SEVENTH FRAMEWORK PROGRAMME

Grant agreement for: Public Procurement of Innovative solutions (PPI) Pilot[*]

Annex I - "Description of Work"

Project acronym: STOPandGO

Project full title: " Sustainable Technology for Older People – Get Organised "

Grant agreement no: 621013

Version date: 2014-06-18

Table of Contents

Part A

Workplan Tables

Project Number [1]	621013	Project Acronym [2]	STOPandGO

One form per project

General information

Project title [3]	Sustainable Technology for Older People – Get Organised
Starting date [4]	01/04/2014
Duration in months [5]	36
Call (part) identifier [6]	CIP-ICT-PSP-2013-7

Activity code(s) most relevant to your topic [7]	:		
Free keywords [8]		Innovative procurement, local flexibility, telehealth and telecare services, outcome-oriented, interoperability, sustainability	

Abstract [9]

The STOPandGO (Sustainable Technologies for Older People - Get Organised) consortium is a group of buyers and associated experts which offers an innovative procurement process aimed at securing cost-effective, care pathway oriented, sustainable and scale ICT-based telehealth and telecare services which will achieve clearly defined clinical and social outcomes. The target population to benefit from these products and services are frail and dependent elderly people, perhaps living with long term conditions such as Chronic Heart Failure and Diabetes, and their carers. This innovative procurement process will identify and evaluate a standard specification (with sufficient local flexibility) that can be used across the EU to enable scale deployment. The coordinated procurement process which will be used in diverse localities in four EU nation states will bring tested products and services to a much wider market, commencing with a target of 5,000 users. Interoperability and relevant standards will be built into the specification. The new procurement process and the services themselves will be fully evaluated and then widely disseminated through the STOPand GO Learning Network. The STOPandGO consortium includes the UK Department of Health, with its unique experience of operating the 3millionlives project and the Whole System Demonstrator evaluation, in addition to experienced and enthusiastic buyers from Italy, the Netherlands and Spain. As a procurement pilot our project will include buyers who are already willing and able to procure relevant products and services, but who are keen to take this opportunity to pilot our innovative procurement process. In order to ensure that our process is appropriate to the EU market we will initially conduct an Open Market Consultation and engage with relevant stakeholders across the clinical and social environment within the four contributing nations.

A2:
List of Beneficiaries

Project Number [1]		621013	Project Acronym [2]		STOPandGO

List of Beneficiaries

No	Name	Short name	Country	Project entry month[10]	Project exit month
1	STICHTING SMART HOMES	SMH	Netherlands	1	36
2	TELECARE SERVICES ASSOCIATION LBG	TSA	United Kingdom	1	36
3	INSTITUTO DE SALUD CARLOS III	ISCIII	Spain	1	36
4	LANCASHIRE CARE NHS FOUNDATION TRUST	NWCAHSN	United Kingdom	1	36
5	ESP CENTRAL LIMITED BY GUARANTEE	ESP	United Kingdom	1	36
6	LSE ENTERPRISE LIMITED	LSEE	United Kingdom	1	36
7	FEDERSANITA SERVIZI SRL	FSA	Italy	1	36
8	AGENZIA REGIONALE SANITARIA DELLA REGIONE CAMPANIA	ARSAN	Italy	1	36
9	ASL Roma D	RMD	Italy	1	36
10	AZIENDA SANITARIA PROVINCIALE DI CATANZARO	ASP CZ	Italy	1	36
11	NHS EASTERN CHESHIRE CLINICAL COMMISSIONING GROUP	EC	United Kingdom	1	36
12	GEMEENTE HELMOND	GMH	Netherlands	1	36

A3:
Budget Breakdown

| Project Number [1] | 621013 | | Project Acronym [2] | STOPandGO |

Participant number in this project [11]	Participant short name	Ind. costs[13]	Estimated eligible costs (whole duration of the project)			Requested EU contribution
			Innovation	Coordination	Total	
1	SMH	T	3,090,000.00	222,331.00	3,312,331.00	840,331.00
2	TSA	F	0.00	58,815.00	58,815.00	58,815.00
3	ISCIII	T	0.00	63,188.00	63,188.00	63,188.00
4	NWCAHSN	F	0.00	27,807.00	27,807.00	27,807.00
5	ESP	F	0.00	53,769.00	53,769.00	53,769.00
6	LSEE	F	0.00	263,563.00	263,563.00	263,562.00
7	FSA	F	0.00	77,622.00	77,622.00	77,622.00
8	ARSAN	T	3,090,000.00	39,664.00	3,129,664.00	657,664.00
9	RMD	F	3,090,000.00	40,017.00	3,130,017.00	658,017.00
10	ASP CZ	F	3,090,000.00	40,017.00	3,130,017.00	658,017.00
11	EC	F	3,870,000.00	56,955.00	3,926,955.00	830,955.00
12	GMH	F	1,000,000.00	56,955.00	1,056,955.00	256,955.00
Total			17,230,000.00	1,000,703.00	18,230,703.00	4,446,702.00

Note that the budget mentioned in this table is the total budget requested by the Beneficiary and associated Third Parties.

* The following funding schemes are distinguished

Collaborative Project (if a distinction is made in the call please state which type of Collaborative project is referred to: (i) Small of medium-scale focused research project, (ii) Large-scale integrating project, (iii) Project targeted to special groups such as SMEs and other smaller actors), Network of Excellence, Coordination Action, Support Action.

1. Project number

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

2. Project acronym

Use the project acronym as indicated in the submitted proposal. It cannot be changed, unless agreed during the negotiations. The same acronym **should appear on each page of the grant agreement preparation documents** 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 info 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 detailed justification on a separate note.

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. Activity code

Select the activity code from the drop-down menu.

8. Free keywords

Use the free keywords from your original proposal; changes and additions are possible.

9. Abstract

10. 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.

11. The number allocated by the Consortium to the participant for this project.

12. Include the funding % for RTD/Innovation – either 50% or 75%

13. Indirect cost model
    A: Actual Costs
    S: Actual Costs Simplified Method
    T: Transitional Flat rate
    F :Flat Rate

Workplan Tables

Project number

621013

Project title

STOPandGO—Sustainable Technology for Older People – Get Organised

Call (part) identifier

CIP-ICT-PSP-2013-7

Funding scheme

Public Procurement of Innovative solutions (PPI) Pilot

Project Number [1]	621013	Project Acronym [2]	STOPandGO

LIST OF WORK PACKAGES (WP)						
WP Number [53]	WP Title	Type of activity [54]	Lead beneficiary number [55]	Person-months [56]	Start month [57]	End month [58]
WP 1	Project management and co-ordination	COORD	1	44.00	1	36
WP 2	Preparation of the European Specification Template (EST)	COORD	2	24.50	1	8
WP 3	General Interoperability Aspects	COORD	3	9.00	1	36
WP 4	Legal, Ethical and Regulatory aspects	COORD	6	13.50	1	36
WP 5	Coordinating the Local Tendering Procedures	COORD	11	14.00	6	20
WP 6	Quality control and evaluation	COORD	6	13.50	1	36
WP 7	Coordinating the exploitation: training programmes and regional procurement plans	COORD	7	11.50	1	36
WP 8	Dissemination	COORD	5	12.00	1	36
			Total	142.00		

WT2:
List of Deliverables

Project Number [1]	621013	Project Acronym [2]	STOPandGO

Delive-rable Number [61]	Deliverable Title	WP number [53]	Lead benefi-ciary number	Estimated indicative person-months	Nature [62]	Dissemi-nation level [63]	Delivery date [64]
D1.1	Periodic reporting of project activities	1	1	35.00	R	PU	36
D1.2	Quality plan	1	1	3.00	R	PU	2
D1.3	Report on the activities of the National Mirror Panels	1	7	6.00	R	PU	36
D2.1	Reference Business Case	2	2	14.00	R	PU	5
D2.2	The European Specification Template (EST) and related materials	2	2	10.50	R	PU	8
D3.1	Interoperability requirements: STOPandGO Interoperability Framework	3	3	3.00	O	CO	8
D3.2	Guidelines on interoperability assessment for deployments	3	3	3.00	R	PP	20
D3.3	Analysis of overall performance of the STOPandGO Interoperability Framework (final report)	3	3	3.00	R	PU	36
D4.1	Report summarising key legal, ethical and regulatory issues in the four countries	4	6	3.00	R	PU	6
D4.2	Preparation of interim guidelines document for procurers on legal, regulatory	4	6	3.00	R	PU	8

Delive-rable Number [61]	Deliverable Title	WP number [53]	Lead benefi-ciary number	Estimated indicative person-months	Nature [62]	Dissemi-nation level [63]	Delivery date [64]
	and ethical issues						
D4.3	Final version of STOPandGO Legal, Ethical and Regulatory issues handbook for procurement	4	6	4.00	R	PU	34
D4.4	Report with lessons learnt on RLE and recommendations for procurement process	4	6	3.50	R	PU	34
D5.1	Report on the locality adoption of the project documentation and their intended usage	5	11	8.00	R	PU	12
D5.2	Report about the execution of the local tendering procedures	5	11	6.00	R	PU	20
D6.1	Evaluation framework for STOPandGO and related handbook for its application	6	6	5.00	R	PU	8
D6.2	Evaluation results	6	1	4.00	R	PU	36
D6.3	Analysis of results, lessons learnt about the evaluation processes	6	6	4.50	R	PU	36
D7.1	Consolidated release of the Reference Business Case	7	7	2.50	O	PU	31
D7.2	Consolidated release of the European Specification Template and the related materials	7	7	3.00	O	PU	36

Delive-rable Number [61]	Deliverable Title	WP number [53]	Lead benefi-ciary number	Estimated indicative person-months	Nature [62]	Dissemi-nation level [63]	Delivery date [64]
D7.3	Report on the comparison among the exploitation plans in the localities that decided to adopt the project's materials	7	7	3.00	R	PU	36
D7.4	Report on the lessons learned and recommendations about the appropriate usage of the PPI instrument in the field of eHealth	7	7	3.00	R	PU	36
D8.1	Report on dissemination activities	8	5	12.00	R	PU	36
			Total	142.00			

WT3:
Work package description

Project Number [1]	621013	Project Acronym [2]	STOPandGO

Work package number [53]	WP1	Type of activity [54]	COORD
Work package title	Project management and co-ordination		
Start month	1		
End month	36		
Lead beneficiary number [55]	1		

Objectives

This WP supports the administrative issues and the internal organization of the consortium on the following activities:
• To reach the objectives of the project within the agreed budget and time lines
• To orchestrate the work and ensure effective communication between all parties
• To establish a quality policy and ensure the quality of the work and deliverables
• To ensure that decisions are made on the basis of data and factual information
• To solve issues or conflicting situations
• To register all elements of the work appropriately and to time
• To link all the actions of the project to the risk assessment and control patterns
• To ensure that an infrastructure is set up in order to support the above.
In Italy and Spain, a partner will act as National Facilitator and will set up mirror panels to support the activities of the project in the various WPs. The Executive Board (EB) will be supported by the European Learning Network (ELN) and an Advisory Board (AB). The coordinator Smart Homes will work together with LSEE in setting up the ELN and AB, and LSEE will have a major role (as reflected in their PMs for WP1) in managing these bodies and IPR issues.

Description of work and role of partners

Task 1.1 - Administration
The organization leading this WP is responsible for:
• Organising and running project meetings
• Ensuring all elements of the work are registered appropriately and to time
• Collecting, submitting and distributing project deliverables
• Compiling and producing project reports, including Annual Reports and six-monthly progress reports
• Managing financial reports and payments
• Scheduling and progressing deliverables and reporting short-falls to the Executive Committee
• Organise regular reporting of work at all levels, links with EU Project Officer
• Organise regular reporting and accountability for financial management
• All other general project administrative tasks

Task 1.2 - Internal coordination among the WPs
The EB will perform the following activities:
• to ensure that STOPandGO procurement and technical objectives are met
• to monitor and assess STOPandGO achievements in terms of innovation
• to identify readjustments when needed at an operational level
• to ensure that the same terminology is used and a common understanding is reached
• to create, highlight and possibly identify synergy and dependencies, highlight exchanges and deliveries between WP's
• to highlight STOPandGO objectives and innovation and to assist with the review and adjust internal and official deliverables.

