belgium. The Faculty of Medicine and Pharmacy offers a broad range of health sciences undergraduate programs and several post-graduate courses. Researchers conduct high standing research in the domains of chronic care, integrated care, end-of-life care, diabetes, medical imaging, neurology and public health and have a widespread network offering collaboration with several universities in Belgium, Europe and other continents. The Department of Family Medicine (HUIS), established in 1986, runs research on chronic and integrated care, cardiovascular prevention, diagnostic testing, chronic obstructive pulmonary disease, stroke and access to healthcare and end-of-life care. VUB, specifically the HUIS, has a broad experience via the collaboration with the European Union's Seventh Framework Programme for Research, Technological development and Demonstration under Grant Agreement n°305821 (PROJECT INTEGRATE: Benchmarking Integrated Care for better Management of Chronic and Age-related Conditions in Europe) where HUIS hold responsibility for the WP on policy recommendations. HUIS serves as National Expert Centre to the FP-7 Project IMPLEMENT (www.eu-implement.eu). HUIS is also a long-term partner to the World Health Organization (WHO) as they contribute substantially to the development of the global and European strategies on people-centred and integrated care. From that experience HUIS can bring together policy relevant evidence and provide recommendations and policy options to policy makers in order to foster the integration of care.

Key staff of participant

Bert Vrijhoef, is Professor of Care Coordination at the Medical School of the University of Brussels, Belgium and Professor of Health Systems and Policy at the School of Public Health at National University of Singapore. He is Senior PI at Tilburg University and Maastricht University Medical Center, the Netherlands. He leads multiple studies about care coordination, E-health, advanced nursing, and redesigning health care delivery and advises the Dutch Ministry of Health, Sports and Welfare. He was a consortium partner of EU project DISMEVAL (2008-2012) and is consortium partner of Project INTEGRATE (2012-2016). He has authored over 190 scientific publications and was awarded by various organizations for his teaching and research work incl. the Commonwealth Fund (US). Professor Vrijhoef is Editor-in-Chief of the International Journal of Care Coordination (SAGE). He has a PhD in Medical Sociology from Maastricht University and a MSc in Health Policy and Management from Erasmus University Rotterdam.

Dr Liesbeth Borgermans has teaching position as a Professor of Chronic Care within the Medical School of the University of Brussels (Department of Family Medicine and Chronic Care). Her field of expertise is on health services research with an emphasis on chronic and integrated care. She is a member of the Board of the International Foundation for Integrated Care and a Project partner for the FP-7 EU Project Integrate. Liesbeth currently supports both WHO Europe and WHO global with the development of their strategies on people-centred and integrated care and acts as an advisor to the Federal Ministry of Health in Belgium. Liesbeth holds a Master's degree in Medical-Social Sciences & Hospital Management and a PhD in Medical Sciences, Catholich University Leuven.

Junior researcher: to be appointed.

Participant organisation (4) – UVEG

Competence, experience and leadership

Polibienestar (UVEG) is a Public Research Institute belonging to the University of Valencia. It consists of an **interdisciplinary team** with 24 senior and 18 junior researchers with national and European experience in **health and social policies** combining researchers from various disciplines such as medicine, psychology, economics, sociology, social work, political science and law among others. This allows to carry out interdisciplinary research, innovation and social

technology, technical advice and training in the field of public policies and assessment. Polibienestar also advises the Administration and private entities in the design, planning and implementation of health and social policies and services. Polibienestar has a broad experience in cooperation and participation in European networks such as EIP on AHA: the B3 Action Group on Integrated Care and the D4 Action Group on Age Friendly Communities where Polibienestar leads the ICT group. Other relevant projects include: APPCARE, Urban Health Centre 2.0, ASSEHS, AFEINNOVET, CAP4ACCESS, HOST. Polibienestar has strong leadership position and capacity to carry out number of activities such as (a) policy recommendations and guidelines to advice policy makers in different topics, especially in the promotion of integrated care and healthy ageing; (b) use of different assessment tools of health and care systems; (c) identification, analysis and evaluation of policies, programmes and interventions; (d) detection, design and assessment of good practices and initiatives in the field of active an healthy ageing, integrated care and independent living.

Key staff of participant

Prof. Jorge Garcés Ferrer is Full Professor of Social Policy, director of the Polibienestar Research Institute and Prince of Asturias Distinguished Visiting Professor at Georgetown University (Washington, DC, USA), Guest Professor at the University of Innsbruck (Austria) and at Erasmus University of Rotterdam (The Netherlands) and Guest Researcher at the Universities of Washington, Oxford and Cambridge. His research has been focused on Comparative Social Policy in Europe, especially on ageing and social innovation and on the increase of efficiency and effectiveness of long term care policies in Europe.

Estrella Durá Ferrandis is PhD in Psychology by the University of Valencia (1989) and has a Specialist degree in Clinical Psychology. Currently, she works as a Professor at the Department of Personality, Evaluation and Psychological Treatment of the University of Valencia. Her researches have been focused on the field of health psychology, specifically on topics related to health promotion, disease prevention and psychosocial implications of chronic diseases. She has received funding for R & D projects from both the National and the Autonomic Plans and has experience in European projects.

Elisa Valía Cotanda has a degree in Architecture by the Universidad Politécnica de Valencia (2008), an Executive Master Degree in Innovation by the Industrial Organisation School in Madrid (2012) and a Master Degree in International Studies and European Union Studies by the Universitat de València (2014). In Polibienestar she participates in research projects at European level related to the design and implementation of public policies aiming at increasing the sustainability, efficiency and effectiveness of health systems, improving the quality of life of older people and advancing in the integration of health and social care systems. She is doing her PhD on an innovative model for management of frail patients after hospital discharge.

Participant organisation (5) – Kronikgune

Competences, Experience and leadership

Kronikgune is the research centre created by the Department of Health and Consumers Affairs of the Basque Country (Spain) as part of the regional Strategy to Tackle the Challenge of Chronicity in this region. It is one of the specialised regional entities in the design, implementation and assessment of the regional policies and strategies in chronic care. Kronikgune is an international excellence centre in research on chronicity, entrusted with institutional representation on international projects and actions aimed at developing products and services and their deployment for the whole Basque population (2,2M inhabitants). Kronikgune evaluates and demonstrates innovative pilot activities in order to assess their efficiency and their capacity to be scaled up throughout the Basque Health System (Osakidetza). Kronikgune has a clear international vocation aiming to establish interregional partnerships with other European regions, emphasising knowledge oriented to the implementation and extension of products and services in any health system. Kronikgune is well experienced with the coordination and management of the European projects: ASSEHS, ACT, EIP on AHA (B3 Action

Group on Integrated Care), CareWell, MasterMind and United4Health.

Key staff of participant

Esteban de Manuel Keenoy, MD University of Navarra, holds a Master degree in Community Health, University of London and a Specialist degree in Family Medicine, Autonomous University of Madrid. He has been Regional Director in Andalucía (Spain) of Primary Health Care and Health Promotion and later, Academic Director of the Andalucian School of Public Health. From 2003, he was CEO of the Institute of Health Sciences of Aragón (Spain), and responsible for health R&D and knowledge management. Since July 2011, he is in charge of KRONIKGUNE, the Basque Centre for Health Services Research and Chronicity set up by the Basque Government to study ageing, chronic diseases and healthy living. He has been involved in national and international projects advising on public health and health systems development. His main expertise is on strategic management, human resources development and knowledge management in health services and research.

Joana Mora Amengual, Pharmaceutical by University of Barcelona, she holds a Master's degree in Integrated Care Health Management at Esade Business School (Barcelona) and a Master in Pharmaceuticals Company Management at University of Barcelona. From 2011 until now, she has been Project Manager in KRONIKGUNE. She has been involved in the system-wide reform towards integrated care, focused specifically in defining the new funding and commissioning model in the Basque Country and bottom-up innovation.

Lucia Prieto Remon holds a degree in Business Management from the Basque Country School of Economics and is trained in health economics by the Loyola Leadership School. She worked for the Basque Health Department Research and Innovation Foundation from 2012 until November 2013, when she joined Kronikgune.

Sara Ponce holds a PhD in Pharmacy at the University of the Basque Country and Master degree in Innovation and Technology management at the Faculty of Humanities of the University of Deusto. She has worked as researcher in national (University of Basque Country, Inasmet-Tecnalia), and international research centres (Groningen University, Johns Hopkins University). She joined Kronikgune in November 2013 working as project manager of European projects.

Participant organisation (6) - Osakidetza

Competence, experience and leadership

Osakidetza is the public healthcare system of the Basque Country, a region located in the north of Spain. Osakidetza was created by the Health Department of the Basque Government in 1983. All the public hospitals and primary care of the Basque Region are under this organisation. Osakidetza has experience with the management of the European projects, mainly through its participation in United4health, MasterMind and ASSEHS project.

Key staff of participant

Josu Xabier Llano Hernaiz MD, Head of Unit "e-health projects" in Osatek, a public company within Osakidetza. In recent years he has been engaged in the design, development and deployment of the multi-channel service platform "Osarean" in the Basque Public health system. Osarean comprises a basket of ICT based services for the population, i.e. a patients' portal, on-line health advice or access to clinical information through a personal health folder. He is currently working on the implementation of several telemonitoring services (COPD, cardiac disease) and on-line education and monitoring of bipolar patients. He actively participates in international projects focused on promoting patient interaction with the healthcare system through ICT and patient empowerment by accessing clinical information.

Begoña Gomez Bravo, has a degree in Biological Sciences at the UPV/EHU and Master in Health Administration from the National School of Health. Attached to the Directorate of Health Care of the Central Organisation Osakidetza since 2009, she is a member of the design, development and implementation team of the Osarean multichannel platform, and is responsible for several project areas: Web Portal, Appointment, Active Patient Dashboard and Health Folder. She also

has experience in the management and implementation of the European projects: SUSTAINS and UnitedforHealth.

I**gor Zabala Rementería,** has degree in Psychology and Master in Human Resources and Postgraduate in training programmes. He is currently Head of the Health Care Integration and Chronicity Service. From 2010-2015, he was member of the Office for the Strategy of Chronicity in Basque Health Service. His expertise goes with human resources development and knowledge management in health services as on the design of training programmes, especially for clinicians.

Alfonso Casi Casanellas is a family doctor in Osakidetza, Lakuabizkarra Health Centre, Vittoria-Gasteiz. He is member of the Development and Implementation Team of the Osarean multichannel platform, being responsible for a basket of ICT based services for the population, including the patients' portal, on-line health advice and access to clinical information through a personal health folder.

Participant organisation (7) – ARES PUGLI

Competence, experience and leadership

Ares Puglia (ARES PUGLI) is the technical support of the Regional Government's Healthcare Department. Together with Health Districts and Hospital Trusts it is responsible for organising healthcare services of the entire region in order to guarantee the adequate delivery of services. Ares Puglia has substantial experience with management of the European projects. Ares Puglia was in charge of running the EU programme Interreg IIIA – Italy- Albania Axe II – Environment and Health – 2.2 Healthcare System. Currently involved in three EU projects submitted under the FP7 Framework, CIP and Health programmes, namely: Credits4health, CareWell and ASSEHS. Those projects all tackle relevant issues in EU strategies and priorities in the field of health and wellbeing such as health promotion, management of chronic patients, ICT and sustainability of healthcare systems and risk stratification. Ares Puglia also coordinates the B3 Action Group on Integrated Care's work stream on Patient Empowerment (AA6). Ares Puglia has a track record of leadership skills - it leads specific projects to guarantee the clinical governance of the Regional Healthcare System, including the implementation of an integrated approach to chronic patients according to the Chronic Care Model. Ares Puglia also represents Puglia Region in the "Interregional group on Health" in the Committee of the Regions, in which Ares Puglia stands in the Executive Bureau.

Key staff of participant

Elisabetta Anna Graps MD is specialist in Public Health and Preventive Medicine, with a background in in epidemiology, hygiene and hospital organisation, quality and appropriateness assessment, management and analysis of health information flows to support top management strategies in healthcare service organisation. She is the Head of Department of "Health Services Performances Assessment" at Ares Puglia and is coordinator of HTA Regional Group. She is a member of the Italian HTA network (RiHTA) under the National Healthcare Agency (Age.Na.S.) coordination, and works in different interregional groups to produce HTA and horizon scanning reports. She is also a scientific manager and member of scientific committees at a regional level in different European projects.

Francesca Avolio has a legal background with specific competence in the management and organisation of the healthcare service. She is responsible for the "Service for Health Internationalisation" and management of relationships with the EU. As manager of the "Accreditation, Quality and Research" Department at Ares Puglia, she supports senior management in procedures related to health service planning to guarantee the essential level of healthcare delivery. She is a Qualified Lead Auditor and responsible for the Quality Assessment of healthcare delivery at a regional level. She is a member of the Regional Commission accountable for the implementation of the Integrated Chronic Care Model in Puglia, also known as the "Care Programme" where she works on the definition of policies and strategies to tackle health inequalities. She is a member of the Executive Bureau of the Interregional Group on

Health in the Committee of the Regions in Brussels. She is committed to the B3 Action Group on Integrated Care and currently manages three EU projects submitted under FP7 framework, CIP and Health programme: Credits4health, Carewell and ASSEHS.

Participant organisation (8) – FNOL

Competence, experience and leadership

The University Hospital Olomouc (FNOL) is a major regional hospital providing general and specialised healthcare services. They are, in particular, focusing on telemonitoring of patients with advanced failure or heart infarct. The aim is to improve the health conditions of the target populations. FNOL is a Reference Site of the EIP on AHA and has been rewarded by EC for its excellence in innovation. FNOL is also active member of the B3 Action Group on Integrated care and the CORAL thematic network. FNOL has also experience with the management of large scale deployment projects such as United4Heath.

Key staff of participant

Zdeněk Gütter in experienced in the development and implementation of new eHealth projects for patients and hospitals in the Czech Republic and, consequently, he manages implementation teams. He carries out these activities in collaboration with Palacký University Olomouc, where he participates in projects regarding implementation of eHealth methods and establishing partnerships and cooperation in the field of telemedicine.

Miloš Táborský is Head of the First Department of Internal Medicine-Cardiology, responsible for management of the cardiology department where he aims to implement innovative methods in cardiology, particularly telemedicine. He is a professional guarantor of projects aimed at partnership and cooperation in telemedicine, establishment of Czech National eHealth Centre, implementation of eHealth methods into medical disciplines educated at the University and the creation of a new online interactive textbook of cardiology.

Tomas Kara, M.D., PhD is Vice-Chair for Research and Development at Department of Cardiovascular Diseases of University Hospital Olomouc in Czech Republic. He has a special research interest in development of new methods/technologies for cardiovascular diseases treatment and diagnostics.

Participant organisation (9) – NLL

Competence, experience and leadership

The **County Council of Norrbotten (NLL)** is a public elected body and is the main provider of health care, including primary health care in the county of Norrbotten with a population of about 240.000 inhabitants. The Council has substantial experience of EU funded programmes, including: FP 6 project Cogknow; Interreg III A projects Cross-border dental care and e-Home HealthCare@North Calotte; InterReg IV A project Borderless Care; Interreg IV C project Regional Telemedicine Forum; CIP PSP LSP projects Renewing Health and SUSTAINS; and the CIP PSP project MOMENTUM. The Council has also been the lead partner for the NPP projects MyHealth@Age and lately Remodem (2012-2014). In addition, the Council has been the lead partner in many regional development projects funded by the regional ERDF programme and other national development projects.

Key staff of participant

Lisa Lundgren is the Project Director for the Development Department of Norrbotten County Council with e-health and innovation as primary areas of responsibility. Areas of expertise include project development, implementation and steering. Ms. Lundgren will focus mainly on the project steering as well as implementation and dissemination of results related to this project.

Gustav Söderlund is the E-health Strategic Officer at Norrbotten County Council, Sweden. He has a background in product design, developing consumer electronic products in Europe and

Asia. Gustav holds an MSc in Ergonomic Design Engineering from Luleå University of Technology.

Elisabeth Eero is an Operations Manager of Primary Care in Norrbotten County Council. She also holds the title of process manager for the Council in the area of rural medicine. Her work focuses on distance spanning integrated care and the implementation of virtual care rooms.

Mari Huhtanen is Advanced Clinical Nurse supporting the work of Ms. Elisabeth Eero in the implementation of rural medicine solutions. She focuses on at home care solutions specialising in geriatrics and new approaches in home care reducing unnecessary transportation of patients in home care settings.

Carina Jenslid is a Controller at the Department of Finance and Planning at the County Council of Norrbotten. She has specialist knowledge in the area of budgeting, monitoring and financial reporting of EU projects in many different application areas.

Ulf Bergma is the Director of Primary Care in the Luleå/Boden primary care area with approximately 100 000 inhabitants, and operates seven clinics for specialist care within psychiatry, internal medicine, geriatrics and rehabilitation as well as 13 primary health care centers in Luleå and Boden

Participant organisation (10) – EHTEL

Competence, experience and leadership

EHTEL is an association that brings together a wide range of stakeholders crucial for the improvement of health and social care with health IT. EHTEL provides its 60+ corporate members with a platform for information, representation, networking and co-operation. With EHTELconnect (www.ehtelconnect.eu), the association draws on the expertise of EHTEL's highly experienced and multi-stakeholder membership to offer expert advice and educational services to individuals and organisations working in the field of digital healthcare. EHTEL is experienced in the coordination and management of, and engagement with, the European networks and projects: MOMENTUM Thematic Network, ENGAGED, EIP on AHA B3 Action Group on Integrated Care. EHTEL is the leading forum for decision makers and doers in Europe, engaged in supporting the transformation of the health care practice in Europe through eHealth.

Key staff of participant

Marc Lange has a 20+ years' experience in project and programme management of international/European projects in social security, eGovernment and eHealth. His experience covers domains such as (1) supporting EU Member States and the European Commission in coordinating the deployment of their national projects, (2) facilitating sharing good practices in a multi-disciplinary environment, (3) observing, analysing and synthesising the progresses of this knowledge sharing process (4) contributing to policy definition for deploying innovative ICT services for the health care sector, in particular. Thanks to this experience and his Secretary General position in EHTEL, he has a global understanding of the state of affairs in eHealth in Europe and beyond.

Dr Stephan Schug, MD, MPH, acts as Chief Medical Officer of EHTEL and has a long track record in European eHealth and telemedicine with a focus on innovation, interoperability and integrated care. Stephan has been involved in strategic European telehealth projects like RENEWING HeALTH (Coordinator of the User Advisory Board), United4Health and MOMENTUM. Likewise he engages in activities related to interoperable and patient driven eHealth services like e.g. CALLIOPE, eHealth Governance Initiative, SUSTAINS and Antilope.

Diane Whitehouse: Diane holds the position of Principal eHealth Policy Analyst in EHTEL. Since 2008, she has concentrated on the areas of policy development, stakeholder engagement and telehealth. She is currently involved in the United4Health and VALUeHEALTH projects. Until 2007, Diane was a Scientific Officer in the 'ICT for Health' Unit of the European Commission's General Directorate CNECT. Diane is a social scientist whose work focuses on the social, organisational, and ethical aspects of ICT: her several books in this field are well-known.

Myriam De Greef has extensive expertise in managing communication programmes and is a savvy event organiser, for both the private and public sectors. She has organised many ICT events, including eHealth, eInclusion and eGovernment Ministerial conferences while working at the European Commission. At EHTEL, Myriam organises various workshops and conferences and liaises with the EHTEL community, with a special focus on social networks.

9.4. External and internal risk analysis and contingency planning

The SCIROCCO consortium recognises the following potential external and internal project risks:

Identified Risk	Likelihood	Impact	Contingency planning
Bankruptcy of one of the beneficiaries.	L	H	The Consortium Agreement mitigates the risk.
Serious underperformance of one of the beneficiaries.	L	H	The Consortium Agreement mitigates the risk.
Withdrawal of partner	L	H	The Consortium Agreement mitigates the risk.
Motivations to scaling-up and exchange of good practices can change in the participating regions.	L	H	The potential new partner/regions for the collaboration will be identified to mitigate the risk.
The B3-MM will not show the anticipated benefits.	M	H	Three refinements of the B3-MM based on the experience of five European regions to mitigate the risk.
Development of the B3-MM tool takes more time than planned.	M	H	Flexibility of the Project Plan mitigates the risk. Tasks that do not directly depend on the tool can be prioritised.
Maturity of regions and good practices too heterogeneous to allow coaching and twinning.	M	H	Involvement of new collaborating regions is envisaged to mitigate the risks. A number of regions participating in the EIP on AHA have already expressed an interest to test the B3-MM in the process of twinning and coaching.
Experience from regions too heterogeneous to draw meaningful lessons learned.	M	H	Preliminary work of EIP on AHA on collection and analysis of good practices in integrated care and other EU initiatives mitigate the risk.
Target group is harder to reach than foreseen	M	H	Identification of champions at local, regional and European level to canvas the support for SCIROCCO findings at the start of the project mitigate the risk.
Insufficient interest in participating in Final Conference or other SCIROCCO dissemination activities.	M	H	Advanced, timely planning of the events, stimulating programme, engagement of the partners in the preparation of the dissemination activities mitigate the risks.

9.5. Financial management

Acting as the point of contact between the EC and the consortium, distribution of the financial contribution, reviewing and approval of all reports and deliverables including financial claims will be performed by the Project Coordinator (NHS 24). NHS 24 will work closely with the finance departments of the participating organisations to ensure that all budget related actions are performed correctly and within the rules and regulations set out by the Commission and the Consortium Agreement. This includes the establishment of safe, effective operating procedures for financial management adapted for the financial system of each partner to ensure that received funds are correctly distributed and accounted for and that cost statements are received and appropriate audits are undertaken. The Project Co-ordinator (NHS 24) will manage and facilitate any necessary decisions regarding any re-allocation of budgets between beneficiaries in consistent with the details agreed in the Consortium Agreement.

10. BUDGET

10.1. Content description and justification

The SCIROCCO budget has been constructed based around the extensive and deep skills available within the consortium of partners and their complimentary alignment with the aims and objectives of the proposed work. Table 7 shows the distribution of efforts to each of the SCIROCCO's work packages. The highest proportion (nearly 50% of the budget) of the human resources are directed to WP6 and WP7 as self-assessment, twinning and coaching processes are essential activities to deliver on SCIROCCO objectives. These include the actual self-assessment process in 5 European regions, data collection and identification of maturity gaps, development of regional Action Plans to address these gaps as well as finalisation of SCIROCCO online tool. It is therefore envisaged that these work packages will require substantial inputs and time of SCIROCCO partners as well as high level of interactions with other WPs, e.g. WP2, WP3 and WP5. The efforts to the activities of maturity assessment of good practices (WP4), documenting the key lessons learned across the EU regions (WP8) and the development and validation of SCIROCCO tool (WP3 and WP5) are well balanced. Approximately 12% of budget is allocated to the evaluation activities of SCIROCCO project (WP3) which will be carried out throughout the entire duration of the project. The work for evaluation activities is reflected in 3 major streams: (a) testing validity and reliability of B3-MM; (b) measuring of knowledge transfer; (3) assessing implementation fidelity of SCIROCCO. In every stream, separate data will be collected and analysed by means of various methods. The collection and analysis of qualitative data are time consuming. The requested EC 60% support of the budget is shared evenly across all the partners evidencing the institutional support for this important work.

In order to ensure the SCIROCCO work is truly integrated and provide the necessary opportunities to discuss and disseminate its progress and findings, 13% of budget has been allocated for travel to consortium meetings, and joint workshops. Over the 32 months of the SCIROCCO project there will be a kick-off meeting, held in Luxembourg, 4 Project Assemblies to ensure collaborative working within the consortium, locations to be confirmed and a final conference, to be held in Brussels, to disseminate the final results. As the location of the Consortium meetings has yet to be decided, the budget for this activity has been allocated to NHS 24 as SCIROCCO Project Co-ordinator and as such will be arranged by NHS 24. The allocation of the budget for the final conference has been allocated to EHTEL due to their proximity in Brussels and policy expertise. There is an expectation that regional partners will have a maximum of 4 people attending project meetings, EHTEL will have a maximum of 2 persons attending and Universities likely to have 1 in attendance, up to a maximum of 2. The travel budget has been increased for NLL, this is due to the travel costs for the region being

significantly higher due to their remote proximity. This increase in budget will allow for fully coordinated working with partners, ensuring that expertise is transferred at EU level.

There will also be additional twinning and coaching activities undertaken within the project, the project month allocation and travel budget is representative of this requirement. This activity will require a minimum of 10 face-to-face meetings of the partner regions who will pair to allow facilitation of the twinning and coaching. The process of scaling-up contains interaction between transferring and adopting region, including intensive communication with the aim to transfer right information, build trust and confidence, and to collect data in order to manage, evaluate and ensure continuity of scaling-up process beyond duration of SCIROCCO project.

Other costs have been have been allocated NHS 24 as Project Co-ordinator for development of the final SCIROCCO tool for use within the project and production of the final tool.