Task 1.3 - Liaison with external bodies and support to Advisory Board and ELN

A liaison will be established with external bodies, as the subgroup on Telemedicine of COCIR and the EIP AHA Action Groups (in particular B3 Integrated Care).
This task will also support the logistics of the Advisory Board (AB) and of the European Learning Network, and will manage the interaction between the project and their members.

Task 1.4 - Support to National activities
Two partners, respectively in IT and ES, will act as National Facilitators and will set up two kinds of Mirror Panels in its own country (one for the procurers, one for the providers). They will convene them periodically to orchestrate input to the project activities, to provide comments on the project outputs and to collaborate with the project as specified in the various WPs. Representatives of these panels will be members of the Advisory Board.

NOTE: Additional Mirror Panels may be established in other countries; their representatives will be included in the Advisory Board, however their activities will not receive a financial support by the project.

Person-Months per Participant

Participant number [10]	Participant short name [11]	Person-months per participant
1	SMH	22.50
2	TSA	2.00
3	ISCIII	2.00
4	NWCAHSN	1.00
5	ESP	2.00
6	LSEE	10.00
7	FSA	2.00
8	ARSAN	0.50
9	RMD	0.50
10	ASP CZ	0.50
11	EC	0.50
12	GMH	0.50
	Total	44.00

List of deliverables

Delive-rable Number [61]	Deliverable Title	Lead benefi-ciary number	Estimated indicative person-months	Nature [62]	Dissemi-nation level [63]	Delivery date [64]
D1.1	Periodic reporting of project activities	1	35.00	R	PU	36
D1.2	Quality plan	1	3.00	R	PU	2
D1.3	Report on the activities of the National Mirror Panels	7	6.00	R	PU	36
		Total	44.00			

Description of deliverables

D1.1) Periodic reporting of project activities: Delivery dates are throughout. [PMs of the previous partner (12) SAS have all been allocated to SMH and will be re-distributed whenever a new procurer will enter the project by means of an amendment] [month 36]

D1.2) Quality plan: [month 2]

D1.3) Report on the activities of the National Mirror Panels: Delivery dates M20,36 [month 36]

Milestone number [59]	Milestone name	Lead benefi-ciary number	Delivery date from Annex I [60]	Comments
MS1	Set up of the Advisory Board	6	2	
MS2	Set up of mirror panels in Italy and Spain	7	2	

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WT3:
Work package description

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Project Number [1]	621013	Project Acronym [2]	STOPandGO

Work package number [53]	WP2	Type of activity [54]	COORD
Work package title	Preparation of the European Specification Template (EST)		
Start month	1		
End month	8		
Lead beneficiary number [55]	2		

Objectives

The objective of this WP (together with the following WP3 and WP4 on general interoperability aspects and legal/ethical/regulatory issues) is to reach consensus at the European level on the fair and transparent development of an innovative European Specification Template (the PPI Pilot), which will be delivered and tested through locality tenders (WP5). This activity involves a comprehensive stakeholder engagement and consultation exercise for each locality associated with the PPI Pilot, which will enable the identification and assessment of all stakeholder concerns but especially those regarding issues such as ethical considerations, user safety and confidentiality.

Key objectives for this work package are the production of three products:
a Reference Business Case (e.g. user requirements, cost data on equipment and services) usable at the European level
the outcome-based European Specification Template (EST), validated by a formal Open Market Consultation
additional material to facilitate the application of the Template
The approval of these documents is the main milestone for the preparatory phase and marks the start of the locality procurements as per WP5. A consolidated version of these documents will be produced in WP7, after the evaluation of the Pilot in WP6.

Description of work and role of partners

Task 2.1 - Structured collection of information to build the Reference Business Case
The information could include:
description of current and planned formal programmes about care&cure provision, with the professional profiles involved
range of health conditions covered and social care risks addressed, with outcomes data such as mortality rates, emergency admissions, etc.
number of current telehealth and telecare users in the relevant locality and age range
levels of usage in terms of the type of service (and associated equipment)
levels of usage in terms of cost
qualitative data covering user satisfaction/confidence, if available
qualitative data covering informal carer perceptions (e.g. how confident do they feel that the service is improving quality of life/reducing risk etc.), if available
The providers will provide input about the currently available solutions, care&cure services augmented by technology, costs and lessons learned by their clients.

Task 2.2 – Develop a Reference Business Case
The acquired information will be aggregated and harmonised enhancing the most relevant and promising topics, by considering three perspectives:
the input suggested by analysis of the locality policies on health and social care
the locality telehealth/telecare initiatives
the international trends (evidence, best practices and market)
The goal is to build a generalised Reference Business Case, specifying the potential range of components that could be involved in the tenders, in terms of:
organisational models and locality priority settings
types of professional profiles and their reciprocal roles, including contact centres

potential criteria of patients stratification, according to clinical and social features

types of potential economic and contractual arrangements, including the role of the managers to allocate resources and control the change management processes within the procuring organisations

types of service delivery solutions (supported by technology), including the connection of telehealth and telecare services with the existing information systems, with the related interoperability issues

Task 2.3 – Produce the European Specification Template (EST) and related materials

The EST will promote an innovative procurement process founded on the service delivery approach and hence will be developed by taking into account inputs from all procurers (both direct and through the Procurement Coordinator), WP3, WP4 and the Open Market Consultation (Task 2.4) The European Specification Template will include

criteria to assess the bids for each component of the tender

a detailed list of potential indicators that could be later used to evaluate the deployment of the contracts.

The related activities, coordinated by the Procurement Coordinator and approved by the Executive Board, will produce a robust specification capable of being used by any procurer within Europe; based on a consensus-driven, iterative process of intermixed bottom-up and top-down steps.

This activity will begin with a clear definition of terms and metrics so that usage levels can be accurately and consistently measured across all participating localities.

This work will develop high-level scenarios for each selected topic, valid across Europe, giving consideration to the functionalities of the solutions available, or potentially available, now. Additional stakeholders might be engaged in the refinement of the scenarios, to obtain a coherent set of broad European scenarios, together with the high-level specifications of the infrastructures to be offered at the jurisdictional level.

This task will also produce the guidelines of how to apply the European Specification Template at the level of a locality.

Task 2.4 – Open Market Consultation of the European Specification Template

It is important to note that since the start of the project informal open market dialogue has been ongoing in each participating country and used to modify the content of this submission. Following more detailed discussions with the Advisory Board and within the EIP-AHA B3 Action Group about "Integrated Care", the European Specification Template will be submitted to a formal Open Market Consultation (OMC) and as suggested in the Guidelines for Applicants, the OMC will be announced via a PIN (Prior Information Notice) published in the OJEU, to provide additional input on and confirm the following issues:

models of service provision that provide the most effective benefits

solutions to assist in achieving identified outcomes on a leasing, payment by results basis

Input from the Advisory Board, the locality procurement teams and the Procurement Coordinator will be sought regarding the most comprehensive and efficient manner by which the OMC will take place but is likely to minimally involve:

use of a broad-based on-line questionnaire

at least one workshop supported by the use of webinars to ensure the involvement of all

N.B. It will be important to ensure penetration of, and input derived from other relevant organisations (who may not have seen the PIN e.g. SME's) through use of academic (e.g. Universities), trade association (e.g. TSA), carer/patient/service-user group, Mirror Panel (Spain and Italy) routes across the EU; a catalogue of which to be created during Task 2.1 and with feedback from the Advisory Board.

The result will be an enhanced and validated version of the European Specification Template, which will then be tested in WP5 by the tenders and evaluated in WP6; a final version of the European Specification Template will be produced in WP7 towards the end of the project.

Person-Months per Participant		
Participant number [10]	Participant short name [11]	Person-months per participant
1 SMH		2.00
2 TSA		4.00
3 ISCIII		1.50
4 NWCAHSN		1.00

Person-Months per Participant

Participant number [10]	Participant short name [11]	Person-months per participant
5	ESP	1.00
6	LSEE	6.00
7	FSA	2.00
8	ARSAN	1.00
9	RMD	1.00
10	ASP CZ	1.00
11	EC	2.00
12	GMH	2.00
	Total	24.50

List of deliverables

Delive-rable Number [61]	Deliverable Title	Lead benefi-ciary number	Estimated indicative person-months	Nature [62]	Dissemi-nation level [63]	Delivery date [64]
D2.1	Reference Business Case	2	14.00	R	PU	5
D2.2	The European Specification Template (EST) and related materials	2	10.50	R	PU	8
		Total	24.50			

Description of deliverables

D2.1) Reference Business Case: [month 5]

D2.2) The European Specification Template (EST) and related materials: [month 8]

Schedule of relevant Milestones

Milestone number [59]	Milestone name	Lead benefi-ciary number	Delivery date from Annex I [60]	Comments
MS3	Baseline data set for KPIs	2	4	
MS4	Draft EST	6	5	
MS5	Publication of PIN (Prior Information Notice) in the OJEU	2	5	
MS6	Consultation on Business Case and EST with the Advisory Board	6	5	
MS7	Consensus meeting with EIP-AHA B3	7	7	
MS8	Formal workshop for the Open Market Consultation	6	7	

WT3:
Work package description

Project Number [1]	621013	Project Acronym [2]	STOPandGO

Work package number [53]	WP3	Type of activity [54]	COORD
Work package title	General Interoperability Aspects		
Start month	1		
End month	36		
Lead beneficiary number [55]	3		

Objectives

This Work Package will define the framework of interoperability requirements and mechanisms needed to support the STOPandGO compliant deployments across a constellation of telehealth/telecare services in different national/regional/local environments, enabling synergies with existing legacy systems and allowing for smooth integration of new components.

This framework will help procurers to take advantage of the benefits provided by adopting appropriate interoperability requirements addressing their specific needs.

To achieve this main objective, the WP will:

• Develop a shared perspective and approach for the practical implementation of sound interoperability solutions for the telehealth/telecare systems to be procured. It will be targeted to achieve a predefined pragmatic level of interoperability (technical, semantic, organisational and legal) as required by the set of services and the different implementation contexts. This interoperability framework will rely on the critical analysis of existing practical experience for telehealth/telecare systems, both internally from STOPandGO partners and externally from other relevant sources. It will exploit the large and deep involvement of STOPandGO partners on standardization bodies (ISO-CEN, HL7, Continua Alliance) and research projects on the matter;

• Identify, analyse and adopt the most suitable standards and guidelines for the interoperability specifications as a critical part of the general specifications;

• Produce criteria for the continuous assessment on interoperability aspects, before, during and after the tendering process, including interoperability testing in the implemented pilots;

• Develop guidelines on interoperability as a companion of the European Specification Template, as part of the materials that will be delivered at the end of the project;

• Contribute with its results to the EIP-AHA effort, regarding interoperability and standards aspects in the deployment at scale of telehealth/telecare systems for integrated care in Europe. Furthermore, it is expected that results will contribute to the construction of the European Interoperability Framework for eHealth and Public Services.

Dependencies: This WP will work closely with the other WPs under the general coordination of the Project. Particularly continuous inter-working will be maintained with WP2 and WP5 on Procurement and Tendering Process. The WP4 on Legal and Ethical aspects will provide basic inputs, particularly to the works on legal interoperability. Furthermore its results will serve as input to the proposed activities of Evaluation and Dissemination WPs.

Description of work and role of partners

Task 3.1 - Definition of the STOPandGO Interoperability Framework
This task will provide a common reference framework concerning the scope and issues addressed at the WP considering the four levels of Technical, Semantic, Organisational and Legal Interoperability following the recommendations from the European Interoperability Framework (EIF). The task will start with the creation of the STOPandGO Interoperability Working Group (IWG), i.e. a network of interoperability experts associated with contracting authorities through which knowledge, experience, criteria, guidelines and outcomes could be shared along the procurement process and during the implementation and evaluation of the deployments.
The Interoperability framework will be based in pre-existing knowledge and experiences provided by the STOPandGO partners and from other relevant parties through the network of interoperability experts.