Project branding, the website, including leaflet and further dissemination material will be managed by WP2 as such additional costs have been allocated to EHTEL as WP2

10.2. Summary of staff effort

	WP 1	WP 2	WP 3	WP4	WP5	WP6	WP7	WP8	Total PM
1 NHS 24	**7**	2	1	4	1	10	10	2	37
2 UEDIN	1	1	0	0	**12**	2	2	2	20
3 VUB	1	1	**20**	0	2	2	2	2	30
4 UVEG	1	1	7	0	0	0	4	**7**	20
5 Kronikgune	1	1	1	**10**	1	7	10	2	28
6 Osakidetza	0	1	0	4	1	10	10	2	23
7 ARES PUGLI	1	1	1	4	1	10	**12**	2	32
8 FNOL	0	1	1	4	1	10	10	2	29
9 NLL	1	1	1	4	1	**12**	10	2	32
10 EHTEL	1	**7**	0	0	0	0	0	4	12
Total PMs	**14**	**17**	**32**	**30**	**20**	**63**	**60**	**27**	**263**

10.3. Detailed budget

Applicant Number/ Short Name	**1/ NHS 24**		
(If affiliated entity: Affiliated to which Applicant number/Short name)	NA		
(A) Direct personnel costs			
Staff function	**Monthly Cost**	**Estimated Person-month**	**Sum Cost (€)**
European Service Development Manager	**€6103**	**30.0**	**€183,090**
Project Manager/ Project Coordinator	**€6103**	**7.0**	**€42,721**
		Total person month	**Total Costs (€) for (A)**
		37.00	**€225,804**
	Justification		
	NHS 24 will act as Co-ordinator for SCIROCCO providing overall project		

	management, support to Consortium and act towards EC as the main representative of SCIROCCO (WP1). NHS 24 will also support dissemination activities of SCIROCCO (WP2). NHS 24 coordination and management of local health and social care authorities to ensure the inputs for WP4, WP6 and WP7.	
(B) Direct costs of sub-contracting	**Costs (€)**	**Task(s)/Justification**
	€0	NA
Total Costs (€) of (B)	**€0**	
	Justification	
(C) Other direct costs		
(C.1) Travel	**Costs (€)**	**Justification**
	€30,000	Attendance at Kick-off meeting, 4 Project meetings and Final Conference. Further travel will be required in relation to twinning and coaching activity, knowledge transfer and dissemination of SCIROCCO.
(C.2) Equipment	**Costs (€)**	**Justification**
	€0	NA
(C.3) Other goods and services	**Costs (€)**	**Justification**
	€43,000	**€3000** - Development of SCIROCCO tool as a final deliverable. **€40000** – Costs to cover arrangements for Kick-of Meeting, Project Assemblies and other twinning/coaching activities. Location of meetings to be decided.
Total Costs (€) of (C)	**€73000**	
(D) Indirect Costs	**Total Costs (€)**	
(Max. 7% on A, B and C)	**€20,916.28**	
Total estimated eligible costs	**€319,720.28**	

Applicant Number/ Short Name	**2/UEDIN**		
(If affiliated entity: Affiliated to which Applicant number/Short name)	NA		
(A) Direct personnel costs			
Staff function	**Monthly Cost**	**Estimated Person-month**	**Sum Cost (€)**
Professor	**€7008**	**20.00**	**€141,760**
		Total person month	**Total Costs (€) for (A)**
		20.00	**€141,760**
	Justification		
	Professor of Dependable Systems within the School of Informatics, University of Edinburgh will lead the development of SCIROCCO tool and		

	manage/coordinate activities of WP5.		
(B) Direct costs of sub-contracting	**Costs (€)**	**Task(s)/Justification**	
	€0	NA	
Total Costs (€) of (B)	**€0**		
(C) Other direct costs			
(C.1) Travel	**Costs (€)**	**Justification**	
	€15,000	Participation in Kick-off meeting, Projects meetings and final conference. Attendance at other additional (dissemination) meetings as required.	
(C.2) Equipment	**Costs (€)**	**Justification**	
	€0	NA	
(C.3) Other goods and services	**Costs (€)**	**Justification**	
	€0	NA	
Total Costs (€) of (C)	**€15,000**		
(D) Indirect Costs	**Total Costs (€)**		
(Max. 7% on A, B and C)	**€10,973.20**		
Total estimated eligible costs	**€167,773.20**		

Applicant Number/ Short Name	**3/VUB**		
(If affiliated entity: Affiliated to which Applicant number/Short name)	NA		
(A) Direct personnel costs			
Staff function	**Monthly Cost**	**Estimated Person-month**	**Sum Cost (€)**
Senior Researcher app	**€9584**	**12**	**€115,008**
Junior Researcher app	**€7277**	**18**	**€130,986**
		Total person month	**Total Costs (€) for (A)**
		30.0	**€245,994**
	Justification		
	Researcher expertise to undertake evaluation activities of SCIROCCO project (across all SCIROCCO WPs) and management and coordination of WP3.		
(B) Direct costs of sub-contracting	**Costs (€)**	**Task(s)/Justification**	
	€0	NA	
Total Costs (€) of (B)	**€0**		
	Justification		
	NA		
(C) Other direct costs			
(C.1) Travel	**Costs (€)**	**Justification**	

	€15,000	Participation in Kick-off meeting, Projects meetings and final conference. Attendance at other additional (dissemination, twining/coaching) meetings as required.
(C.2) Equipment	**Costs (€)**	**Justification**
	€0	NA
(C.3) Other goods and services	**Costs (€)**	**Justification**
	€0	NA
Total Costs (€) of (C)	**€15,000**	
(D) Indirect Costs	**Total Costs (€)**	
(Max. 7% on A, B and C)	**€18,269.58**	
Total estimated eligible costs	**€279,263.58**	

Applicant Number/ Short Name	**4/UVEG**		
(If affiliated entity: Affiliated to which Applicant number/Short name)	NA		
(A) Direct personnel costs			
Staff function	**Monthly Cost**	**Estimated Person-month**	**Sum Cost (€)**
Project Manager	**€6200**	**2**	**€12,400**
Junior Researcher	**€4060**	**10**	**€40,600**
Senior Researcher	**€6200**	**8**	**€49,600**
		Total person month	**Total Costs (€) for (A)**
		20.00	**€102,600**
	Justification		
	Project manager expertise to coordinate and manage WP8. Senior Researcher and Junior Researcher will bring the expertise for WP3 on evaluation.		
(B) Direct costs of sub-contracting	**Costs (€)**	**Task(s)/Justification**	
	€0	NA	
Total Costs (€) of (B)	**€0**		
	Justification		
	NA		
(C) Other direct costs			
(C.1) Travel	**Costs (€)**	**Justification**	
	€15,000	Attendance at Kick-off meeting, 4 Project meetings and Final Conference and other dissemination meetings as required.	
(C.2) Equipment	**Costs (€)**	**Justification**	
	€0	NA	

(C.3) Other goods and services	Costs (€)	Justification
	€0	NA
Total Costs (€) of (C)	€15,000	
(D) Indirect Costs	Total Costs (€)	
(Max. 7% on A, B and C)	€8,232	
Total estimated eligible costs	€125,832	

Applicant Number/ Short Name	5/Kronikgune		
(If affiliated entity: Affiliated to which Applicant number/Short name)	NA		
(A) Direct personnel costs			
Staff function	Monthly Cost	Estimated Person-month	Sum Cost (€)
Director	€7000	1	€7,000
Coordinator	€6000	4	€24,000
Project Manager (WP3 Lead)	€4750	14	€66,500
Project Manager (Evaluation & Data Analysis)	€4750	9	€42,750
		Total person month	Total Costs (€) for (A)
		28.00	€140,250
	Justification		
	Director – Overall Project Management. Coordinator – Management and coordination with local healthcare organisations to ensure the implementation of the project and identification of good practices at a regional Level (WP4-WP7). Project Manager – Management and Co-ordination of WP4. Project Manager (Evaluation & Data Analysis) – Project Manager Responsible for Evaluation and Data analysis (WP3-WP4)		
(B) Direct costs of sub-contracting	Costs (€)	Task(s)/Justification	
(please repeat line for each subcontract foreseen)	€0	NA	
Total Costs (€) of (B)	€0		
	Justification		
	NA		
(C) Other direct costs			
(C.1) Travel	Costs (€)	Justification	
	€30,000	Attendance at Kick-off meeting, 4 Project meetings and Final Conference. Further travel will be required in relation to twinning and coaching and dissemination activities.	
(C.2) Equipment	Costs (€)	Justification	

	€0	NA
(C.3) Other goods and services	**Costs (€)**	**Justification**
Total Costs (€) of (C)	**€30,000**	
(D) Indirect Costs	**Total Costs (€)**	
(Max. 7% on A, B and C)	**€11,917.50**	
Total estimated eligible costs	**€182,167.50**	

Applicant Number/ Short Name	**6/Osakidetza**		
(If affiliated entity: Affiliated to which Applicant number/Short name)	NA		
(A) Direct personnel costs			
Staff function	**Monthly Cost**	**Estimated Person-month**	**Sum Cost (€)**
Manager	**€8000**	**3**	**€24,000**
Healthcare Professional (Specialist)	**€7500**	**8**	**€60,000**
Healthcare Professional (Primary Care Doctor)	**€6000**	**4**	**€24,000**
HealthCare Professional (Nurse)	**€6000**	**4**	**€24,000**
IT Manager	**€5500**	**4**	**€22,000**
		Total person month	**Total Costs (€) for (A)**
		23.0	**€ 154,000**
	Justification		
	Manager – Responsible for the continuous improvement of the implementation of improvement processes within the organisation (WP4). Healthcare Professional (Specialist) – Leader at regional level of implementation processes (WP4, WP6, WP7). Healthcare Professional (Primary Care Doctor)/ (Nurse) – Member of the multidisciplinary team (WP4, WP6, WP7). IT Manager – Responsible for IT developments (WP4, WP6, WP7).		
(B) Direct costs of sub-contracting	**Costs (€)**	**Task(s)/Justification**	
	€0	NA	
Total Costs (€) of (B)	**€0**		
	Justification		
	NA		
(C) Other direct costs			
(C.1) Travel	**Costs (€)**	**Justification**	
	€30,000	Attendance at Kick-off meeting, 4 Project meetings and Final Conference. Further travel will be required in relation to twinning and coaching	

		activities.
(C.2) Equipment	**Costs (€)**	**Justification**
(C.3) Other goods and services	**Costs (€)**	**Justification**
	€0	NA
Total Costs (€) of (C)	**€30,000**	
(D) Indirect Costs	**Total Costs (€)**	
(Max. 7% on A, B and C)	**€12,880**	
Total estimated eligible costs	**€196,880**	

Applicant Number/ Short Name	**7/ ARES PUGLI**		
(If affiliated entity: Affiliated to which Applicant number/Short name)	NA		
(A) Direct personnel costs			
Staff function	**Monthly Cost**	**Estimated Person-month**	**Sum Cost (€)**
Epidemiologist	**7000**	**5**	**35,000**
Healthcare Engineering	**6000**	**20**	**12,0000**
Regional Manager	**6000**	**5**	**30,000**
Coordinator	**3000**	**2**	**6,000**
		Total person month	**Total Costs (€) for (A)**
		32.0	**€191,000**
	Justification		
	Healthcare Engineer, Epidemiology, Coordinator and Management will bring the expertise to manage and coordinate WP7. As for the regional health and social care authority further inputs are required for WP4-WP6 and WP8.		
(B) Direct costs of sub-contracting	**Costs (€)**	**Task(s)/Justification**	
	€0	NA	
Total Costs (€) of (B)	**€0**		
	Justification		
	NA		
(C) Other direct costs			
(C.1) Travel	**Costs (€)**	**Justification**	
	€30,000	Attendance at Kick-off meeting, 4 Project meetings and Final Conference. Further travel will be required in relation to dissemination/twining and coaching activities.	
(C.2) Equipment	**Costs (€)**	**Justification**	

(C.3) Other goods and services	**Costs (€)**	**Justification**
	€0	NA
Total Costs (€) of (C)	**€30,000**	
(D) Indirect Costs	**Total Costs (€)**	
(Max. 7% on A, B and C)	**€15,470**	
Total estimated eligible costs	**€236,470**	

Applicant Number/ Short Name	**8/FNOL**		
	NA		
(A) Direct personnel costs			
Staff function	**Monthly Cost**	**Estimated Person-month**	**Sum Cost (€)**
Leader	**€3 850**	**9**	**€34,650**
Medical Expert	**€3 850**	**9**	**€34,650**
Technical Expert	**€3 050**	**8**	**€24,400**
Partner Coordinator	**€2 600**	**3**	**€7,800**
		Total person month	**Total Costs (€) for (A)**
		29.0	**€101,500**
	Justification		
	Leader will co-ordinate the inputs of FNOL across SCIROCCO WPs as required and will be supported by partner coordinator. Medical and Technical expert will be primarily engaged in the knowledge transfer and self-assessment activities.		
(B) Direct costs of sub-contracting	**Costs (€)**	**Task(s)/Justification**	
	€0	NA	
Total Costs (€) of (B)	**€0**		
	Justification		
	NA		
(C) Other direct costs			
(C.1) Travel	**Costs (€)**	**Justification**	
	€30,000	Attendance at Kick-off meeting, 4 Project meetings and Final Conference. Further travel will be required in relation to dissemination, twinning and coaching activities.	
(C.2) Equipment	**Costs (€)**	**Justification**	
	€0	NA	
(C.3) Other goods and services	**Costs (€)**	**Justification**	
	€0	NA	
Total Costs (€) of (C)	**€0**		
(D) Indirect Costs	**Total Costs (€)**		

(Max. 7% on A, B and C)	**€9,205**	
Total estimated eligible costs	**€140,705**	

Applicant Number/ Short Name	**9/NLL**		
(If affiliated entity: Affiliated to which Applicant number/Short name)			
(A) Direct personnel costs			
Staff function	**Monthly Cost**	**Estimated Person-month**	**Sum Cost (€)**
Project Coordinator	**€6086.66**	**1.5**	**€9130**
Project Manager	**€5470.31**	**5.5**	**€30,086**
Scientific Expert	**€13512.37**	**10**	**€135,124**
Assistant	**€4684.46**	**5**	**€23,422**
Scientific Expert	**€10473.33**	**10**	**€104,733**
		Total person month	**Total Costs (€) for (A)**
		32.0	**€302,495**
	Justification		
	Project manager will co-ordinate and manage WP6, supported by Assistant. The inputs of NLL across all WPs will be ensured through the project co-ordinator. Scientific experts will provide the expertise on the local integrated care interventions and twinning and coaching activities (WP7).		
(B) Direct costs of sub-contracting	**Costs (€)**	**Task(s)/Justification**	
		NA	
Total Costs (€) of (B)			
	Justification		
(C) Other direct costs			
(C.1) Travel	**Costs (€)**	**Justification**	
	€40,000	Attendance at Kick-off meeting, 4 Project meetings and Final Conference. Further travel will be required in relation to dissemination and twinning and coaching activities. Higher travel budget due to remote location. This will ensure attendance at meetings and coherent working between NLL and wider consortium.	
(C.2) Equipment	**Costs (€)**	**Justification**	
	€0		
(C.3) Other goods and services	**Costs (€)**	**Justification**	
	€0		
Total Costs (€) of (C)	**€40,000**		

(D) Indirect Costs	Total Costs (€)	
(Max. 7% on A, B and C)	**€23,974.65**	
Total estimated eligible costs	**€366,469.65**	

Applicant Number/ Short Name	**10/EHTEL**		
(If affiliated entity: Affiliated to which Applicant number/Short name)	NA		
(A) Direct personnel costs			
Staff function	**Monthly Cost**	**Estimated Person-month**	**Sum Cost (€)**
Management	**€13 000**	**5**	**€65,000**
Policy Analyst	**€11 500**	**4**	**€46,000**
Event Organiser	**€11 000**	**1**	**€11,000**
Assistant	**€5 000**	**2**	**€10,000**
		Total person month	**Total Costs (€) for (A)**
		12	**€132,000**
	Justification		
	EHTEL management will provide the expertise in the coordination and management of WP2 and he will be supported by Event Organiser. The expertise for WP8 will be secured via EHTEL Policy analyst. EHTEL is also responsible for the set-up and management of SCIROCCO Policy Advisory Group. EHTEL staff work on the projects on the following principles; • Freelance staff are contracted to ensure flexibility and adaptability to meet work demands. • Staff are contracted with a minimum of 10 years expertise in the field of ICT healthcare to ensure maximum efficiency. • Extensive Policy expertise (Policy Analyst)		
(B) Direct costs of sub-contracting	**Costs (€)**	**Task(s)/Justification**	
(	**€0**		
Total Costs (€) of (B)	**€0**		
	Justification		
	NA		
(C) Other direct costs			
(C.1) Travel	**Costs (€)**	**Justification**	
	€15,000	Participation in Projects meetings and presentations of the project at various conferences to ensure maximum visibility of project activity.	
(C.2) Equipment	**Costs (€)**	**Justification**	
	€0		
(C.3) Other goods and services	**Costs (€)**	**Justification**	
	€30,000	€15,000 - for organisation of the Final Conference €5,000 – for publication of flyers and promotional	

		materials. €10,000 – Development of the branding of the project, development, and maintenance of website.
Total Costs (€) of (C)	**€30,000**	
(D) Indirect Costs	**Total Costs (€)**	
(Max. 7% on A, B and C)	**€12,390**	
Total estimated eligible costs	**€189,390**	

11. PREVIOUS AND CURRENT GRANTS RELEVANT TO THE PROGRAMME (LIMITED TO THE LAST 3 YEARS)

Title: Advancing Care Coordination and Telehealth Deployment
Acronym: ACT
Lead partner: Philips Healthcare
Partner: NHS 24
Project duration: (1 February 2013 – 30 October 2015)

12. CURRENT APPLICATIONS RELEVANT TO THE PROGRAMME

Topic: Support for the implementation and scaling up of good practices in the areas of integrated care, frailty prevention, adherence to medical plans and age-friendly communities
Title: Health on my tracked and leveled care
Acronym: Homytal
Lead partner: Local Health Unit Milano 2, Lombardy Region
Partner: NHS 24

13. EXCEPTIONAL UTILITY

The exceptional utility does not apply to SCIROCCO's project.

14. COLLABORATING STAKEHOLDERS

The following collaborating stakeholders, organisations and individual persons have been already contacted by SCIROCCO in order to increase the technical and scientific content of the project, as well as its relevance for different stakeholders in the EU. SCIROCCO will seek collaboration with the following stakeholders:

Institution	Contact person (First name / last name)	City & Country
CORAL	Edwin Mermans	Nord Brabant, Netherlands
IBM UK Ltd	John Crawford	London, UK
IFIC (International Foundation for Integrated Care)	Fiona Lyne	Oxford, United Kingdom
EUREGHA (European Regional and Local Health Authorities)	Dr Toni Dedeu	Brussels, Belgium
PJ Safarik University, Department of Social and Behavioural Medicine	Dr Iveta Rajnicova Nagyova	Kosice, Slovakia
EUPHA Section on Chronic Diseases	Dr Iveta Rajnicova Nagyova	Utrecht, Netherlands
University of Ljublana	Dr Vesna Dolnicar	Ljublana, SLovenia
Innovation Directorate, Hospital Clinic	Dr Albert Alonso	Barcelona, Spain

ESTIMATED BUDGET FOR THE ACTION (page 1 of 2)

	Estimated eligible[1] costs (per budget category)					EU contribution			Action's estimated receipts		
	A. Direct personnel costs	B. Direct costs of subcontracting	C. Other direct costs	D. Indirect costs[2]	Total costs	Reimbursement rate %	Maximum EU contribution[3]	Maximum grant amount[4]	Income generated by the action	Financial contributions given by third parties to the beneficiary	Action's total receipts
	A.1 Employees (or equivalent) A.2 Natural persons under direct contract and seconded persons		C.1 Travel C.2 Equipment C.3 Other goods and services								
Cost form[5]	Actual	Actual	Actual	Flat-rate 7%[6]							
	a	b	c	d = 0.07×(a +b+c)	e = a+b+c+d	f	g= e×f	h	k	l	m=k+l
1. NHS 24	225804.00	0.00	73000.00	20916.28	319720.28			191831.00	0.00	0.00	0.00
2. UEDIN	141760.00	0.00	15000.00	10973.20	167733.20			100639.00	0.00	0.00	0.00
3. VUB	245994.00	0.00	15000.00	18269.58	279263.58			167558.00	0.00	0.00	0.00
4. UVEG	102600.00	0.00	15000.00	8232.00	125832.00			75499.00	0.00	0.00	0.00
5. KRONIKGUNE	140250.00	0.00	60000.00	14017.50	214267.50			128560.00	0.00	0.00	0.00
6. Osakidetza	154000.00	0.00	0.00	10780.00	164780.00			98868.00	0.00	0.00	0.00
7. ARES PUGLI	191000.00	0.00	30000.00	15470.00	236470.00			141882.00	0.00	0.00	0.00
8. FNOL	101500.00	0.00	30000.00	9205.00	140705.00			84423.00	0.00	0.00	0.00
9. NLL	302495.00	0.00	40000.00	23974.65	366469.65			219881.00	0.00	0.00	0.00
10. EHTEL	132000.00	0.00	45000.00	12390.00	189390.00			113634.00	0.00	0.00	0.00
Total consortium	1737403.00	0.00	323000.00	144228.21	2204631.21	60.00[7]	1322778.73	1322775.00	0.00	0.00	0.00

ESTIMATED BUDGET FOR THE ACTION (page 2 of 2)

(1) See Article 6 for the eligibility conditions
(2) The indirect costs claimed must be free of any amounts covered by an operating grant (received under any EU or Euratom funding programme). A beneficiary that receives an operating grant during the action's duration cannot claim any indirect costs for the year(s)/reporting period(s) covered by the operating grant
(3) This is the theoretical amount of the EU contribution that the system calculates automatically (by multiplying all the budgeted costs by the reimbursement rate). This theoretical amount is capped by the 'maximum grant amount' (that the Agency decided to grant for the action) (see Article 5.1)
(4) The 'maximum grant amount' is the maximum grant amount decided by the Agency. It normally corresponds to the requested grant, but may be lower
(5) See Article 5 for the cost forms
(6) flat rate : 7% of eligible direct costs
(7) The reimbursement rate is applied at consortium level only (i.e. to the total costs). The reimbursement rate is normally 60% (or 80% in cases of exceptional utility)

ANNEX 3

ACCESSION FORM FOR BENEFICIARIES

THE UNIVERSITY OF EDINBURGH (UEDIN), SC005336, established in OLD COLLEGE, SOUTH BRIDGE, EDINBURGH EH8 9YL, United Kingdom, GB592950700 ('the beneficiary'), represented for the purpose of signing this Accession Form by the undersigned,

hereby agrees

to become beneficiary (‘2’)

in Grant Agreement No 710033 (‘the Agreement’)

between NHS 24 (SCOTLAND) **and** *the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) ('the Agency'), under the power delegated by the European Commission ('the Commission'),*

for the action entitled ‘SCALING INTEGRATED CARE IN CONTEXT (SCIROCCO)’.

and mandates

the coordinator to submit and sign in its name and on its behalf any **amendments** to the Agreement, in accordance with Article 39.

By signing this Accession Form, the beneficiary accepts the grant and agrees to implement the grant in accordance with the Agreement, with all the obligations and conditions it sets out.

SIGNATURE

For the beneficiary

ANNEX 3

ACCESSION FORM FOR BENEFICIARIES

VRIJE UNIVERSITEIT BRUSSEL (VUB), 449012406, established in PLEINLAAN 2, BRUSSEL 1050, Belgium, BE0449012406 ('the beneficiary'), represented for the purpose of signing this Accession Form by the undersigned,

hereby agrees

to become beneficiary (‘3’)

in Grant Agreement No 710033 (‘the Agreement’)

between NHS 24 (SCOTLAND) **and** *the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) ('the Agency'), under the power delegated by the European Commission ('the Commission'),*

for the action entitled ‘SCALING INTEGRATED CARE IN CONTEXT (SCIROCCO)’.

and mandates

the coordinator to submit and sign in its name and on its behalf any **amendments** to the Agreement, in accordance with Article 39.

By signing this Accession Form, the beneficiary accepts the grant and agrees to implement the grant in accordance with the Agreement, with all the obligations and conditions it sets out.

SIGNATURE

For the beneficiary

ANNEX 3

ACCESSION FORM FOR BENEFICIARIES

UNIVERSITAT DE VALENCIA (UVEG), Decreto Nr 128/2004 , established in AVENIDA BLASCO IBANEZ 13, VALENCIA 46010, Spain, ESQ4618001D ('the beneficiary'), represented for the purpose of signing this Accession Form by the undersigned,

hereby agrees

to become beneficiary (‘4’)

in Grant Agreement No 710033 (‘the Agreement’)

between NHS 24 (SCOTLAND) **and** *the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) ('the Agency'), under the power delegated by the European Commission ('the Commission'),*

for the action entitled ‘SCALING INTEGRATED CARE IN CONTEXT (SCIROCCO)’.

and mandates

the coordinator to submit and sign in its name and on its behalf any **amendments** to the Agreement, in accordance with Article 39.

By signing this Accession Form, the beneficiary accepts the grant and agrees to implement the grant in accordance with the Agreement, with all the obligations and conditions it sets out.