Task 3.2 - Definition of Interoperability Requirements for the STOPandGO procurement process
This task will define a set of interoperability requirements which translate the procurers' needs and desires to the market. These requirements will be developed aiming to be clear for vendors knowing what is expected. These specifications will be forwarded and promoted also within the appropriate standard developing organizations. The interoperability requirements will be established in coherence with the overall specifications in WP2. Finally the Interoperability Procurement Specs will be produced.

Task 3.3 - Conformance of procurement documentation to ISO/EN 13940
This task will focus on the common definition of the concepts managed in the procurement process based on the set of concepts on continuity of care provided by the norm ISO/EN 13940 (ContSys), following the interoperability framework defined. The main objective is to harmonize the concepts across the different STOPandGO sites, setting the bases for the organisational interoperability and facilitating the development of similar specifications for procurements across borders.

Task 3.4 – Guidelines on Interoperability Assessment
The complexity of model interoperations between all system types and the impossibility of cataloguing them has precluded the publication of a general method of measuring interoperability. Because of the difficulty in adopting a general interoperability measurement method, this Task will relay upon a problem decomposition approach in order to quantify interoperability in an actionable way. Following that, technical, semantic, organisational and legal dimensions will be addressed in a separate way. The task will produce Interoperability Assessment guidelines for the different stages of the procurement process, from the inception of the system to the evaluation of the implemented pilots after tendering.

Task 3.5 - Evaluation of the interoperability performance in the different localities
This task aims to measure and document the interoperability level of performance achieved by the implemented systems according to the requirements and evaluation methods specified in Task 3.4. It will be devoted to the overall analysis of the information collected about the interoperability approaches, procedures and achievements along all the procurement process (before, during and after) in STOPandGO, making new evidence coming to light from the experience cumulated through the Project practical implementation. The results of this task will be a very interesting input for the normalization European process, so they will be submitted to the EIP-AHA initiative and to the TC 251 of CEN.

Person-Months per Participant

Participant number [10]	Participant short name [11]	Person-months per participant
1	SMH	1.50
2	TSA	0.00
3	ISCIII	3.00
5	ESP	0.00
6	LSEE	1.00
7	FSA	0.00
8	ARSAN	0.50
9	RMD	0.50
10	ASP CZ	0.50
11	EC	1.00
12	GMH	1.00
	Total	9.00

Delive-rable Number [61]	Deliverable Title	Lead benefi-ciary number	Estimated indicative person-months	Nature [62]	Dissemi-nation level [63]	Delivery date [64]
D3.1	Interoperability requirements: STOPandGO Interoperability Framework	3	3.00	O	CO	8
D3.2	Guidelines on interoperability assessment for deployments	3	3.00	R	PP	20
D3.3	Analysis of overall performance of the STOPandGO Interoperability Framework (final report)	3	3.00	R	PU	36
	Total		9.00			

Description of deliverables

D3.1) Interoperability requirements: STOPandGO Interoperability Framework: [month 8]

D3.2) Guidelines on interoperability assessment for deployments: M10, M20 [month 20]

D3.3) Analysis of overall performance of the STOPandGO Interoperability Framework (final report): [month 36]

Schedule of relevant Milestones

Milestone number [59]	Milestone name	Lead benefi-ciary number	Delivery date from Annex I [60]	Comments
MS9	Input to WP2 on conformance to ISO/EN 13940	3	4	
MS10	Agreed input on standards to WP2	3	5	
MS11	Dialogue with CEN and other standardization bodies	3	34	

Project Number [1]	621013	Project Acronym [2]	STOPandGO

One form per Work Package			

Work package number [53]	WP4	Type of activity [54]	COORD
Work package title	Legal, Ethical and Regulatory aspects		
Start month	1		
End month	36		
Lead beneficiary number [55]	6		

Objectives

This Work Package is focused on all legal and ethical issues related to the execution of the project itself as well as all those related to the tendering process and subsequent service provision and evaluation. This involves providing guidance and examples of good practice to help advise on best standards in the management, encryption, storage, transfer and analysis of electronic and physical personal data subject to the provisions of EC Directive 95/46/EC and further national/regional requirements in respect of both electronic and physical data. It will also ensure that any changes in European legal requirements during the lifetime of the project are complied with where necessary. It will also provide guidance and examples of good practice in respect of any ethical and consent issues in respect of data collected from different end users (including service providers, service users and their families) , for instance on their experiences in using / providing the innovative services supplied. In most instances these data will be managed by project partners, but in some instances sub-contractors could potentially be involved (e.g. in respect of local assessment and evaluation).
The principal objectives are therefore:
- To help ensure the use of rigorous standards and protocols to ensure the privacy and security of all collected electronic and physical data
- To assess the need for ethical approval in respect of any data collection and interaction with service providers and service users in each of the four countries and to provide support for any ethical application procedures (or exemptions) that must be obtained at either a central or country specific level.
- To help monitor and provide information and support to help in compliance with ethical requirements throughout the lifetime of the project.
- To develop a guide on managing legal, ethical and regulatory issues across countries asp part of procurement process for the roll out of proven innovative technologies in order to help limit the liability of the supplier and to safeguard the rights of end users.
- To develop a comprehensive map of the legal contexts applicable in innovative procurement in the four countries, including European, national and regional requirements.
- To undertake a limited analysis to identify any further major potential additional issues in respect of procurement that might be seen in some other parts of Europe due to differences in system structures
- To undertake an analysis of results and cross-comparison of experiences to generate "lessons learnt" and recommendations.

Dependencies: it provides input to WP2. It provides helpdesk support to WP5, WP6

Description of work and role of partners

Task 4.1 - Analysis of privacy and ethical requirements for the development, implementation and assessment of the procurement process.
This task will involve an analysis of the types of data that need to be collected, scope for anonymising data, and the need to obtain service user experiential assessments. This will involve providing guidance and examples of good practice to help advise on best standards in the management, encryption, storage, transfer and analysis of electronic and physical personal data subject to the provisions of EC Directive 95/46/EC and further national/regional requirements in respect of both electronic and physical data. Special attention will be put cross-border and cross-sector information sharing. Any potential ethical issue will be analysed and a plan developed to comply with any ethical procedures.

Task 4.2 - Analysis of the legal frameworks governing innovative public procurement procedures.
European, national, regional and local standards, regulations and legislation will be analysed to help collate key information to help make the procurement process as clear as possible for procurers.

Task 4.3 - Development of guidelines for procurers and requirements to be included in the tender template to assure the bidders will be compliant with Legal, Regulatory and Ethical issues.
Procurers are very much familiar with data protection, but sub-contracting services is a common risk for lack of compliance. Also STOPandGO consortium is very much aware of the need of imposing a high ethical level requirement in the procurement tender. Regulatory requirements (such as accessibility) and the applicable legal framework for service provision will be included.

Task 4.4 - Legal, ethical and regulatory helpdesk.
Help and support will be provided throughout the project for partners and help in complying, making applications for any ethical approvals that might at all be needed (or required to demonstrate exemptions).

Task 4.5 - Analysis of results and generation of lessons learnt and recommendations

Person-Months per Participant

Participant number [10]	Participant short name [11]	Person-months per participant
1	SMH	2.00
2	TSA	0.00
3	ISCIII	1.00
5	ESP	1.00
6	LSEE	4.00
7	FSA	0.50
8	ARSAN	1.00
9	RMD	1.00
10	ASP CZ	1.00
11	EC	1.00
12	GMH	1.00
	Total	13.50

List of deliverables

Deliverable Number [61]	Deliverable Title	Lead beneficiary number	Estimated indicative person-months	Nature [62]	Dissemination level [63]	Delivery date [64]
D4.1	Report summarising key legal, ethical and regulatory issues in the four countries	6	3.00	R	PU	6
D4.2	Preparation of interim guidelines document for procurers on legal, regulatory and ethical issues	6	3.00	R	PU	8
D4.3	Final version of STOPandGO Legal, Ethical and Regulatory issues handbook for procurement	6	4.00	R	PU	34

	List of deliverables					

Delive-rable Number [61]	Deliverable Title	Lead benefi-ciary number	Estimated indicative person-months	Nature [62]	Dissemi-nation level [63]	Delivery date [64]
D4.4	Report with lessons learnt on RLE and recommendations for procurement process	6	3.50	R	PU	34
		Total	13.50			

	Description of deliverables

D4.1) Report summarising key legal, ethical and regulatory issues in the four countries: [month 6]

D4.2) Preparation of interim guidelines document for procurers on legal, regulatory and ethical issues: [month 8]

D4.3) Final version of STOPandGO Legal, Ethical and Regulatory issues handbook for procurement: [month 34]

D4.4) Report with lessons learnt on RLE and recommendations for procurement process: [month 34]

	Schedule of relevant Milestones

Milestone number [59]	Milestone name	Lead benefi-ciary number	Delivery date from Annex I [60]	Comments
MS12	LRE helpdesk becomes operative	6	3	

Project Number [1]	621013	Project Acronym [2]	STOPandGO

Work package number [53]	WP5	Type of activity [54]	COORD
Work package title	Coordinating the Local Tendering Procedures		
Start month	6		
End month	20		
Lead beneficiary number [55]	11		

Objectives

This work package is focussing on the locality tendering procedures; it builds on the activities at EU level carried out in WP2, WP3 and WP4. The Procurement Coordinator and the Executive Board will coordinate the local activities by the procurers, from the preparation of the tenders up to the signature of the contracts.
Thus the key objectives are:
• to adopt and localize the Reference Business Case and the European Specification Template according to the needs of the locality;
• to award and sign off the contracts.
Additional procurers, in addition to the partners of the project, may wish to manage a tendering process according to the STOPandGO materials; however their deployments will not be evaluated by the project and will not receive a financial support by the project.

Dependencies: receives input from WP2, WP3, WP4; it is a prerequisite for WP6, WP7

Description of work and role of partners

Task 5.1 – Adoption of the Business Case and the European Specification Template.
The clinical and operational staff and procurement specialists from the partner organisations will adopt and translate the materials produced by the project (Business case, European Specification Template, etc.) according to their respective contexts, under the supervision of the Executive Board, to obtain a locality version compatible with the European Specification Template developed in WP2.
This material will be suitable for a wider debate beyond the project, for exploitation with early adopters in WP7, and for dissemination purposes in WP8.
Each locality will assess the current and planned organization of its healthcare and social services, and will perform a stocktake for each tender, to determine current telehealth/telecare usage to assist with baselining Key Performance Indicators, so that they will be able to further refine their Business Case:
• Setting out the cost of procuring and delivering the service and how those costs are broken down;
• Specifying the clinical, social, commercial, financial and economic benefits expected from the programme with indications of how and when these will be realised.

Having adopted the European Specification Template, the locality will be able to refine it in accordance to its local needs pending final approval by the Executive Board; the steps involved in producing the service specification for each tender, together with the appropriate assessment criteria, are as follows:
• Define ambition (identify numbers using risk stratification tools). This activity will need to achieve a balance between careful selection of suitable users based on clinical need, user safety and risk assessment and the imperative to scale up service provision in order to reduce costs;
• Define the distinctions and common features of telehealth and telecare. Some users will need care packages composed of elements of both;
• Use available materials and learning from previous projects to identify required outcomes;
• Define what is meant by integrated care and ensure that the specification clearly states how this will contribute to the required outcomes;
• Define the interface between primary care and acute (secondary/hospital) services in both directions, i.e. the criteria for determining when hospital admission (including outpatient services) is appropriate for users and care plans for discharged patients;

• Define service standards for the user.

Task 5.2 - Manage the locality procurement procedure
Each locality, coordinated by the Procurement Coordinator and verified at the level of the Executive Board and aligned with the other localities within the WP, will issue its invitations to tender and assess the tender responses according to the normal EU/National legislation and current guidance, managing the tendering procedure up to the signature of the contract and the formal OJEU Award Notice. The contract will be awarded to the Most Economically Advantageous Tender, rather than merely on price.