SIGNATURE

For the beneficiary

ANNEX 3

ACCESSION FORM FOR BENEFICIARIES

ASOCIACION CENTRO DE EXCELENCIA INTERNACIONAL EN INVESTIGACION SOBRE CRONICIDAD (KRONIKGUNE) ES5, ASB161422011, established in RONDA DE AZKUE 1 TORRE DEL BILBAO EXHIBITION CENTRE, BARAKALDO 48902, Spain, ESG95646014 ('the beneficiary'), represented for the purpose of signing this Accession Form by the undersigned,

hereby agrees

to become beneficiary (‘5’)

in Grant Agreement No 710033 (‘the Agreement’)

between NHS 24 (SCOTLAND) **and** *the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) ('the Agency'), under the power delegated by the European Commission ('the Commission'),*

for the action entitled ‘SCALING INTEGRATED CARE IN CONTEXT (SCIROCCO)’.

and mandates

the coordinator to submit and sign in its name and on its behalf any **amendments** to the Agreement, in accordance with Article 39.

By signing this Accession Form, the beneficiary accepts the grant and agrees to implement the grant in accordance with the Agreement, with all the obligations and conditions it sets out.

SIGNATURE

For the beneficiary

ANNEX 3

ACCESSION FORM FOR BENEFICIARIES

Servicio Vasco de Salud Osakidetza (Osakidetza), established in Alava 45, Vitoria-Gasteiz 01006 , Spain, ESS5100023J ('the beneficiary'), represented for the purpose of signing this Accession Form by the undersigned,

hereby agrees

to become beneficiary (‘6’)

in Grant Agreement No 710033 (‘the Agreement’)

between NHS 24 (SCOTLAND) **and** *the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) ('the Agency'), under the power delegated by the European Commission ('the Commission'),*

for the action entitled ‘SCALING INTEGRATED CARE IN CONTEXT (SCIROCCO)’.

and mandates

the coordinator to submit and sign in its name and on its behalf any **amendments** to the Agreement, in accordance with Article 39.

By signing this Accession Form, the beneficiary accepts the grant and agrees to implement the grant in accordance with the Agreement, with all the obligations and conditions it sets out.

SIGNATURE

For the beneficiary

ANNEX 3

ACCESSION FORM FOR BENEFICIARIES

AGENZIA REGIONALE SANITARIA PUGLIESE (ARES PUGLI), CF05747190725, established in VIA CADUTI DI TUTTE LE GUERRE 15, BARI 70126 , Italy, IT05747190725 ('the beneficiary'), represented for the purpose of signing this Accession Form by the undersigned,

hereby agrees

to become beneficiary (‘7’)

in Grant Agreement No 710033 (‘the Agreement’)

between NHS 24 (SCOTLAND) **and** *the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) ('the Agency'), under the power delegated by the European Commission ('the Commission'),*

for the action entitled ‘SCALING INTEGRATED CARE IN CONTEXT (SCIROCCO)’.

and mandates

the coordinator to submit and sign in its name and on its behalf any **amendments** to the Agreement, in accordance with Article 39.

By signing this Accession Form, the beneficiary accepts the grant and agrees to implement the grant in accordance with the Agreement, with all the obligations and conditions it sets out.

SIGNATURE

For the beneficiary

ANNEX 3

ACCESSION FORM FOR BENEFICIARIES

FAKULTNI NEMOCNICE OLOMOUC (FNOL), 00098892, established in I.P. PAVLOVA 185/6, OLOMOUC 775 20, Czech Republic, CZ00098892 ('the beneficiary'), represented for the purpose of signing this Accession Form by the undersigned,

hereby agrees

to become beneficiary (‘8’)

in Grant Agreement No 710033 (‘the Agreement’)

between NHS 24 (SCOTLAND) **and** *the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) ('the Agency'), under the power delegated by the European Commission ('the Commission'),*

for the action entitled ‘SCALING INTEGRATED CARE IN CONTEXT (SCIROCCO)’.

and mandates

the coordinator to submit and sign in its name and on its behalf any **amendments** to the Agreement, in accordance with Article 39.

By signing this Accession Form, the beneficiary accepts the grant and agrees to implement the grant in accordance with the Agreement, with all the obligations and conditions it sets out.

SIGNATURE

For the beneficiary

ANNEX 3

ACCESSION FORM FOR BENEFICIARIES

NORRBOTTENS LÄNS LANDSTING (NLL), 232100-0230 , established in ROBERTSVIKSGATAN 7, LULEA 97189, Sweden, SE232100023001 ('the beneficiary'), represented for the purpose of signing this Accession Form by the undersigned,

hereby agrees

to become beneficiary (‘9’)

in Grant Agreement No 710033 (‘the Agreement’)

between NHS 24 (SCOTLAND) **and** *the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) ('the Agency'), under the power delegated by the European Commission ('the Commission'),*

for the action entitled ‘SCALING INTEGRATED CARE IN CONTEXT (SCIROCCO)’.

and mandates

the coordinator to submit and sign in its name and on its behalf any **amendments** to the Agreement, in accordance with Article 39.

By signing this Accession Form, the beneficiary accepts the grant and agrees to implement the grant in accordance with the Agreement, with all the obligations and conditions it sets out.

SIGNATURE

For the beneficiary

ANNEX 3

ACCESSION FORM FOR BENEFICIARIES

EUROPEAN HEALTH TELEMATICS ASSOCIATION (EHTEL) AISBL, 140482000, established in RUE DE TREVES 49 51, BRUXELLES 1040, Belgium, BE0472058913 ('the beneficiary'), represented for the purpose of signing this Accession Form by the undersigned,

hereby agrees

to become beneficiary (‘10’)

in Grant Agreement No 710033 (‘the Agreement’)

between NHS 24 (SCOTLAND) **and** *the Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) ('the Agency'), under the power delegated by the European Commission ('the Commission'),*

for the action entitled ‘SCALING INTEGRATED CARE IN CONTEXT (SCIROCCO)’.

and mandates

the coordinator to submit and sign in its name and on its behalf any **amendments** to the Agreement, in accordance with Article 39.

By signing this Accession Form, the beneficiary accepts the grant and agrees to implement the grant in accordance with the Agreement, with all the obligations and conditions it sets out.

SIGNATURE

For the beneficiary

ⓘ print format A4 landscape

MODEL ANNEX 4 CHAFEA MGA — MULTI

FINANCIAL STATEMENT FOR *[BENEFICIARY [name]/AFFILIATED ENTITY [name]]* FOR REPORTING PERIOD [reporting period]

	Eligible [1] costs (per budget category)					Receipts			EU contribution
	A. Direct personnel costs	B. Direct costs of subcontracting	C. Other direct costs	D. Indirect costs [2]	Total costs	Income generated by the action	Financial contributions given by third parties to the beneficiaries	Total receipts	Requested EU contribution [3]
	A.1 Employees A.2 Natural persons under direct contract and seconded persons		C.1 Travel C.2 Equipment C.3 Other goods and services						
Cost form [4]	Actual	Actual	Actual	Flat-rate [5] 7%					
	a	b	c	d = 0,07 * (a + b + c)	e = a + b + c + d	f	g	h = f + g	i
[short name beneficiary/affiliated entity]									

The beneficiary/affiliated entity hereby confirms that:
The information provided is complete, reliable and true.
The costs declared are eligible (see Article 6).
The costs can be substantiated by adequate records and supporting documentation that will be produced upon request or in the context of checks, reviews, audits and investigations (see Articles 12, 13 and 17).
For the last reporting period: that all the receipts have been declared (see Article 5.3.3).

ⓘ Please declare all eligible costs, even if they exceed the amounts indicated in the estimated budget (see Annex 2). Only amounts that were declared in your individual financial statements can be taken into account lateron, in order to replace other costs that are found to be ineligible.

[1] See Article 6 for the eligibility conditions

[2] The indirect costs claimed must be free of any amounts covered by an operating grant (received under any EU or Euratom funding programme); see Article 6.2.D. If you have received an operating grant during this reporting period, you cannot claim any indirect costs

[3] You may request up to 100% of the total cost declared. The reimbursement rate mentioned in Article 5.2 applies only at consortium level (and will only be checked by the Agency at the payment of the balance)

[4] See Article 5 for the cost forms

[5] Flat rate : 7% of eligible direct costs

ⓘ print format A4 landscape

ANNEX 4 CHAFEA MGA — MULTI: Details

A. Direct personnel costs

A.1 Employees

Name/Function	No of hours worked for the project	Hourly rate	Total costs
	(a)	(b)	(c) = (a) * (b)
		Total for A.1 Employees	

A.2 Natural persons under direct contract and seconded persons

Name/Function	No of hours worked for the project	Hourly rate	Total costs
	(a)	(b)	(c) = (a) * (b)
		Total for A.2 Natural persons under direct contract and seconded persons	
		Total for A. Direct personnel costs	

B. Direct costs of subcontracting

Invoice Number	Subcontractor and Description of task	Price
	Total for B. Direct costs of subcontracting	

C. Other direct costs

C.1 Travel

Description (Name of person travelling, meeting as referenced in the technical report, place of the meeting)	Travel cost	No of days	Daily rate	Total costs
	(a)	(b)	(c)	(d) = (a) + ((b) * (c))
			Total for C.1 Travel	

C.2 Equipment

Invoice Number	Description of the equipment	Purchase price	Date of purchase	Depreciation method (36 or 60 month)	Number of month of depreciation allocated to the project	% of use for the purpose of the project	Total costs
		(a)	(b)	(c)	(d)	(e)	(f) = ((d)/(c) * (e)) * (a)
						Total for C.2 Equipment	

C.3 Other goods and services

Invoice Number	Description of service or good	Purchase price
	Total for C.3 Other goods and services	
	Total for C. Other direct costs	

ANNEX 5

MODEL OF THE CERTIFICATE ON THE FINANCIAL STATEMENTS

- **For options *[in italics in square brackets]*: choose the applicable option. Options not chosen should be deleted.**
- **For fields in [grey in square brackets]: enter the appropriate data**

TABLE OF CONTENTS

Terms of Reference for an Independent Certificate on Financial Statements and Report on Findings on costs declared under a Grant Agreement financed under the Health and Consumer Programmes 2014-2020

This document sets out the '**Terms of Reference (ToR)**' under which

[insert name of the beneficiary] ('the Beneficiary')]

agrees to engage

[**insert legal name of the auditor**] ('the Auditor')

to issue an Independent Certificate on the Financial Statements' ('CFS') referred to in Articles 15.3 and 15.4 of the Agreement based on the compulsory reporting template stipulated by the Agency, and

to produce an independent Report of findings ('the Report') concerning the Financial Statement(s)[1] drawn up by the *[Beneficiary] [Affiliated Entity]* for the [Health] / [Consumer] Programme 2014-2020 grant agreement [insert number of the grant agreement, title of the action, acronym and duration from/to] ('the Agreement'),

The Agreement has been concluded under the [Health] / [Consumer] Programme 2014-2020 between the Beneficiary and *Consumers, Health, Agriculture and Food Executive Agency (CHAFEA) ('the Agency'), under the powers delegated by the European Commission ('the Commission').*

The *Agency* is mentioned as a signatory of the Agreement with the Beneficiary only. The Agency is not a party to this engagement.

1.1 Subject of the engagement

The coordinator must submit to the Agency the final report within 60 days following the end of the each reporting period which should include, amongst other documents, a CFS for each beneficiary (and linked affiliated entity), for which the total contribution in the form of reimbursement of actual costs as referred to in Article 5.2 of the Agreement is at least EUR 750.000, and which requests a reimbursement in that form of EUR 325 000 or more, as reimbursement of actual costs calculated on the basis of its usual cost accounting practices. The CFS must cover the reporting period of the beneficiary (or linked Affiliated Entity) concerned by the payment.

The Beneficiary must submit to the coordinator the CFS for itself and for its linked Affiliated Entity, if the CFS must be included in the interim and final reports according to Articles 15.3 and 15.4 of the Agreement.

The CFS is composed of the following documents:

[1] By which costs under the Agreement are declared (see template 'Model Financial Statements' in Annex 4 to the Grant Agreement).

- The Terms of Reference ('the ToR') to be signed by the *[Beneficiary] [Affiliated Entity]* and the Auditor;
- the Auditor's Certificate on Financial Statements and Independent Report of Findings ('the Report') to be issued on the Auditor's letterhead, dated, stamped and signed by the Auditor (or the competent public officer) which includes the agreed-upon checks (laid down in the Annex I to the Report) to be performed by the Auditor, and the standard findings ('the Findings') to be confirmed by the Auditor.

If the CFS must be included in the interim and final report according to Articles 15.3 and 15.4 of the Agreement, the request for interim payment or payment of the balance to the Agreement cannot be made without the CFS. However, the payment for reimbursement of costs covered by the CFS does not preclude the Agency, the European Anti-Fraud Office and the European Court of Auditors from carrying out checks, reviews, audits and investigations in accordance with Article 17 of the Agreement.

1.2 Responsibilities

The *[Beneficiary] [Linked Affiliated Entity]:*

- must draw up the Financial Statement(s) for the action financed by the Agreement in compliance with the obligations under the Agreement. The Financial Statement(s) must be drawn up according to the *[Beneficiary's] [Linked Affiliated Entity's]* accounting and book-keeping system and the underlying accounts and records;
- must send the Financial Statement(s) to the Auditor;
- is responsible and liable for the accuracy of the Financial Statement(s);
- is responsible for the completeness and accuracy of the information provided to enable the Auditor to carry out the checks.;
- accepts that the Auditor cannot carry out the checks unless he/she is given full access to the *[Beneficiary's] [Linked Affiliated Entity's]* staff and accounting as well as any other relevant records and documentation.

The Auditor:

- *[Option 1 by default:* is qualified to carry out statutory audits of accounting documents in accordance with Directive 2006/43/EC of the European Parliament and of the Council of 17 May 2006 on statutory audits of annual accounts and consolidated accounts, amending Council Directives 78/660/EEC and 83/349/EEC and repealing Council Directive 84/253/EEC or similar national regulations*]*.
- *[Option 2 if the Beneficiary or Linked Affiliated Officer has an independent Public Officer:* is a competent and independent Public Officer for which the relevant national authorities have established the legal capacity to audit the Beneficiary*]*.

The Auditor:

- must be independent from the Beneficiary *[and the Linked Affiliated Entity]*, in particular, it must not have been involved in preparing the *[Beneficiary's] [Linked Affiliated Entity's]* Financial Statement(s);
- must plan work so that the checks may be carried out and the Findings may be assessed;
- must adhere to the checks laid down in Annex I to the Report and the compulsory report format;
- must carry out the engagement in accordance with this ToR;

- must document matters which are important to support the Report;
- must base its Report on the evidence gathered;
- must submit the Report to the *[Beneficiary] [Linked Affiliated Entity]*.

The Agency sets out the list of checks to be carried out by the Auditor which is defined in detail in the Annex I to the Report. The Auditor has to examine the Financial Statements and verify the supporting documentation in order to provide a reasonable assurance on their correctness.

1.3 Applicable Standards

The Auditor must comply with these Terms of Reference and with[2]:

- the International Standard on Related Services ('ISRS') 4400 *Engagements to perform Agreed-upon Procedures regarding Financial Information* as issued by the International Auditing and Assurance Standards Board (IAASB);
- the *Code of Ethics for Professional Accountants* issued by the International Ethics Standards Board for Accountants (IESBA). Although ISRS 4400 states that independence is not a requirement for engagements to carry out agreed-upon checks, the Agency requires that the Auditor also complies with the Code's independence requirements.

The Auditor's Report must state that there is no conflict of interests in establishing this Report between the Auditor and the Beneficiary *[and the Linked Affiliated Entity]*, and must specify - if the service is invoiced - the total fee paid to the Auditor for providing the Report.

1.4 Reporting

The Report must be written in the language of the Agreement.

Under Article 17 of the Agreement, the Agency, the European Anti-Fraud Office and the Court of Auditors have the right to audit any work that is carried out under the action and for which costs are declared from *the European Union* budget. This includes work related to this engagement. The Auditor must provide access to all working papers (e.g. recalculation of hourly rates, verification of the time declared for the action) related to this assignment if the Agency, the European Anti-Fraud Office or the European Court of Auditors requests them.

1.5 Timing

The CFS must be provided together with the request for the interim and balance payment, if required according to Articles 15.3 and 15.4 of the Agreement.

1.6 Other terms

[2] Supreme Audit Institutions applying INTOSAI-standards may carry out the Procedures according to the corresponding International Standards of Supreme Audit Institutions and code of ethics issued by INTOSAI instead of the International Standard on Related Services ('ISRS') 4400 and the Code of Ethics for Professional Accountants issued by the IAASB and the IESBA.

[*The [Beneficiary] [Linked Affiliated Entity] and the Auditor can use this section to agree other specific terms, such as the Auditor's fees, liability, applicable law, etc. Those specific terms must not contradict the terms specified above.*]

[legal name of the Auditor	[legal name of the *[Beneficiary][Linked Affiliated Entity]*]
[name & function of authorised representative]	[name & function of authorised representative]
[dd Month yyyy]	[dd Month yyyy]
Signature of the Auditor	Signature of the *[Beneficiary][Linked Affiliated Entity]*

Independent certificate on the financial statements declared under grant agreements signed under the Health and Consumer Programmes 2014-2020

(To be submitted by each beneficiary if the maximum grant amount in the form of reimbursement of 'actual costs' is at least EUR 750 000 and if it requests a reimbursement of actual costs of at least EUR 325 000 (see Articles 15.3 and 15.4)
To be drawn up and signed by an approved auditor or, in case of public bodies, by a competent and independent public officer (and printed on their letterhead).)

To
[name of contact person(s)], [Position]
[[*Beneficiary's*] [*Linked Affiliated Entity's*] name]
[Address]
[dd Month yyyy]

Dear [Name of contact person(s)],

As agreed under the terms of reference dated [dd Month yyyy]

with *[OPTION 1: [insert name of the beneficiary] ('the Beneficiary')] [OPTION 2: [insert name of the linked Affiliated Entity ('the Linked Affiliated Entity), Affiliated Entity linked to the Beneficiary [insert name of the beneficiary] ('the Beneficiary')],*

we

[name of the auditor] ('the Auditor'),

established at

[full address/city/state/province/country],

represented by

[name and function of an authorised representative],

have carried out an audit relating to the provisions of the Terms of Reference, the costs declared in the Financial Statement(s)[3] of the *[Beneficiary] [Linked Affiliated Entity]*, the documents provided in their support , to which this Certificate is attached, and which is to be presented to Agency together with the request for payment under the grant agreement [insert grant agreement reference: number, title of the action and acronym] ('the Agreement'), for the following period (s) covered by Agreement [insert period(s) covered by the Financial Statements].

The audit and subsequent checks were carried out solely to assist Agency in evaluating whether the*[Beneficiary][Linked Affiliated Entity's]* costs in the accompanying Financial Statement(s) were declared in accordance with the Agreement. The Agency will draw its own conclusions from the Report and any additional information it may require.

The above mentioned Financial Statement(s) of the *[Beneficiary] [Linked Affiliated Entity]*, their supporting documentation and accounting records were examined in accordance with

[3] By which the Beneficiary declares costs under the Agreement (see template 'Financial Statement' in Annex 4 to the Agreement).

the upon-agreed checks , as detailed in Annex I to the Report, in order to provide Agency with the following reasonable assurance:

- the amount of the total eligible costs (*[insert amount in number]* (*[insert amount in words*[4]*]*)) declared in the attached Financial Statement(s) of the *[Beneficiary] [Linked Affiliated Entity]* is complying with the following cumulative conditions, as defined in the Article 6.1 of the Agreement:
  - ✓ they are actual and recorded in the *[Beneficiary's] [Linked Affiliated Entity's]* accounts at the date of the establishment of this audit certificate;
  - ✓ they have been incurred during the periods covered by the Financial Statement(s) concerned by this audit certificate;

    [they also include the eligible costs incurred in drawing up the final reports referred to in Article 15 of the Agreement, which may be incurred up to two calendar months after the end of the action;]
  - ✓ they are determined in accordance with the beneficiary's accounting standards applicable in the country where the *[Beneficiary] [Linked Affiliated Entity]* is established, and with the beneficiary's usual cost accounting practices;
  - ✓ they comply with the national law on taxes, labour and social security applicable in the country where the *[Beneficiary] [Linked Affiliated Entity]* is established;
  - ✓ they are exclusive of any non-eligible costs identified below which are established in Article 6.4 of the above mentioned agreement with the Agency:
    - return on capital;
    - debt and debt service charges;
    - provisions for future losses or debts;
    - interest owed;
    - doubtful debts;
    - currency exchange losses;
    - bank costs charged by the beneficiary's bank for transfers from the Agency;
    - deductible VAT;
    - costs incurred during suspension of the implementation of the action;
    - excessive or reckless expenditure;
    - contributions in kind provided by third-parties;
    - costs declared under another EU or Euratom grant, in particular, indirect costs if beneficiary is already receiving an operating grant financed by EU or Euratom in the same period.
  - ✓ [they are claimed according to the EUR conversion rate as defined in the Article 15.5 of the Agreement;
- as declared in the Financial Statement(s) of the *[Beneficiary] [Linked Affiliated Entity*] and only for the request of payment of the balance, the total amount of receipts for the total period covered by this(those) Financial Statement(s) is equal to (*[insert amount in number]* (*[insert amount in words*[5]*]*) ;

[4] In EUR.

[5] In EUR.

- accounting procedures used in the recording of eligible costs and receipts respect the accounting rules of the State in which the beneficiary is established and permit the direct reconciliation between the costs and receipts incurred for the implementation of the project covered by the Agreement and the overall statement of accounts relating to the beneficiary's overall business activity[6];
- based on our audit, we can conclude that the financial management of the grant was carried out in an acceptable manner and in compliance with the requirements of *[grant agreement reference: title, acronym, number]*
- our company [organisation – for competent public officers] is qualified to deliver this audit certificate in full compliance with the Articles 15.3 and 15.4 of the agreement;

  [Relevant information establishing this qualification is included with this audit certificate;][7]

The list of Findings, Exceptions and Further remarks, if any, is presented in the Report annexed to this Certificate.

The Certificate on Financial Statement(s) and Report was prepared solely for the confidential use of the *[Beneficiary] [Linked Affiliated Entity]* and the Agency, and only to be submitted to the Agency in connection with the requirements set out in Articles 15.3 and 15.4 of the Agreement. The Certificate and Report may not be used by the *[Beneficiary] [Linked Affiliated Entity]* or by the Agency for any other purpose, nor may it be distributed to any other parties. The Agency may only disclose these documents to authorised parties, in particular to the European Anti-Fraud Office (OLAF) and the European Court of Auditors.

Both Certificate and Report relate only to the Financial Statement(s) submitted to the Agency by the *[Beneficiary] [Linked Affiliated Entity]* for the Agreement. Therefore, they do not extend to any other of the [*Beneficiary's*] [*Linked Affiliated Entity's*] Financial Statement(s).

There was no conflict of interest[8] between the Auditor and the Beneficiary *[and Linked Affiliated Entity]* in establishing these documents. As declared in the Financial Statement(s) the total fee paid to the Auditor for providing the Report was EUR _____ (including EUR_____ of deductible VAT).

.

[legal name of the Auditor]
[name and function of an authorised representative]

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[6] Article 6.1.

[7] If the auditor is not known internationally or for a competent public officer whose competence to provide an audit certificate has not been attested to by its national authorities.

[8] A conflict of interest arises when the Auditor's objectivity to establish the certificate is compromised in fact or in appearance when the Auditor for instance:
- was involved in the preparation of the Financial Statements;
- stands to benefit directly should the certificate be accepted;
- has a close relationship with any person representing the beneficiary;
- is a director, trustee or partner of the beneficiary; or
- is in any other situation that compromises his or her independence or ability to establish the certificate impartially.

[dd Month yyyy]
Signature of the Auditor

Report of Findings on costs declared under grant agreement signed under Health and Consumer Programmes 2014-2020

Not applicable Findings

We examined the Financial Statement(s) stated above and considered the following Findings not applicable:

Explanation (to be removed from the Report):

*If a Finding was not applicable, it must be marked as '**N.A**.' ('Not applicable') in the corresponding row on the right-hand column of the table and means that the Finding did not have to be corroborated by the Auditor and the related check(s) did not have to be carried out.*

The reasons of the non-application of a certain Finding must be obvious i.e.

i) if no cost was declared under a certain category then the related Finding(s) and check(s) are not applicable;

ii) if the condition set to apply certain check(s) are not met the related Finding(s) and those check(s) are not applicable. For instance, for 'beneficiaries with accounts established in a currency other than euro' the check and Finding related to 'beneficiaries with accounts established in euro' are not applicable. Similarly, if no additional remuneration is paid, the related Finding(s) and check(s) for additional remuneration are not applicable.

List here all Findings considered not applicable for the present engagement and explain the reasons of the non-applicability.
….

Exceptions

The *[Beneficiary] [Linked Affiliated Entity]* provided the Auditor all the documentation and accounting information needed by the Auditor to carry out the requested checks and evaluate the Findings.