Person-Months per Participant

Participant number [10]	Participant short name [11]	Person-months per participant
1	SMH	2.00
2	TSA	1.00
3	ISCIII	1.00
5	ESP	0.00
6	LSEE	2.00
7	FSA	1.00
8	ARSAN	1.00
9	RMD	1.00
10	ASP CZ	1.00
11	EC	2.00
12	GMH	2.00
	Total	14.00

List of deliverables

Deliverable Number [61]	Deliverable Title	Lead beneficiary number	Estimated indicative person-months	Nature [62]	Dissemination level [63]	Delivery date [64]
D5.1	Report on the locality adoption of the project documentation and their intended usage	11	8.00	R	PU	12
D5.2	Report about the execution of the local tendering procedures	11	6.00	R	PU	20
			Total	14.00		

Description of deliverables

D5.1) Report on the locality adoption of the project documentation and their intended usage: SAS & SMH [SAS is not participating anymore, but will be replaced (intended) by a new procurer -> a procurer should lead WP5] [month 12]

D5.2) Report about the execution of the local tendering procedures: SAS & SMH [SAS is not participating anymore, but will be replaced (intended) by a new procurer -> a procurer should lead WP5] [month 20]

Schedule of relevant Milestones				
Milestone number [59]	Milestone name	Lead beneficiary number	Delivery date from Annex I [60]	Comments
MS13	OJEU Notice published about all the local tenders	6	11	
MS14	All invitations to Tender drawn up and sent to short listed bidders	6	19	
MS15	After the standstill period, all contracts signed	6	18	

WT3:
Work package description

Project Number [1]	621013	Project Acronym [2]	STOPandGO

Work package number [53]	WP6	Type of activity [54]	COORD
Work package title	Quality control and evaluation		
Start month	1		
End month	36		
Lead beneficiary number [55]	6		

Objectives

This WP is focused on the evaluation and quality assessment of the project development and project outcomes. The main objectives are:
- Evaluation of the achievement of project objectives (public procurement procedure, quality of services provided, experience in local implementation, quality of feedback from service users and service providers …).
- Evaluation of agreed key indicators on the quality and impact of the project sites in terms of including quality of service provided, impact on health status of target population and informal carers, budgetary impacts and return on investment
- Evaluation of the contribution of the project to the achievement of the EIP-AHA objectives.
- Contribution to the European Knowledge Base by extracting lessons learnt from the comparative analysis.
To develop this work it will be necessary first to define the evaluation methodology and secondly to apply it. The results of this work package should be useful for adoption and refinement of innovative procurement procedure, decisions making on extension or adoption of services and cross-learning.

Dependencies: It starts in M1 to monitor the activities on the indicators in WP2. The main operational phase follows the signature of contracts in WP5. It influences the exploitation in WP7 and the dissemination in WP8.

Description of work and role of partners

Task 6.1 - Development of an evaluation framework for STOPandGO.
During this task the specific elements to be evaluated will be identified as the time that the scope of the tendering process is being determined in earlier work packages. This will help determine a range of generic outcome measures for all countries, as well as potentially some country specific outcomes depending on how the scope of tenders may differ.. These outcomes will both inform the ongoing implementation of innovation but also can be used in terms of judging the performance of service providers in line with any stipulations set out in contracts for service provision. This information can also be used by service providers to improve the quality of services providers, e.g. drawing on feedback and experience from end users.
When possible, existing methodologies already in use in Europe will be adopted (as MAST or FIM, for example). The contribution to the EIP-AHA will be evaluated using the framework currently under development by IPTS, if available.
Complete plan of evaluation including indicators, evaluation procedure and adequate timescale for collection of data will be developed.
The collection of necessary data from pilot sites will be included as part of tender requirements and subsequent contracts with procurers.

Task 6.2 - Actual services deployment and continuous evaluation.
The providers will deploy their services and each local procurer will monitor the steps in the advancement of the contract in its locality, reporting continuously to the Executive Board about quality control and evaluation of the service provision.
Evaluation will be performed by collecting data and applying the adopted methodology to get the full set of indicators, described in previous task.

Task 6.3 - Analysis of results.
The obtained results will be analysed, when necessary further inquiries will be made to identify the reasons behind unexpected results.

Comparative analysis will be performed and lesson learnt will be developed.

Person-Months per Participant

Participant number [10]	Participant short name [11]	Person-months per participant
1	SMH	1.00
2	TSA	0.00
3	ISCIII	1.50
5	ESP	0.00
6	LSEE	3.00
7	FSA	1.00
8	ARSAN	1.00
9	RMD	1.00
10	ASP CZ	1.00
11	EC	2.00
12	GMH	2.00
	Total	13.50

List of deliverables

Delive-rable Number [61]	Deliverable Title	Lead benefi-ciary number	Estimated indicative person-months	Nature [62]	Dissemi-nation level [63]	Delivery date [64]
D6.1	Evaluation framework for STOPandGO and related handbook for its application	6	5.00	R	PU	8
D6.2	Evaluation results	1	4.00	R	PU	36
D6.3	Analysis of results, lessons learnt about the evaluation processes	6	4.50	R	PU	36
		Total	13.50			

Description of deliverables

D6.1) Evaluation framework for STOPandGO and related handbook for its application: [month 8]

D6.2) Evaluation results: [month 36]

D6.3) Analysis of results, lessons learnt about the evaluation processes: [month 36]

Schedule of relevant Milestones

Milestone number [59]	Milestone name	Lead benefi-ciary number	Delivery date from Annex I [60]	Comments
MS16	All contracts commencing service delivery	6	16	

Project Number [1]	621013	Project Acronym [2]	STOPandGO

One form per Work Package			
Work package number [53]	WP7	Type of activity [54]	COORD
Work package title	Coordinating the exploitation: training programmes and regional procurement plans		
Start month	1		
End month	36		
Lead beneficiary number [55]	7		

Objectives

The ultimate goal of the PPI instrument is to stimulate a progressive process of adoption of innovative solutions; the project will develop a handbook with a Business Plan to advise future "Early Adopters" of such schemes. Therefore the project will revise the tendering materials (Business Case, European Specification Template, educational materials, etc.), using the accumulated advancing insight, knowledge and experience acquired through the project and in particular within the initial deployments.

To take advantage of the lessons learned and of the structured know how, during and after the project end, STOPandGO will promote training programmes and the propagation of the procurement activities to new named localities.

Dependencies: it is related with the main WPs on procurement and deployment (WP2, WP5, WP6). It provides input to the dissemination activities in WP8.

Description of work and role of partners

Task 7.1 – Training programme on the STOPandGO methodology
A training programme will be developed to support businesses and government agencies, as well new potential procurers, on the procurement processes according to the material produced by the project. The first version of the programme will be based on the version of the project's materials produced within WP2.
The programme will be first applied in UK and Italy, as part of the identified WPs in STOPandGO; it will continue up to the end of the project and beyond:
• UK - Development of Continuing Professional Development (CPD) for vendor and purchaser actors based on extension of existing TSA Codes of Practice and emerging CCG procurement guidance;
• IT – FSA, through its ongoing collaboration with the National High School of Administration - SSPA of the Council of Ministers, will introduce the topics of the project within suitable courses for public healthcare managers. In addition it will organize training programmes among its members, also through its CPD programme "SALUSNET" for Continuing Education in Medicine (ECM).
Further organisations may be willing to organise training programmes in additional localities, adopting the STOPandGO materials; however these activities will not be considered as a contractual obligation for the other project's partners.

Task 7.2 – Consolidated release of the Reference Business Case, the European Specification Template and the related materials.
The task focuses on the assessment of the EST and of the related materials for its application. It will consider the actual adaptability and usability of the specification in the local contexts, to perform a revision of the Reference Business Case and the European Specification Template, together with the materials to facilitate the exploitation of the Template by the Early Adopters in their particular context. The training programme of Task 7.1 will be revised accordingly.
An earmarked discussion will be carried on within the EIP-AHA Action Group B3 "Integrated Care" to reach consensus on the consolidated release of these materials, which could be then endorsed by the Action Group. The most significant parts of the STOPandGO consolidated materials will be translated into the languages of the involved countries.

Task 7.3 – Lessons learned about the PPI instrument and exploitation plans based the project materials

The lessons learned by the STOPandGO project will be systematized for the benefit of the next use in similar topics, to produce recommendations about strengths and weaknesses of the PPI instrument and to suggest its optimal usage, as well the risks and the challenges to be faced. For this purpose, this WP will monitor the advancement of the PPI pilot since the beginning.

The process of change management demonstrated with the PPI deployments should continue with a set of explicit Programmes in various jurisdictions. They will propagate the experience of the procurers within the project (i.e. the pathfinders, acting as Innovators) to fast followers localities (Early Adopters) and eventually to entire Regions (Early Majority), after an assessment of the benefits and obstacles related to the tender(s), a re-assessment of priorities and needs across the jurisdiction, and an extension in various zones and/or for different target populations.

The lessons learned and the comparison among the locality exploitation activities will provide useful suggestions to further refine the project's materials.

Person-Months per Participant

Participant number [10]	Participant short name [11]	Person-months per participant
1	SMH	1.00
2	TSA	1.00
3	ISCIII	1.00
4	NWCAHSN	1.00
5	ESP	1.00
6	LSEE	1.00
7	FSA	3.00
8	ARSAN	0.50
9	RMD	0.50
10	ASP CZ	0.50
11	EC	0.50
12	GMH	0.50
	Total	11.50

List of deliverables

Deliverable Number [61]	Deliverable Title	Lead beneficiary number	Estimated indicative person-months	Nature [62]	Dissemination level [63]	Delivery date [64]
D7.1	Consolidated release of the Reference Business Case	7	2.50	O	PU	31
D7.2	Consolidated release of the European Specification Template and the related materials	7	3.00	O	PU	36
D7.3	Report on the comparison among the exploitation plans in the localities that decided to adopt the project's materials	7	3.00	R	PU	36

List of deliverables

Delive-rable Number [61]	Deliverable Title	Lead benefi-ciary number	Estimated indicative person-months	Nature [62]	Dissemi-nation level [63]	Delivery date [64]
D7.4	Report on the lessons learned and recommendations about the appropriate usage of the PPI instrument in the field of eHealth	7	3.00	R	PU	36
		Total	11.50			

Description of deliverables

D7.1) Consolidated release of the Reference Business Case: [month 31]

D7.2) Consolidated release of the European Specification Template and the related materials: [month 36]

D7.3) Report on the comparison among the exploitation plans in the localities that decided to adopt the project's materials: [month 36]

D7.4) Report on the lessons learned and recommendations about the appropriate usage of the PPI instrument in the field of eHealth: M8, M20, M36 Delivery [month 36]

Schedule of relevant Milestones

Milestone number [59]	Milestone name	Lead benefi-ciary number	Delivery date from Annex I [60]	Comments
MS17	Schedule and syllabus for the training programmes	6	12	
MS18	Exploitation plans by procurers of different localities outside the project, as Early Adopters	7	34	
MS19	Translations of the most significant parts of the STOPandGO consolidated materials into National lan	7	34	

Project Number [1]	621013	Project Acronym [2]	STOPandGO

One form per Work Package			

Work package number [53]	WP8	Type of activity [54]	COORD
Work package title	Dissemination		
Start month	1		
End month	36		
Lead beneficiary number [55]	5		

Objectives

The principal purpose of the WP is to spread best practice as it emerges over a wide variety of media. There are three innovations being prototyped:
1. An outcomes based service specification that does not prescribe the technological means to deliver services (it is technology/supplier agnostic);
2. Best value Most Economically Advantageous Tender (MEAT) assessment of tenders and selection based on KPIs that demonstrate improved life outcomes (added Healthy Life Years - HLY), and an element of payment by results (PBR);
3. The ongoing management and evaluation of services based on output and outcome KPIs.
A further objective is to share learning with other PPI projects, primarily from the SILVER and HAPPI programmes. This shared experience shared across networks and be fed back to the EC and at relevant public H2020 information/briefing events.
STOPandGO is a pathfinder project. There is scope for rapid and significant improvement in the effectiveness and economy of services that support Independent Healthy Living through widespread adoption of the STOPandGO materials.
In this WP we will raise awareness of the project and promulgate know-how, including of measures that will establish better procurement of more relevant services, in locations outside of the project in a timely manner.
The PPI instrument is of itself innovative, with a clear purpose to promote coherent, innovative procurements that result in the evolution of the market.
EIP-AHA is the privileged environment for dissemination. Hundreds of organizations manifested their commitments towards the goals of Horizon 2020 and in particular on Active and Healthy Ageing actual programs.