Explanation (to be removed from the Report):

- *If the Auditor was not able to successfully complete a procedure requested,. The reason such as the inability to reconcile key information or the unavailability of data that prevents the Auditor from carrying out the audit must be indicated below.*
- *If the Auditor cannot corroborate a standard finding after having carried out the corresponding audit, it must state, the reasons why the Finding was not fulfilled and its possible impact must be explained here below.*

List here any exceptions and add any information on the cause and possible consequences of each exception, if known. If the exception is quantifiable, include the corresponding amount.
….

Example (to be removed from the Report):

1. *The Beneficiary was unable to substantiate the Finding number 1 on … because ….*
2. *Finding number 30 was not fulfilled because the methodology used by the Beneficiary to calculate daily costs was different from the one accepted by the Agency. The differences were as follows: …*
3. *After carrying out the agreed checks to confirm the Finding number 31, the Auditor found a difference of _____ EUR. The difference can be explained by …*

Further Remarks

In addition to reporting on the results of the specific procedures carried out, the Auditor would like to make the following general remarks:

Example (to be removed from the Report):

1. *Regarding Finding number 8 the conditions for additional remuneration were considered as fulfilled because …*
2. *In order to be able to confirm the Finding number 15 we carried out the following additional procedures: ….*

ANNEX I to the Report on Findings: Agreed-upon checks to be performed and standard findings to be confirmed by the Auditor

The Agency reserves the right to i) provide the auditor with additional guidance regarding the checks to be followed or the facts to be ascertained and the way in which to present them (this may include sample coverage and findings) or to ii) change the checks, by notifying the Beneficiary in writing. The list of checks to be carried out by the auditor in order to confirm the standard findings is laid down in the table below.

If this certificate relates to a Linked Affiliated Entity, any reference here below to 'the Beneficiary' is to be considered as a reference to 'the Linked Affiliated Entity'.

The 'result' column has three different options: 'C', 'E' and 'N.A.':

- 'C' stands for 'confirmed' and means that the auditor can confirm the 'standard finding' and, therefore, there is no exception to be reported.
- 'E' stands for 'exception' and means that the Auditor carried out the checks but cannot confirm the 'standard finding', or that the Auditor was not able to carry out a specific check (e.g. because it was impossible to reconcile key information or data were unavailable),
- 'N.A.' stands for 'not applicable' and means that the Finding did not have to be examined by the Auditor and the related check(s) did not have to be carried out. The reasons of the non-application of a certain Finding must be obvious i.e. i) if no cost was declared under a certain category then the related Finding(s) and check(s) are not applicable; ii) if the condition set to apply certain checks(s) are not met then the related Finding(s) and checks(s) are not applicable. For instance, if no additional remuneration is paid, the related Finding(s) and check(s) for additional remuneration are not applicable.

Ref	Checks	Standard finding	Result (C / E /N.A)
A	**ACTUAL PERSONNEL COSTS CALCULATED BY THE BENEFICIARY IN ACCORDANCE WITH ITS USUAL COST ACCOUNTING PRACTICE**		
	The Auditor draws the full list of persons (including *employees and natural persons working under a direct contract)* whose costs were declared in the Financial Statement(s) in order to carry out the checks indicated in the consecutive points of this section A. (The Auditor sampled _____ people out of the total of _____ people.		

Ref	Checks	Standard finding	Result (C / E /N.A)
A.1	**PERSONNEL COSTS** For the persons declared by the beneficiary or Linked Affiliated Entity in the Financial Statement, and working under an employment contract or equivalent act (general procedures for individual actual personnel costs) To confirm standard findings 1-5 listed in the next column, the Auditor reviewed following information/documents provided by the Beneficiary: o a list of the persons declared by Beneficiary or Linked Affiliated Entity indicating the period(s) during which they worked for the action, their position (classification or category) and type of contract; o the payslips of the employees; o reconciliation of the personnel costs declared in the Financial Statement(s) with the accounting system (project accounting and general ledger) and payroll system; o information concerning the employment status and employment conditions of the declared personnel, in particular their employment contracts or equivalent; o the Beneficiary's usual policy regarding payroll matters (e.g. salary policy, overtime policy, variable pay); o applicable national law on taxes, labour and social security and o any other document that supports the personnel costs declared.	1) The employees were i) directly hired by the Beneficiary in accordance with its national legislation, ii) under the Beneficiary's sole technical supervision and responsibility and iii) remunerated in accordance with the Beneficiary's usual practices.	
		2) Personnel costs were recorded in the Beneficiary's accounts/payroll system.	
		3) Costs were adequately supported and reconciled with the accounts and payroll records.	
		4) Personnel costs did not contain any ineligible elements.	
		5) There were no discrepancies between the personnel costs charged to the action and the costs recalculated by the Auditor.	

Ref	Checks	Standard finding	Result (C / E /N.A)
	Further procedures if 'additional remuneration' is paid To confirm standard factual findings 6-8 listed in the next column, the Auditor: o reviewed relevant documents provided by the Beneficiary (legal form, legal/statutory obligations, the Beneficiary's usual policy on additional remuneration, criteria used for its calculation…); o recalculated the amount of additional remuneration eligible for the action based on the supporting documents received (full-time or part-time work, exclusive or non-exclusive dedication to the action, etc.)**.** *IF ANY PART OF THE REMUNERATION PAID TO THE EMPLOYEE IS NOT MANDATORY ACCORDING TO THE NATIONAL LAW OR THE EMPLOYMENT CONTRACT ("ADDITIONAL REMUNERATION") AND IS ELIGIBLE UNDER THE PROVISIONS OF ARTICLE 6.2.A., THIS CAN BE CHARGED AS ELIGIBLE COST TO THE ACTION.*	6) The Beneficiary paying "additional remuneration" was a non-profit legal entity.	
		7) The amount of additional remuneration paid corresponded to the Beneficiary's usual remuneration practices and was consistently paid whenever the same kind of work or expertise was required.	
		8) The criteria used to calculate the additional remuneration were objective and generally applied by the Beneficiary regardless of the source of funding used.	
	<u>For natural persons included in the sample and working with the Beneficiary under a direct contract other than an employment contract, such as consultants (no subcontractors).</u> To confirm standard factual findings 9-13 listed in the next column the Auditor reviewed following information/documents provided by the Beneficiary:	9) The natural persons reported to the Beneficiary (worked under the Beneficiary's instructions).	
		10) They worked on the Beneficiary's premises (unless otherwise agreed with the	

Ref	Checks	Standard finding	Result (C / E /N.A)
	○ the contracts, especially the cost, contract duration, work description, place of work, ownership of the results and reporting obligations to the Beneficiary; ○ the employment conditions of staff in the same category to compare costs and; ○ any other document that supports the costs declared and its registration (e.g. invoices, accounting records, etc.).	Beneficiary).	
		11) The results of work carried out belong to the Beneficiary.	
		12) Their costs were not significantly different from those for staff who performed similar tasks under an employment contract with the Beneficiary.	
		13) The costs were supported by audit evidence and registered in the accounts.	
A.2	**PRODUCTIVE HOURS** To confirm standard factual findings 14-19 listed in the next column, the Auditor reviewed relevant documents, especially national legislation, labour agreements and contracts and time records of the persons included in the sample, to verify that: ○ the annual productive hours applied were calculated in accordance with one of the methods described below, ○ the full-time equivalent (FTEs) ratios for employees not working full-time were correctly calculated.	14) The Beneficiary applied method [*choose one option and delete the others*] [**A**: 1720 hours] [**B**: the 'total number of hours worked'] [**C**: 'annual productive hours' used correspond to usual accounting practices]	
	If the Beneficiary applied method B, the auditor verified that the correctness in which the total number of hours worked was calculated and that the contracts specified the annual	15) Productive hours were calculated annually.	

Ref	Checks	Standard finding	Result (C / E /N.A)
	workable hours. If the Beneficiary applied method C, the auditor verified that the 'annual productive hours' applied when calculating the hourly rate were equivalent to at least 90 % of the 'standard annual workable hours'. The Auditor can only do this if the calculation of the standard annual workable hours can be supported by records, such as national legislation, labour agreements, and contracts. *BENEFICIARY'S PRODUCTIVE HOURS' FOR PERSONS WORKING FULL TIME SHALL BE ONE OF THE FOLLOWING METHODS:* ***A.*** *1720 ANNUAL PRODUCTIVE HOURS (PRO-RATA FOR PERSONS NOT WORKING FULL-TIME)* ***B.*** *THE TOTAL NUMBER OF HOURS WORKED BY THE PERSON FOR THE BENEFICIARY IN THE YEAR (THIS METHOD IS ALSO REFERRED TO AS 'TOTAL NUMBER OF HOURS WORKED' IN THE NEXT COLUMN). THE CALCULATION OF THE TOTAL NUMBER OF HOURS WORKED WAS DONE AS FOLLOWS: ANNUAL WORKABLE HOURS OF THE PERSON ACCORDING TO THE EMPLOYMENT CONTRACT, APPLICABLE LABOUR AGREEMENT OR NATIONAL LAW PLUS OVERTIME WORKED MINUS ABSENCES (SUCH AS SICK LEAVE OR SPECIAL LEAVE).* ***C.*** *THE STANDARD NUMBER OF ANNUAL HOURS GENERALLY APPLIED BY THE BENEFICIARY FOR ITS PERSONNEL IN ACCORDANCE WITH ITS USUAL COST ACCOUNTING PRACTICES (THIS METHOD IS ALSO REFERRED TO AS 'TOTAL ANNUAL PRODUCTIVE HOURS' IN THE NEXT*	16) For employees not working full-time the full-time equivalent (FTE) ratio was correctly applied. *If the Beneficiary applied method B.* 17) The calculation of the number of 'annual workable hours', overtime and absences was verifiable based on the documents provided by the Beneficiary. *If the Beneficiary applied method C.* 18) The calculation of the number of 'standard annual workable hours' was verifiable based on the documents provided by the Beneficiary.	

Ref	Checks	Standard finding	Result (C / E /N.A)
	COLUMN). THIS NUMBER MUST BE AT LEAST 90% OF THE STANDARD ANNUAL WORKABLE HOURS. *'ANNUAL WORKABLE HOURS' MEANS THE PERIOD DURING WHICH THE PERSONNEL MUST BE WORKING, AT THE EMPLOYER'S DISPOSAL AND CARRYING OUT HIS/HER ACTIVITY OR DUTIES UNDER THE EMPLOYMENT CONTRACT, APPLICABLE COLLECTIVE LABOUR AGREEMENT OR NATIONAL WORKING TIME LEGISLATION.*	19) The 'annual productive hours' used for calculating the hourly rate were consistent with the usual cost accounting practices of the Beneficiary and were equivalent to at least 90 % of the 'annual workable hours'.	
A.3	**TIME RECORDING SYSTEM** To verify that the time recording system ensures the fulfilment of all minimum requirements and that the hours declared for the action were correct, accurate and properly authorised and supported by documentation, the Auditor made the following checks for the persons included in the sample that declare time as worked for the action on the basis of time records: o description of the time recording system provided by the Beneficiary (registration, authorisation, processing in the HR-system); o its actual implementation; o time records were signed at least monthly by the employees (on paper or electronically) and authorised by the project manager or another manager; o the hours declared were worked within the project period; o there were no hours declared as worked for the action if HR-records showed absence due to holidays or sickness (further cross-checks with travels are carried out in B.1 below) ;	20) All persons recorded their time dedicated to the action on a **daily/ weekly/ monthly** basis using a **paper/computer-based** system. (*delete the answers that are not applicable)*	
		21) Their time-records were authorised at least monthly by the project manager or other superior.	
		22) Hours declared were worked within the project period and were consistent with the presences/absences recorded in HR-records.	