Dependencies: It receives input by all the previous WPs.

Description of work and role of partners

Task 8.1 Dissemination through EIP AHA and H2020 information days.
The lessons learned by the project, and in particular the STOPandGO materials (EST + Guidelines on Interoperability, LRE issues, evaluation and education), will be systematically disseminated in public related events, e.g. on EIP-AHA and at the H2020 Information days.

Task 8.2 European Learning Network (ELN).
The ELN, working closely with the European Knowledge Tree Group, will be developed as a relevant dissemination channel. As a network of networks it will disseminate high-level news and updates on progress of STOPandGO. Membership will be such that it links through:
• Across Europe - European Knowledge Tree Group activity across this domain, AAL Forum, Care Assistance Search Agency (CASA) project, EIP AHA and PPI programmes/projects (e.g. SILVER; HAPPI)
• UK - ESP and HealthTech and Medicines Knowledge Transfer Networks, TSA, 3millionlives
• The Netherlands – Slimmer Leven 2020 ('Smarter Living 2020') innovation network, Brainport, the province of Noord-Brabant and Stichting Smart Homes partner communities
• Italy – FSA, the Italian Federation of Healthcare Trusts and Municipalities, which will involve the network of their members.

Task 8.3 Web and media based dissemination.

• UK – ESP will actively host the project portal carrying news items, public deliverables, articles and collateral from events, blogs (including that of project leaders); a dedicated twitter account; a TSA online presence; linkage to the Telecare Learning and Innovation Network; journalistic description of the project.
• The Netherlands – Smart Homes web portal, LinkedIn groups on domotics and smart living, web portal of the province Noord Brabant.
• IT – FSA will disseminate the know how through its initiative, named "CATALIS", which involves a community about care&cure services augmented by technology, providing a portal, a newsletter, a documentation centre, a discussion forum, face-to-face workshops involving also industry and top management of the local trusts and municipalities
• All Partners will support dissemination through their own websites, and similar connectors to promulgate material developed throughout the project.
• Extensions of education and training material generated in other WPs will also be disseminated in this manner.

Task 8.4 Programme of dedicated events
Presentations at relevant events, such as: the European Knowledge Tree Group, the AAL Forum 2014, Domotics and Smart Living Fair 2014, Health & ICT fair 2014, EKTG 2014. Events to be determined in quarterly rolling review.

Person-Months per Participant

Participant number [10]	Participant short name [11]	Person-months per participant
1	SMH	2.00
2	TSA	1.00
3	ISCIII	1.50
4	NWCAHSN	1.00
5	ESP	3.00
6	LSEE	2.00
7	FSA	1.50
8	ARSAN	0.00
9	RMD	0.00
10	ASP CZ	0.00
11	EC	0.00
12	GMH	0.00
	Total	12.00

List of deliverables

Deliverable Number [61]	Deliverable Title	Lead beneficiary number	Estimated indicative person-months	Nature [62]	Dissemination level [63]	Delivery date [64]
D8.1	Report on dissemination activities	5	12.00	R	PU	36
	Total		12.00			

Description of deliverables

D8.1) Report on dissemination activities: M12,24,36 [month 36]

Schedule of relevant Milestones

Milestone number [59]	Milestone name	Lead benefi-ciary number	Delivery date from Annex I [60]	Comments
MS20	Launch of project website with associated twitter account and linkedin group	5	2	
MS21	Schedule of dissemination events established (rolling quarterly review)	5	4	M4, etc.
MS22	Dissemination of finalised EST via web and physical events	6	9	
MS23	Announcement of successful tenders, publication of service specifications	5	15	
MS24	Annual public project meetings and press releases with news of results	5	32	M8,20,32
MS25	Public dissemination materials on PPI instrument	1	36	throughout

Project Number [1]	621013	Project Acronym [2]	STOPandGO

List and Schedule of Milestones

Milestone number [59]	Milestone name	WP number [53]	Lead beneficiary number	Delivery date from Annex I [60]	Comments
MS1	Set up of the Advisory Board	WP1	6	2	
MS2	Set up of mirror panels in Italy and Spain	WP1	7	2	
MS3	Baseline data set for KPIs	WP2	2	4	
MS4	Draft EST	WP2	6	5	
MS5	Publication of PIN (Prior Information Notice) in the OJEU	WP2	2	5	
MS6	Consultation on Business Case and EST with the Advisory Board	WP2	6	5	
MS7	Consensus meeting with EIP-AHA B3	WP2	7	7	
MS8	Formal workshop for the Open Market Consultation	WP2	6	7	
MS9	Input to WP2 on conformance to ISO/EN 13940	WP3	3	4	
MS10	Agreed input on standards to WP2	WP3	3	5	
MS11	Dialogue with CEN and other standardization bodies	WP3	3	34	
MS12	LRE helpdesk becomes operative	WP4	6	3	
MS13	OJEU Notice published about all the local tenders	WP5	6	11	
MS14	All invitations to Tender drawn up and sent to short listed bidders	WP5	6	19	
MS15	After the standstill period, all contracts signed	WP5	6	18	

Milestone number [59]	Milestone name	WP number [53]	Lead beneficiary number	Delivery date from Annex I [60]	Comments
MS16	All contracts commencing service delivery	WP6	6	16	
MS17	Schedule and syllabus for the training programmes	WP7	6	12	
MS18	Exploitation plans by procurers of different localities outside the project, as Early Adopters	WP7	7	34	
MS19	Translations of the most significant parts of the STOPandGO consolidated materials into National lan	WP7	7	34	
MS20	Launch of project website with associated twitter account and linkedin group	WP8	5	2	
MS21	Schedule of dissemination events established (rolling quarterly review)	WP8	5	4	M4, etc.
MS22	Dissemination of finalised EST via web and physical events	WP8	6	9	
MS23	Announcement of successful tenders, publication of service specifications	WP8	5	15	
MS24	Annual public project meetings and press releases with news of results	WP8	5	32	M8,20,32
MS25	Public dissemination materials on PPI instrument	WP8	1	36	throughout

WT5:
Tentative schedule of Project Reviews

Project Number [1]	621013	Project Acronym [2]	STOPandGO

Tentative schedule of Project Reviews			
Review number [65]	Tentative timing	Planned venue of review	Comments, if any
RV 1	12	Brussels Review	
RV 2	24	Onsite Review	
RV 3	36	Brussels Review	Depending on the possibilities, RV3 could be onsite instead of RV2

WT6:
Project Effort by Beneficiary and Work Package

Project Number [1]	621013	Project Acronym [2]	STOPandGO

Indicative efforts (man-months) per Beneficiary per Work Package

Beneficiary number and short-name	WP 1	WP 2	WP 3	WP 4	WP 5	WP 6	WP 7	WP 8	Total per Beneficiary
1 - SMH	22.50	2.00	1.50	2.00	2.00	1.00	1.00	2.00	34.00
2 - TSA	2.00	4.00	0.00	0.00	1.00	0.00	1.00	1.00	9.00
3 - ISCIII	2.00	1.50	3.00	1.00	1.00	1.50	1.00	1.50	12.50
4 - NWCAHSN	1.00	1.00	0.00	0.00	0.00	0.00	1.00	1.00	4.00
5 - ESP	2.00	1.00	0.00	1.00	0.00	0.00	1.00	3.00	8.00
6 - LSEE	10.00	6.00	1.00	4.00	2.00	3.00	1.00	2.00	29.00
7 - FSA	2.00	2.00	0.00	0.50	1.00	1.00	3.00	1.50	11.00
8 - ARSAN	0.50	1.00	0.50	1.00	1.00	1.00	0.50	0.00	5.50
9 - RMD	0.50	1.00	0.50	1.00	1.00	1.00	0.50	0.00	5.50
10 - ASP CZ	0.50	1.00	0.50	1.00	1.00	1.00	0.50	0.00	5.50
11 - EC	0.50	2.00	1.00	1.00	2.00	2.00	0.50	0.00	9.00
12 - GMH	0.50	2.00	1.00	1.00	2.00	2.00	0.50	0.00	9.00
Total	44.00	24.50	9.00	13.50	14.00	13.50	11.50	12.00	142.00

Project Number [1]		621013		Project Acronym [2]			STOPandGO				

Activity type	Part. 1 SMH	Part. 2 TSA	Part. 3 ISCIII	Part. 4 NWCAHSN	Part. 5 ESP	Part. 6 LSEE	Part. 7 FSA	Part. 8 ARSAN	Part. 9 RMD	Part. 10 ASP CZ	Part. 11 EC	Part. 12 GMH	Total
Total	34.00	9.00	12.50	4.00	8.00	29.00	11.00	5.50	5.50	5.50	9.00	9.00	142.00

WT8:
Project Effort and costs

Project Number [1]	621013	Project Acronym [2]	STOPandGO

| Project efforts and costs |

Beneficiary number	Beneficiary short name	Estimated eligible costs (whole duration of the project)						Requested EU contribution (€)	Total costs
		Effort (PM)	Personnel costs (€)	Subcontracting (€)	Other Direct costs (€)	Indirect costs OR lump sum, flat-rate or scale-of-unit (€)	Procurement costs (€)		
1	SMH	34.00	199,375.00	0.00	9,000.00	13,956.00	3,090,000.00	3,312,331.00	840,331.00
2	TSA	9.00	52,164.00	0.00	3,000.00	3,651.00	0.00	58,815.00	58,815.00
3	ISCIII	12.50	56,250.00	0.00	3,000.00	3,938.00	0.00	63,188.00	63,188.00
4	NWCAHSN	4.00	23,184.00	0.00	3,000.00	1,623.00	0.00	27,807.00	27,807.00
5	ESP	8.00	47,448.00	0.00	3,000.00	3,321.00	0.00	53,769.00	53,769.00
6	LSEE	29.00	187,442.00	0.00	63,000.00	13,121.00	0.00	263,563.00	263,562.00
7	FSA	11.00	69,740.00	0.00	3,000.00	4,882.00	0.00	77,622.00	77,622.00
8	ARSAN	5.50	34,265.00	0.00	3,000.00	2,399.00	3,090,000.00	3,129,664.00	657,664.00
9	RMD	5.50	34,595.00	0.00	3,000.00	2,422.00	3,090,000.00	3,130,017.00	658,017.00
10	ASP CZ	5.50	34,595.00	0.00	3,000.00	2,422.00	3,090,000.00	3,130,017.00	658,017.00
11	EC	9.00	50,425.00	0.00	3,000.00	3,530.00	3,870,000.00	3,926,955.00	830,955.00
12	GMH	9.00	50,425.00	0.00	3,000.00	3,530.00	1,000,000.00	1,056,955.00	256,955.00
	Total	142.00	839,908.00	0.00	102,000.00	58,795.00	17,230,000.00	1,000,703.00	4,446,702.00

WT9:
Procurement costs

Project Number [1]	621013	Project Acronym [2]	STOPandGO

Summary of Procurement costs per beneficiary

	Participant	Procurement costs per beneficiary
1	SMH	3,090,000.00
2	TSA	0.00
3	ISCIII	0.00
4	NWCAHSN	0.00
5	ESP	0.00
6	LSEE	0.00
7	FSA	0.00
8	ARSAN	3,090,000.00
9	RMD	3,090,000.00
10	ASP CZ	3,090,000.00
11	EC	3,870,000.00
12	GMH	1,000,000.00
	Total	17,230,000.00

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 cannot be changed unless agreed so during the negotiations. 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.

53. Work Package number

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

54. Type of activity

For all FP7 projects each work package must relate to one (and only one) of the following possible types of activity (only if applicable for the chosen funding scheme – must correspond to the GPF Form Ax.v):

• **RTD/INNO =** Research and technological development including scientific coordination - applicable for Collaborative Projects and Networks of Excellence

• **DEM =** Demonstration - applicable for collaborative projects and Research for the Benefit of Specific Groups

• **MGT =** Management of the consortium - applicable for all funding schemes

• **OTHER =** Other specific activities, applicable for all funding schemes

• **COORD =** Coordination activities – applicable only for CAs

• **SUPP =** Support activities – applicable only for SAs

55. Lead beneficiary number

Number of the beneficiary leading the work in this work package.

56. Person-months per work package

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

57. 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.

58. End month

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

59. Milestone number

Milestone number:MS1, MS2, …, MSn

60. Delivery date for Milestone

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

61. Deliverable number

Deliverable numbers in order of delivery dates: D1 – Dn

62. Nature

Please indicate the nature of the deliverable using one of the following codes

R = Report, **P** = Prototype, **D** = Demonstrator, **O** = Other

63. Dissemination level

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

• **PU =** Public

• **PP =** Restricted to other programme participants (including the Commission Services)

• **RE =** Restricted to a group specified by the consortium (including the Commission Services)

• **CO =** Confidential, only for members of the consortium (including the Commission Services)

• **Restreint UE =** Classified with the classification level "Restreint UE" according to Commission Decision 2001/844 and amendments

• **Confidentiel UE =** Classified with the mention of the classification level "Confidentiel UE" according to Commission Decision 2001/844 and amendments

• **Secret UE =** Classified with the mention of the classification level "Secret UE" according to Commission Decision 2001/844 and amendments

64. 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

65. Review number

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

66. Tentative timing of reviews

Month after which the review will take place. Month 1 marking the start date of the project, and all delivery dates being relative to this start date.

67. Person-months per Deliverable

The total number of person-month allocated to each deliverable.

PART B
ICT PSP seventh call for proposals 2013
Public Procurement of Innovative solutions (PPI) pilot

ICT PSP Objective (and sub-objective) identifier:
3.2 Supporting innovative solutions in eHealth, assisted living and for mobility in particular through PPI
b) Active and healthy ageing and assisted living

STOPandGO

Sustainable Technology for Older People – Get Organised

version 1.8 – June 6, 2014

Participant 12, Servicio Andaluz de Salud (SAS) withdrew from STOPandGO. The contract will be signed without SAS, yet, the work plan and task allocation remains for a new procurer that could join the consortium after the contract is signed by means of an amendment. The budget has been temporarily added to the budget of the coordinator Smart Homes, including the SAS work plan (10.5 PMs to SMH in WP1) on the NEF.

Name of coordinating person: **Henk Herman Nap – Smart Homes**
Start of project: April 1st, 2014
Duration: 36 months

List of participants:

Participant no.*	Participant organisation name	Participant short name	Country
1 (Coordinator)	Stichting Smart Homes	SMH	Netherlands
2 (Participant)	Telecare Services Association	TSA	UK
3 (Participant)	Instituto de Salud Carlos III	ISCIII	Spain
4 (Participant)	North West Coast Academic Health Science Network	NWC	UK
5 (Participant)	ESP Central Ltd	ESP	UK
6 (Participant)	LSE Enterprise Ltd	LSEE	UK
7 (Participant)	Federsanita Servizi	FSA	Italy
8 (Participant)*	Agenzia Regionale Sanitaria della Regione Campania	ARSAN	Italy
9 (Participant)*	Azienda Unità Sanitaria Locale of Roma D	RMD	Italy
10 (Participant)*	Azienda Sanitaria Provinciale of Catanzaro	CZ	Italy
11 (Participant)*	Eastern Cheshire Clinical Commissioning Group	EC	UK
~~12 (Participant)*~~	~~Servicio Andaluz de Salud~~	~~SAS~~	~~Spain~~
13 (Participant)*	Gemeente Helmond	GMH	Netherlands

* = Procurers

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PROJECT PROFILE

Acronym: STOPandGO

Full title: Sustainable Technology for Older People – Get Organised

Information on the proposed service/solution
Objectives The overarching strategy of STOPandGO is to pilot an innovative procurement process to improve the lives of older citizens, according to the instrument named "Public Procurement of Innovative Solutions" (PPI). We project will produce and validate a standard "European Specification Template" (EST), that will be enacted in a coordinated manner in six localities, e.g. region within a country. With STOPandGO we will show that an innovative procurement process based on the service delivery approach will prioritise the ongoing evaluation of the achievement of meaningful results of clearly defined clinical and social outcomes. Our Procurer teams are ready with appropriate patient groups in four Member States, which will make up more than 5,000 users. We have identified relevant services and suppliers who will be invited to an open tender. The approach emphasises the importance of developing outcome-based service specifications with clear built in key performance indicators. STOPandGO is in line with the European priority to support the implementation of innovative solutions and purchasing in health care to ensure cost-effective care and enhanced well-being for the aging population. This will encourage organisations to embrace innovative technology at scale, to build a critical mass for healthcare innovations.
Methodology STOPandGO will provide an improved service for older citizens by ensuring good management and governance, procurement, interoperability, legal, ethical and regulatory aspects, coordinated local tendering, quality control and evaluation, dissemination and exploitation. A set of local Tenders will be published by the procurers in close cooperation with the advisors – following EU regulations – and coordinated in each locality by the Executive Board. In the first 20 months we will achieve the following milestones: overall project set-up and governance; application of the procurement process to include identification of outcomes and key performance indicators, preparation of business cases, tendering, and awarding of the contracts to the providers best aligned to the tender design. Providers will deliver the desired outcomes for a sample population of over 5,000 beneficiaries. The remaining months will be spent deploying, monitoring and evaluating the achievement of identified outcomes, as well as continuing the dissemination of best practice deriving from the PPI pilot. The STOPandGO consortium is already in contact with coordinators of other PPI, namely Carole Gandon (PPI – HAPPI project), Gaynor Whyles (PPI –ECOQUIP), and Steven Browning (PPI – SILVER project), to learn from each other and to set up future meetings for the exchange of best practices.

Implementation-deployment-operation key aspects

Following the EST, the tenders in each of the localities will be coordinated by the WP5 leader, supported by the PPI Coordinator. The first 18 months will be spent setting up, defining and executing the EST. All partners will endeavour to procure products and services via tender to benefit over 5,000 people. It is anticipated that the products and services that will be procured will have been put through their own testing and certification where necessary. The evaluation of the PPI Pilot will be ongoing, utilising the Key Performance Indicators that are built into the contract schedule. Initial evaluation will be start at month 4 and run throughout the project phases in an iterative form every three months. Interoperability will be designed to follow the scheme in Work Package 3 and is aimed to meet and support procurers intentions throughout.

Consortium

Our consortium comprises leading government, academic, industry and health and social care organisations. There are two types of partners in the consortium. There are experts who spend effort on coordination, monitoring and support. Then, there are procurers who publish the tender with the support of the experts. The North West Coast Academic Health Science Network in England is a new type of organisational structure, reflecting the need for the NHS to have stronger relationships with the academic communities and industry. The Italian Federation of healthcare trusts and municipalities (Federsanità ANCI) will guide the tenders, assist their evaluation and promote the exploitation among its members after the project. Similar arrangements are in force in The Netherlands and Spain, where both partners have long-term experience and also will contribute. The TSA Integrated Telecare and Telehealth Code of Practice, amongst others, will be utilised to underpin the delivery of high quality, guaranteed, challenging and audited standards for the consumers of the service. ESP – together with the other partners - will promulgate findings and exchange outcomes – among others - to other EU PPI Projects (HAPPI, Silver), the AAL Forum, the EU learning network, etc.

Impact.

The rapidly ageing population across the EU is placing relentless pressure on increasingly scarce health and social care resources. More people live with multiple co-morbidities, and there are fewer people to care for them. The Whole System Demonstrator (WSD) showed that incorporating telehealth and telecare technology into care and cure services can lead to reductions in the need for people to access services, as well as improving their ability to live better lives in their own homes (e.g., quality of life). Our plan is designed to overcome some issues identified in WSD and we will illustrate real improvements in Quality of Life, care and carer programmes, hospital in-patient stay, and other service outcome aspects felt to be essential. In addition, STOPandGO will identify the PPI benefits of STOPandGO for industry and the localities throughout the process in relation to the situation before. By adopting an innovative procurement approach our PPI Pilot will show that the benefits identified in the WSD can be translated from small populations (our pilots represent about 10% of a regional target population) to wider ones, providing for scale uptake of technology and proportional reductions in the pressure on services. We will also show that this approach can be applied across the EU and our Dissemination Work Package.

Other

The STOPandGO procurement process is not in the focus on a particular technological component, but in the integration and in the simultaneous improvement of the models of care and cure, to provide care and cure services augmented by a coherent set of interoperable technological components, with a consequent convincing new stratification of the users, satisfying at the same time the managerial, organisational, clinical and technological perspectives.

Section B1. Relevance

B1.1. Project objectives

Care and cure services augmented by technology can increasingly meet the current needs of older persons and their carers. They have often been developed through publicly funded research and development. Several local programs, usually focusing of specific health issues in a limited area, have demonstrated that these innovative services can significantly improve health and care outcomes, reduce morbidity, improve economy and extend service reach. Most of the initiatives are driven the introduction of the technology, adapting the organizational models in consequence.

Time is ready to reverse the process of adoption of the technology: several effective solutions are available, and the process should start now from a clear engagement of public decision makers to introduce more effective and sustainable service models for care and cure provision, perhaps with different professional profiles and innovative forms of contracts, based on performance. Then the technology could assist (or enable) the desired change.

A principal barrier to wider market uptake of these services is therefore current procurement practice, the majority of which is predicated on specifying technology inputs. For example, in the Netherlands, the highest percentage of increasing expenditure on health and welfare is dependent on purchase of technology. Nevertheless this expenditure does not meet with the needs of the patient. There is an absence of adequate outcomes-based service specifications that preserve the freedom to look for an optimal correspondence between the innovative organisational models and a series of integrated technological solutions.

Sustainable Technology for Older People – Get Organised (STOPandGO) will develop and pilot technology agnostic, outcomes-based procurements that are interoperable, coherent and flexible such that they can be implemented in different contexts and localities across EU Member States. STOPandGO will address the challenge to provide and support a competitive market of cost-effective care and cure services by means of an open tender and implementation to ensure that older people can live independently, move around freely and participate more fully in society.

Most advanced countries in Europe are facing the challenges that arise with the ageing population. Citizens live longer resulting in more senior citizens requiring assistance, care and, often, treatment for chronic diseases. This is accompanied by a decreasing percentage of the population active in the labour force and fewer resources available to support senior citizens. The challenge across Europe is to provide and support a competitive market of cost-effective care and cure services to support older people to live independently, move around freely and participate fully in society. STOPandGO aims to meet this challenge.

Developments in technology, especially telecare and telehealth solutions, offer an affordable route to enhance personalised care for the elderly. Technological development has increasingly shifted towards end-to-end solutions delivered on consumer devices, such as smartphones, tablets and interactive TV. Numerous prototypes, pilots and small-scale implementations have demonstrated the potential of these innovative solutions [1] [2] [3] [4] [5]. However, large-scale deployments have proved elusive, not least because of a lack of an appropriate and comprehensive specification to procure against and which is able to stimulate a combined refinement of the organisational models and of the corresponding set of technological solutions.

Procurers/Buyers, many of which have high degrees of autonomy, have been similarly reluctant to invest their constrained budgets in such services without procurement systems in place to verify effectiveness. Existing markets, constrained by obsolete procurement mechanisms, are unable to cater for these new services.