Ref	Checks	Standard finding	Result (C / E /N.A)
	○ the hours charged to the action matched those in the time recording system. *ONLY THE HOURS WORKED ON THE ACTION CAN BE CHARGED. ALL WORKING TIME TO BE CHARGED SHOULD BE RECORDED THROUGHOUT THE DURATION OF THE PROJECT, ADEQUATELY SUPPORTED BY EVIDENCE OF THEIR REALITY AND RELIABILITY (SEE SPECIFIC PROVISIONS BELOW FOR PERSONS WORKING EXCLUSIVELY FOR THE ACTION WITHOUT TIME RECORDS).*	23) There were no discrepancies between the number of hours charged to the action and the number of hours recorded.	
	<u>If the persons are working exclusively for the action and without time records</u> For the persons selected that worked exclusively for the action without time records, the Auditor verified evidence available demonstrating that they were in reality exclusively dedicated to the action and that the Beneficiary signed a declaration confirming that they have worked exclusively for the action.	24) The exclusive dedication is supported by a declaration signed by the Beneficiary's and by any other evidence gathered.	
B	**COSTS OF SUBCONTRACTING**		
B.1	**The Auditor obtained the detail/breakdown of subcontracting costs and sampled _____ cost items selected randomly** (*full coverage is required if there are fewer than 10 items, otherwise the sample should have a minimum of 10 item, or 10% of the total, whichever number is highest*). To confirm standard factual findings 25-29 listed in the next column, the Auditor reviewed the following for the items included in the sample: ○ the use of subcontractors was foreseen in Annex 1of grant agreement; ○ subcontracting costs were declared in the subcontracting category of the Financial Statement;	25) The use of claimed subcontracting costs was foreseen in Annex 1 to the Agreement and costs were declared in the Financial Statements under the subcontracting category.	
		26) There were documents of requests to different providers, different offers and assessment of the offers before selection of	

Ref	Checks	Standard finding	Result (C / E /N.A)
	○ supporting documents on the selection and award procedure were followed; ○ the Beneficiary ensured best value for money (key elements to appreciate the respect of this principle are the award of the subcontract to the bid offering best price-quality ratio, under conditions of transparency and equal treatment. In case an existing framework contract was used the Beneficiary ensured it was established on the basis of the principle of best value for money under conditions of transparency and equal treatment). In particular, i. if the Beneficiary acted as a contracting authority within the meaning of Directive 2004/18/EC or of Directive 2004/17/EC, the Auditor verified that the applicable national law on public procurement was followed and that the subcontracting complied with the Terms and Conditions of the Agreement. ii. if the Beneficiary did not fall under the above-mentioned category the Auditor verified that the Beneficiary followed their usual procurement rules and respected the Terms and Conditions of the Agreement..	the provider in line with internal procedures and procurement rules. Subcontracts were awarded in accordance with the principle of best value for money. *(When different offers were not collected the Auditor explains the reasons provided by the Beneficiary under the caption "Exceptions" of the Report. The Agency will analyse this information to evaluate whether these costs might be accepted as eligible)*	
	For the items included in the sample the Auditor also verified that: ○ the subcontracts were not awarded to other Beneficiaries in the consortium;	27) The subcontracts were not awarded to other Beneficiaries of the consortium.	
	○ there were signed agreements between the Beneficiary and the subcontractor;	28) All subcontracts were supported by signed agreements between the Beneficiary and the subcontractor.	
	○ there was evidence that the services were provided by subcontractor;	29) There was evidence that the services were provided by the	

Ref	Checks	Standard finding	Result (C / E /N.A)
		subcontractors.	
C	**OTHER ACTUAL DIRECT COSTS**		
C.1	**COSTS OF TRAVEL AND RELATED SUBSISTENCE ALLOWANCES** **The Auditor sampled _____ cost items selected randomly** (*full coverage is required if there are fewer than 10 items, otherwise the sample should have a minimum of 10 item, or 10% of the total, whichever number is the highest*). The Auditor inspected the sample and verified that: o travel and subsistence costs were consistent with the Beneficiary's usual policy for travel. In this context, the Beneficiary provided evidence of its normal policy for travel costs (e.g. use of first class tickets, reimbursement by the Beneficiary on the basis of actual costs, a lump sum or per diem) to enable the Auditor to compare the travel costs charged with this policy; o travel costs are correctly identified and allocated to the action (e.g. trips are directly linked to the action) by reviewing relevant supporting documents such as minutes of meetings, workshops or conferences, their registration in the correct project account, their consistency with time records or with the dates/duration of the workshop/conference; o no ineligible costs or excessive or reckless expenditure was declared.	30) Costs were incurred, approved and reimbursed in line with the Beneficiary's usual policy for travels. 31) There was a link between the trip and the action. 32) The supporting documents were consistent with each other regarding subject of the trip, dates, duration and reconciled with time records and accounting. 33) No ineligible costs or excessive or reckless expenditure was declared.	
C.2	**DEPRECIATION COSTS FOR EQUIPMENT, INFRASTRUCTURE OR OTHER ASSETS** **The Auditor sampled _____ cost items selected randomly** (*full coverage is required*	34) Procurement rules, principles and guides were followed.	

Ref	Checks	Standard finding	Result (C / E /N.A)
	if there are fewer than 10 items, otherwise the sample should have a minimum of 10 item, or 10% of the total, whichever number is the highest). For "equipment, infrastructure or other assets" selected in the sample the Auditor verified that: o the assets were acquired in conformity with the Beneficiary's internal guidelines and procedures; o they were correctly allocated to the action (with supporting documents such as delivery note invoice or any other proof demonstrating the link to the action) o they were entered in the accounting system; o the extent to which the assets were used for the action (as a percentage) was supported by reliable documentation (e.g. usage overview table); The Auditor recalculated the depreciation costs and verified that they were in line with the applicable rules in the Beneficiary's country and with the Beneficiary's usual accounting policy (e.g. depreciation calculated on the acquisition value). The Auditor verified that no ineligible costs such as deductible VAT, exchange rate losses, excessive or reckless expenditure were declared (see Article 6.4 GA).	35) There was a link between the grant agreement and the asset charged to the action.	
		36) The asset charged to the action was traceable to the accounting records and the underlying documents.	
		37) The depreciation method used to charge the asset to the action was in line with the applicable rules of the Beneficiary's country and the Beneficiary's usual accounting policy.	
		38) The amount charged corresponded to the actual usage for the action.	
		39) No ineligible costs or excessive or reckless expenditure were declared.	
C.3	**COSTS OF OTHER GOODS AND SERVICES** **The Auditor sampled _____ cost items selected randomly** (*full coverage is required if there are fewer than 10 items, otherwise the sample should have a minimum of 10 item,*	43) Contracts for works or services did not cover tasks described in Annex 1to the Grant Agreement.	

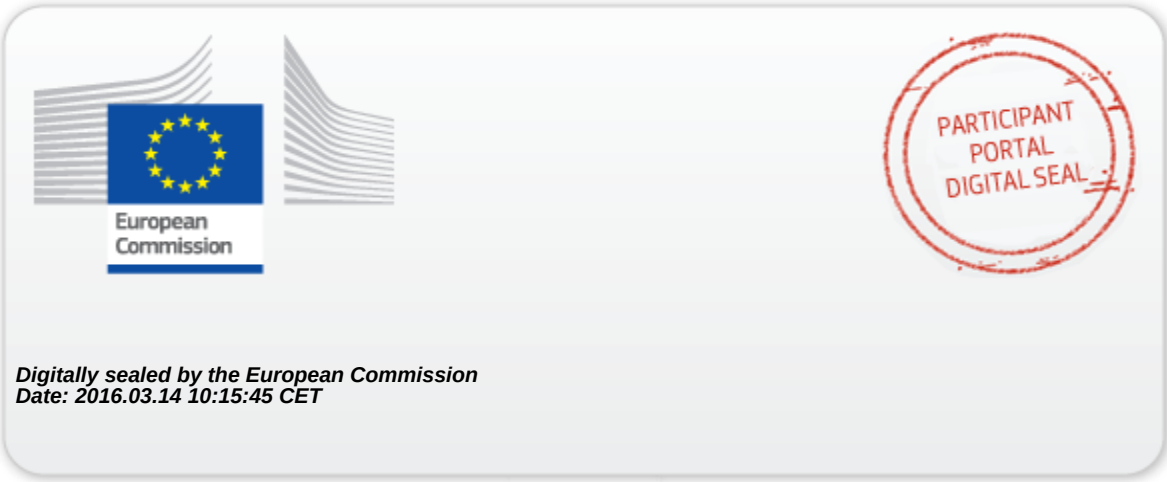
Ref	Checks	Standard finding	Result (C / E /N.A)
	or 10% of the total, whichever number is highest). For the purchase of goods, works or services included in the sample the Auditor verified that: o the contracts did not cover tasks described in Annex 1; o they were correctly identified, allocated to the proper action, entered in the accounting system (traceable to underlying documents such as purchase orders, invoices and accounting); o the goods were not placed in the inventory of durable equipment; o the costs charged to the action were accounted in line with the Beneficiary's usual accounting practices; o no ineligible costs or excessive or reckless expenditure were declared (see Article 6.4 GA). In addition, the Auditor verified that these goods and services were acquired in conformity with the Beneficiary's internal guidelines and procedures, in particular: o if Beneficiary acted as a contracting authority within the meaning of Directive 2004/18/EC or of Directive 2004/17/EC, the Auditor verified that the applicable national law on public procurement was followed and that the procurement contract complied with the Terms and Conditions of the Agreement. o if the Beneficiary did not fall into the category above, the Auditor verified that the Beneficiary followed their usual procurement rules and respected the Terms and Conditions of the Agreement. For the items included in the sample the Auditor also verified that: o the Beneficiary ensured best value for money (key elements to appreciate the respect of this principle are the award of the contract to the bid offering best	44) Costs were allocated to the correct action and the goods were not placed in the inventory of durable equipment.	
		45) The costs were charged in line with the Beneficiary's accounting policy and were adequately supported.	
		46) No ineligible costs or excessive or reckless expenditure were declared. For internal invoices/charges only the cost element was charged, without any mark-ups.	
		47) Procurement rules, principles and guides were followed. There were documents of requests to different providers, different offers and assessment of the offers before selection of the provider in line with internal procedures and procurement rules. The purchases were made in accordance with the principle of best value for money.	

Ref	Checks	Standard finding	Result (C / E /N.A)
	price-quality ratio, under conditions of transparency and equal treatment. In case an existing framework contract was used the Auditor also verified that the Beneficiary ensured it was established on the basis of the principle of best value for money under conditions of transparency and equal treatment); *SUCH GOODS AND SERVICES INCLUDE, FOR INSTANCE, CONSUMABLES AND SUPPLIES, DISSEMINATION (INCLUDING OPEN ACCESS), PROTECTION OF RESULTS, SPECIFIC EVALUATION OF THE ACTION IF IT IS REQUIRED BY THE AGREEMENT, CERTIFICATES ON THE FINANCIAL STATEMENTS IF THEY ARE REQUIRED BY THE AGREEMENT AND CERTIFICATES ON THE METHODOLOGY, TRANSLATIONS, REPRODUCTION.*	*(When different offers were not collected the Auditor explains the reasons provided by the Beneficiary under the caption "Exceptions" of the Report. The Agency will analyse this information to evaluate whether these costs might be accepted as eligible)*	
D	**USE OF EXCHANGE RATES**		
D.1	a) For Beneficiaries with accounts established in a currency other than euros **The Auditor sampled _____ cost items selected randomly and verified that the exchange rates used for converting other currencies into euros were in accordance with the following rules established in the Agreement** (*full coverage is required if there are fewer than 10 items, otherwise the sample should have a minimum of 10 item, or 10% of the total, whichever number is highest)*: *COSTS INCURRED IN ANOTHER CURRENCY SHALL BE CONVERTED INTO EURO AT THE AVERAGE OF THE DAILY EXCHANGE RATES PUBLISHED IN THE C SERIES OF OFFICIAL JOURNAL OF THE EUROPEAN UNION (https://www.ecb.int/stats/exchange/eurofxref/html/index.en.html), DETERMINED OVER THE CORRESPONDING REPORTING PERIOD.* *IF NO DAILY EURO EXCHANGE RATE IS PUBLISHED IN THE OFFICIAL JOURNAL OF THE EUROPEAN UNION FOR THE CURRENCY IN QUESTION, CONVERSION SHALL BE MADE AT THE AVERAGE OF THE MONTHLY ACCOUNTING RATES ESTABLISHED BY THE COMMISSION AND*	48) The exchange rates used to convert other currencies into Euros were in accordance with the rules established of the Grant Agreement and there was no difference in the final figures.	

Ref	Checks	Standard finding	Result (C / E /N.A)
	PUBLISHED ON ITS WEBSITE (http://ec.europa.eu/budget/contracts_grants/info_contracts/inforeuro/inforeuro_en.cfm), DETERMINED OVER THE CORRESPONDING REPORTING PERIOD.		
	b) For Beneficiaries with accounts established in euros **The Auditor sampled _____ cost items selected randomly and verified that the exchange rates used for converting other currencies into euros were in accordance with the following rules established in the Agreement** (*full coverage is required if there are fewer than 10 items, otherwise the sample should have a minimum of 10 item, or 10% of the total, whichever number is highest)*: *COSTS INCURRED IN ANOTHER CURRENCY SHALL BE CONVERTED INTO EURO BY APPLYING THE BENEFICIARY'S USUAL ACCOUNTING PRACTICES.*	49) The Beneficiary applied its usual accounting practices.	

[legal name of the audit firm]
[name and function of an authorised representative]

[dd Month yyyy]
<Signature of the Auditor



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