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[1] http://www.companionable.net/

[2] http://www.netcarity.org/Final_Issue_of_Netcarity_News.936.0.html

[3] http://www.commonwell.eu/commonwell-home/

[4] http://www.independent-project.eu/

[5] http://www.soprano-ip.org/

The STOPandGO consortium will develop a procurement strategy and a European Specification Template (EST) for new interoperable services and outcomes that support active and healthy ageing across member states.

The STOPandGO consortium will oversee the local processes, from adopting the ESP by procurers to produce tenders in different localities to awarding the contracts and evaluating the deployment.

a. Relation to the ICT-PSP work programme

The consortium follows a common open procurement approach, which will help the procurers , to refine their appropriate outcome-based specifications and then run the local tenders, with assessment criteria for selection based on the best value for money.

The evaluation of the success of the deployment performed by the supplier will be measured by Key Performance Indicators (KPIs) that will consider the improvement of the outcomes for people with various long-term conditions, including:

- Improving their experience of health and social care services
- Empowering them and their caregivers to manage their own conditions
- Reducing their number of unplanned admissions
- Reducing their number of readmissions to hospital and long term care
- Reducing their lengths of stay in hospital
- Improving their transition between primary and secondary care

STOPandGO is not a research and development project nor is it a commissioner of services in its own right; rather its focus is testing a procurement approach, which will assist associated procurers' successful delivery of recent assisted-living demonstrators into the market, and at scale. Objective 3.2 of the Work Programme is to support the Public Procurement for Innovative solutions (PPI) in eHealth, active and healthy ageing and assisted living and this objective is reflected in the objectives of the STOPandGO project, which comprise:

- The acceleration of the European Innovation Partnership on Active and Healthy Ageing (EIP AHA) strategic priorities including support for the activities of daily living and the monitoring of chronic conditions, resulting in an improved quality of life for older persons

- A set of common specifications (the EST) for the efficient and widespread procurement of care and cure services augmented by interoperable telecare and telehealth solutions across member and associated states, resulting in economies of scale in the procurement and deployment processes while adhering to EU tender requirements

- The rapid facilitation of real change in the provision and usage of cost-effective and sustainable services such that the target of 5,000 users can be exceeded within the lifetime of the project

- The provision of innovative solutions, enabled (where appropriate) by technology, to older persons and others while safeguarding ethical and privacy issues

- The expansion of the comprehensive socio-economic evidence base for the deployment of contemporary ICT services to support active and healthy ageing and assisted living

- Requirements and best-practices for the widespread procurement and deployment of innovative care and cure services, enhanced by telecare and telehealth, for older persons throughout all regions of the EU

- Recommendations for the wider deployment of telecare/telehealth-enhanced solutions based on contributions from the STOPandGO EU Learning Network

- Trigger growth in the European telecare/telehealth-enhanced care and cure services market

- Dissemination of training and skills for work team members, and stakeholders, which will bring a safer, more legally and ethically prepared support network for older people and their carers.

Table 1. Objectives of the items 3.2b of the Work Programme and how we address them

3.2b objectives	How STOPandGO addresses them
To accelerate the availability and large-scale deployment by stimulating procurements in the field of health and social care, of new ICT based products and services, which have demonstrated in a smaller scale settings significant improvement of independence, functionality and well being of older persons.	The procurement specification put forward as a key deliverable of STOPandGO will be tested in 4 EU countries. The pilots will represent around 10% of the regional need to support people. Following amendment as a part of the evaluation process it will form a tried and tested mechanism for procuring appropriate outcome-based services that will incorporate appropriate technology that in turn will enable the uptake of services in a sustainable and cost-effective manner.
Deployment of ICT-based solutions addressing (one or several) of the defined SIP priority action areas of the EIP AHA: • Health literacy, patient empowerment, ethics and adherence programmes, using innovative tools and services	The products and services that will be used to achieve the service specification will employ a mix and match of technology services that will provide elements of telecoaching, education, and medication compliance as identified by the STOPandGO procurers. Those products and services will use a wide range of appropriate technology enablers available at the time of letting the tender and will include leading edge smartphone apps and text-based telecoaching and telemonitoring.
• Personalised health management	The incorporation of appropriate technology will enable service design to be much better aligned with the needs of individuals.
• Prevention and early diagnosis of functional decline, both physical and cognitive, in older people	The outcomes that will be commissioned will clearly identify opportunities to more carefully monitor early onset of a decline in physical and cognitive capability. For example, we have already identified a system for measuring mobility changes in early dementia patients. We will work extensively with the European Learning Network, User Groups. Industry, and Policy Makers
• Protocols, education and training programmes for health workforce and carers (e.g. comprehensive case management, multimorbidity, polypharmacy, frailty and remote monitoring)	The dissemination work packages, close association with other PPI projects (Silver, ECOQUIP, HAPPI, etc.), EIP-AHA (e.g., C2 action group), the E-NO Falls network in which STOPandGO coordinator 'Smart Homes' is participating, and the close association with the European Learning Network will ensure that appropriate learning materials and other workforce development toolkit that result from the pilots will be mainstreamed.
• Multimorbidity and R&D	Populations will be risk stratified to more accurately identify their needs. This will help to identify that the commissioned services best meet the needs of people living with multimorbidities.
• Capacity building and replicability of successful integrated care systems based on innovative tools and services	As the pilots will benefit around 10% of the need in a regional area, we will build a critical mass and that the agreed specification and procurement process will be capable for responding to the requirements of a scale and integrated care system. Central to the process is the need to ensure that integrated health and social care provision are considered when building appropriate service specifications.
• Assisted daily living for older people with cognitive impairment	Technology and services used really meet the needs of people already identified by procurers and Regions, The provision of very cost-effective telecare devices such as GPS based tracking services, and in-home devices that are specifically designed for people with mental or cognitive impairment will be an integral part of developing a properly integrated approach to service and care pathway design.
• Extending active and independent living through Open and Personalised solutions	Commissioned services will enable people living with long term conditions such as Chronic Heart Failure, Chronic Obstructive Pulmonary Disease and diabetes to live better quality lives in their own homes
• Innovation improving Social Inclusion of older people	The appropriate use of technology when carefully integrated in service provision provides no evidence of the social exclusion of older people, or people in general. Significant improvements in the provision of

3.2b objectives	How STOPandGO addresses them
	smartphone and mobile phone technology, lead to the opportunities of greater inclusion of older people through mobile technology.

b. Details on the content of the European Specification Template (EST)

The goal of the project is to develop and test a European Specification Template , building a common vision among the partners about the PPI instrument. Actually, the EST will be complemented by supporting materials, to provide procurement guidelines and metrics for:

- preparation and management of local tenders;
- bid assessment and ranking, according to a set of common criteria based on the best value for money;
- contract award;
- monitoring progresses of the services deployed;
- evaluation of the benefits realized.

The EST will describe and inter-relate the following components:

- the criteria to place the persons into classes with similar needs;
- the (innovative) care and cure services that are able to cope with the needs;
- the professional profiles that could be involved in the provision of the services;
- the complementary tasks that could be performed by the end users and by the informal carers;
- the functionalities of the technological solutions that could support the professionals, the informal carers and the end users in the respective activities;
- the criteria to assess the offers;
- the criteria to monitors the deployments and to evaluate their outcomes and their performance.

The kernel of the EST will consist of a "catalogue" for *selective outsourcing* of modular services for integrated care&cure, enhanced by technological solutions, and a dictionary of the most relevant professional profiles. It is understood that each local tender will then acquire a set of services and resources that have to be complementary to the existing services and compatible with the in-house systems of the local procuring organizations.

The EST will also include sample specifications of potential target patients, with the criteria to stratify them into classes according to different complementary dimensions, to obtain a case-mix system that places persons into distinct categories according to the type and severity of need (for example, where they sit in the Kaiser Pyramid) and the level of autonomy that is reasonably achievable.

The dimensions to characterize each individual should typically include:
- the age of patients (e.g. over 75),
- the presence of single or multiple health conditions (e.g. CHF in stage IV, mild COPD, non-insulin dependent diabetes, frail state),
- social factors (e.g. living alone),
- setting (e.g. at home, in long-term care facilities)
- specific additional risk factors (e.g. at least one hospital stay for a certain condition in the previous year).

These classes may be interpreted as predictors of the classes of intensity of services, considering also the balance between care and cure services .

A systematization of this kind is provided for example within the interRAI suite, with their RUG III system (Resource Utilization Groups) [6].

For the most relevant classes of stratified target patients the WP2 activities will therefore produce a description of suitable packages of modular care&cure services, detailing a number of aspects that should be considered in a local program, i.e.:
- the list of suitable services already delivered within home care, social services, etc.;
- the related enabling organizational and technological systems in place (e.g. contact centers, helpdesk and technical assistance, etc.);
- the most appropriate professional profiles and skills needed (e.g. GPs, home nurses, care managers, operators of contact centre).

Finally, the template will suggest a schema for the definition of different series of Key *Performance Indicators (KPI)*, respectively related to:
1. the monitoring and evaluation of the service delivery;
2. the assessment of the patients and professionals satisfaction;
3. the assessment of the clinical and social outcomes in the target population.

All the above descriptions should be considered as crucial components of the European Specification Template. The lessons learned through the deployment of the pilot PPI will be used to produce a consolidated release of the EST at the end of the project. Future improvements could include also the quantification of the typical amount of resources could be appropriate for each class of services, and thus an indication of the order of magnitude of the costs.

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[6] http://www.interrai.org

c. Local adoption of the tender template

For each locality, the procurer will specify the actual local tender, which must be fully compatible with the European Specification Template developed by the project and should consider, e.g.:
- a selection of actual classes of end users that will be the target population for the contract, according to a stratification of the users on the severity of needs and on the intensity of services. The classes must be a refinement of the classed described in the EST, compliant with to the predefined dimensions of the template;
- the in-house care & cure services and professionals that will be already present on the concerned area, and that must be coordinated with the services acquired through the contract;
- the technological solutions already deployed in the concerned area (or going to be deployed according to an existing plan), that should be interoperable and synergic with the solutions that will be installed by the supplier, together with the criteria to test their interoperability.
- the training activities foreseen for the professionals employed by the procurer organization and for the users with their informal carers;
- the administrative activities that will be requested, synchronized with the existing ones of the procurer organization;

The tender will describe the Baseline assessments of a number of KPIs, e.g. on:
- current usage of telehealth/telecare services
- public and private sector providers' plans for adoption of telehealth/telecare services
- current proportion of major indicators on Accident & Emergency visits, emergency admissions, elective admissions, bed days and levels of mortality
- commissioning agencies' awareness of telehealth/telecare services

In addition, for each class of end users, it should further specify:
- the number of end users expected in each class;
- a set of Key Performance Indicators (among the ones considered by the EST) to measure the impact of the users' health, e.g. on: Accident & Emergency visits, emergency admissions, elective admissions, bed days, levels of mortality. Their values will be considered as targets to be reached and maintained, for at least a given percentage of users. These KPIs will be eventually used at regular intervals to evaluate the success of the program and to justify the related pro-quota payments to the supplier;
- an appropriate selection of Key Performance Indicators on the operational performance of the services, with their optimal values and the features of the dashboard that should be realized. These KPI will be actually used to monitor the progress of the deployment;
- the criteria to test the satisfaction of users and professionals and to review of commissioning agencies' awareness of telehealth/telecare services.

Local exceptions to the EST should be avoided; however the Executive Board could decide to timely upgrade the content of the EST in response to significant issues arising during the activities of WP5 (local tendering processes) and WP6 (local deployments and evaluation).

d. Assessment of bids

Each bid will be assessed according to an established set of criteria, which may typically include:
- how the further refinements of the classes of users proposed by the supplier are compliant with the EST and the refinements described in the local tender;
- which care and cure services are actually foreseen, for each class of users;
- the number of professionals involved for each role, for each class of users;
- which specific technological solutions are envisaged, for each class of users;
- the type and the number of devices per 100 users foreseen, for each class of users;

- the organizational aspects of contact centres and technical assistance, if foreseen in the local tender;
- the educational material and the hours of training for the professionals employed by the procurer and for each subclass of users, with their informal carers;
- the quantitative milestones envisaged for their progressive release on the field of the above components;
- other measures as may be appropriate in the local context and consistent with the EST.

The precise description of these criteria and the agreed values to be satisfied during each phase of the deployment will be an integral part of the contract. The meeting of specific criteria may be used to trigger payments under the terms of the contract.

e. Dimensions for the Key Performance Indicators

The kinds of evaluations performed by the project will regard: (i) the process of service delivery; (ii) patients and professionals satisfaction; and (iii) clinical and social outcomes in the target population.

During the project, there will be a periodic intermediate evaluation of the advancement of the contracts, comparing the actual ratings vs. planned targets according to predefined indicators of:

- readiness (competence and infrastructures);
- adoption (advancement of the deployment; availability of the care and cure services and of the technological support);
- meaningful use (actual use of the services within the care processes, to effectively support the care and cure processes);
- benefits realized (wrt the required outcomes).

An example of graphical rendering of the indicators on the propagation of a particular kind service (including the health outcomes) could be the following one (used by NEHTA[7]), which for each period compares from one side the planned targets agreed for that period with the actual ratings, from the other side the current situation (i.e. target and ratings) with the situation in the previous period.
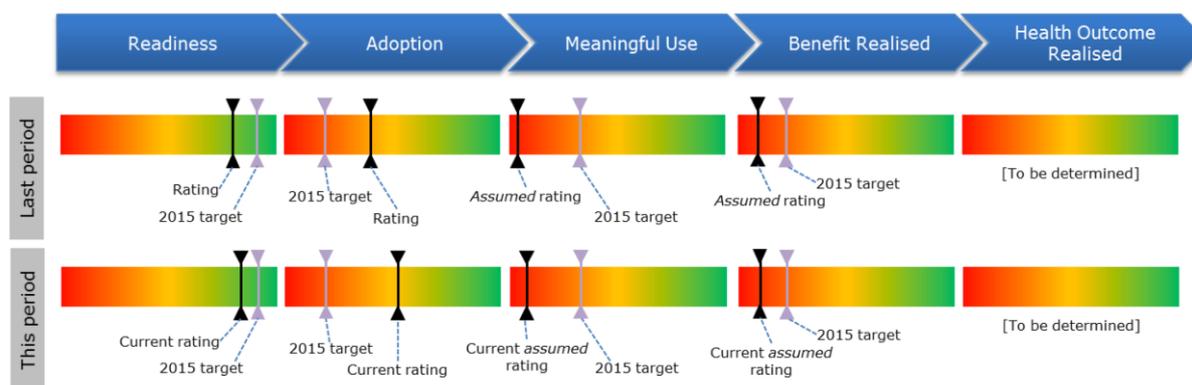
Figure 1. Example of rendering of the dashboard (NEHTA, 2013)

Note that the STOPandGO template (and thus the local tenders and the contracts) will include specific statements involving the precise milestones on the KPIs on health outcomes (in a holistic sense, i.e. related both to wellness and to health conditions), which will be also the basis for the economic aspects of the contracts, specially during the second year of the deployments. However the periods shown in the figure above are too early to consider those outcomes.

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[7] National E-Health Transition Authority. "*NEHTA Scorecard, Organisation Uptake of eHealth, Including PCEHR System*", August 2013, vedi www.nehta.gov.au

The evaluation of the performance in relation to the clinical and social outcomes in the target population can be only initiated during the project, because time constraints do not allow to reach the maturity of the program., unless later on it will be decided to extend the duration of the project.

As a matter of fact, each local contract is supposed to start between months 17 and 20 of the project, i.e. after preparing the tender template and running the procedure of the local tender. Considering also the time needed by the supplier to make the services available, the process of enrolling a significant number of users, the adaptation of the professionals to the new organizational model, a stable situation of the program will perhaps be reached around month 28.

Therefore the most suitable period within the project to evaluate the performance to give a robust evidence in term of clinical outcomes will go from month 30 to month 42onwards.

The duration of the local contracts could be of 2 years, i.e. within the duration of the STOPandGO project, and it

It is expected that additional contracts will follow, in the same localities (and across the entire Regions involved), always according to the EST, perhaps involving more classes of end users and wider areas.

The independence of the EST from any specific technological solution will facilitate the introduction of up-to-date features a least at each renewal of the contracts.

Even if partial evaluation of the impact will be possible in 2016, a proper pervasive evaluation (always performed according to the criteria developed by the project) will be possible in 2017 and beyond.

Examples of indicators to support policy decisions by the procurer organizations

The project will bring forward a pragmatic approach, in order to build a robust and comprehensive list of indicators (compact and easily applicable at the same time) for the care and cure services, specially with regards to both telehealth and telecare issues.

A set of indicators may have an additional application in the context of the policy decisions by the procuring organizations. To give an idea of the potential result of this use, examples of indicators (here mainly from a healthcare perspective) that could be monitored, organized according to the policies of the procurer, could be elaborated during the project, starting from the following suggestions:

Policy Area 1: Improve availability of a service in the care system
- *No. non-urgent contacts, appropriate for tele-triage*
- *No. persons with social needs supported by social services*
- *No. chronic/fragile patients systematically interacting with GPs and other care professionals*

Policy area 2: Outcome evaluation
- *increased Healthy Life Years*
- *No. of users that are satisfying the clinical targets, for each subclass*
- *No. of avoided re-hospitalizations*
- *degree of quality of life improved thanks to telehealth use*
- *money savings for the local and Regional Health System*
- *% patient that have been satisfied by telehealth and that would recommend it*
- *reduction of waiting lists and days in hospital*
- *cost reduction due to travels avoided*
- *reduction in social isolation*

Policy Area 3: Centrality of person (enrolment in shared care plans and adherence)
- *No. patients enrolled in Chronic Disease Management*
- *No. elderly and / or fragile patients enrolled in integrated care*
- *level of support provided to informal carers around an individual*
- *level of adherence of the patient to his/her care plan, and in particular:*
  - *to the therapeutic education (coaching)*
  - *to the recommended lifestyle behaviour*

- *to the medication therapy*

Policy Area 4: Improve efficiency of individual professionals
- *% non-urgent remote interpretation of diagnostic tests from home devices vs. total number of interpretations*
- *% non-urgent tele-consultations between professionals vs. total consultations*
- *% tele-rehabilitation cycles after discharge vs. total rehabilitations*

Policy Area 5: Improve timeliness in urgency situations
- *% tele-consultation in at-risk situations to guide urgent local (lifesaving) activities vs. total consultations*

Policy Area 6: Optimise appropriateness in using hospital resources
- *% early hospital discharges w/ home follow-up vs. total discharges*

Policy Area 7: Improve access to informative/administrative services
- *No. downloaded forms and administrative procedures managed*
- *No. of records shared between agencies*
- *No. citizens accessing information services*

f. The intended usage of the EST in the localities of the PPI Pilot

This paragraph provides a synthetic description of the intended usage of the EST in a number of the different localities involved in the STOPandGO PPI pilot.

B1.1.1 The three Italian procurers and Federsanità ANCI

The Italian Local Healthcare Trusts (Aziende Sanitarie Locali – ASL or Aziende Sanitarie Provinciali – ASP) and Municipalities are involved in a deep process of transformation of the primary care activities.

The institutional mission of the Local Healthcare Trusts is the promotion and protection of health, both individually and collectively the resident population in its territory, to enable the best possible quality of life, providing the essential levels of assistance; an important objective is to ensure, facilitate and properly manage access to the services by citizens-users, also through the primary care centers being activated in several localities.

The Local Healthcare Trusts and the Municipalities are collaborating to protect fragile patients with the identification of clinical, demographic, social and environmental characteristics of the citizens, in order to provide the optimal services. In general, the service recipients are the following ones:
- Older people with single or multiple conditions and a major limitation of autonomy,
- Patients with chronic-evolutionary conditions, for example:
  - Multiple Sclerosis
  - Medium-severe cardiovascular diseases
- Patients at an advanced stage and / or terminal disease, in particular:
  - Oncology
  - AIDS
- Patients needing a protected discharge from hospital, for example:
  - Acute vascular accidents and sequelae
  - Major fractures and sequelae
  - Rehabilitation, also intensive home care
- Patients with acute temporary disabilities that can be treated at home
- Patients who need of special treatments, such as:
  - COPD Fan / long-term oxygen therapy

        o   Home Dialysis
        o   Artificial nutrition

Various organisational models are promoted in Italy by the 21 Regional Authorities (that have in charge the healthcare provision), with a specific attention also to the integration with social issues, which are in charge to the Municipalities.

As a consequence, several Italian organisations expressed a strong commitment to the Action Group B3 - Integrated Care of the EIP on AHA; the Puglia Region coordinates the Action Area 7 on Patient Engagement and the Regions of Veneto, Campania, Emilia Romagna, Lombardia are particularly active members. An Italian Group with 38 members, including also academics and industries, was activated within the community network managed by B3 Action Group on the Yammer platform.

In this context, the three Italian partners acting as procurers in STOPandGO want to put in practice the achievements arising from the Action B3 and to contribute to the success of the Action itself.

They will be assisted by Federsanità ANCI (the Italian Federation of Healthcare Trusts and Municipalities) as National Facilitator and by a mirror panel about STOPandGO with other interested Local Healthcare Trusts and Municipalities, which will be also potential Early Adopters of the European Specification Template developed by the STOPandGO project. Another mirror panel is being organised with the service providers.

Federsanità ANCI is setting up the two panels through its initiative named "*CATALIS*", to support a community of public and private stakeholders about care&cure services augmented by technology, providing a portal, a newsletter, a documentation center, a discussion forum, face-to-face workshops involving also industry and top management of the local trusts and municipalities. More Local Trusts and Municipalities already asked to join the mirror panel of the procurers.

The health needs of the population in the three localities are very similar; the common approach for the tenders in STOPandGO is to cope with the elderly population in a district, with an holistic approach, i.e. without isolating a particular disease, but identifying the classes of citizens involving a similar cluster of services according to the severity of the care and cure needs and the amount of resources required.

All the three Italian procurers <u>are already running tenders and contracts on the topic with various service providers, in a partial and fragmented way,</u> typically considering separate programs for the different health and social conditions and <u>managing separate contracts</u> for the different professional profiles (e.g. GPs, specialists or nurses),, for the information technologies and for the goods (e.g. consumables).

A comprehensive view on the technological innovation (specially telehealth and telecare) could be an opportunity to properly address the major needs of the target population, by stimulating a proactive role of the individuals, by facilitating a more frequent (virtual) contacts with the care&cure professionals, by maintaining an integrated shared record, or even just to get information on how to access community services and home care.

The three Italian procurers want to create a single path for managing the requests for services and their provision, for the most relevant forms of health and social care for the elderly, from the simplest to the most complex. From the point of view of the local decision makers, this approach will assure a greater homogeneity and greater transparency of the evaluation criteria for service management and resource allocation.

Some figures for ASP Catanzaro are provided in Table 2 and Table 3, as an example of the context in one of the Italian localities. The target for the STOPandGO procurement will be limited to a zone of the Catanzaro province, which has a population of 359.457 inhabitants (2013), i.e. about 18,35% of the population of the Calabria Region. During the last year of the project, an exploitation plan will be worked out with the other Local Trusts and Municipalities and with the assistance of the Calabria Region, to progressively produce the tenders across the entire Region.

Table 2. Elderly population of Calabria by age groups in 2012

Age range	Population	% Of Total Population
65 - 74 yr.	180.927	9,2%
>=75 yr	194.781	9,9%
all ages	1.958.418	100,0%

Table 3. The population of Calabria divided by groups of diseases in 2012

Age range	Higher complexity	Medium complexity	Lower complexity	Home care programs	**STOPandGO Target**
65 - 74 yr.	5.609	7.237	9.589	4.739	**853**
>=75 anni	6.428	7.986	10.908	5.101	**969**
all ages	44.568	70.600	97.925	9.939	**1.826**

The actual criteria for enrolling the citizens in the different classes will be decided for each Italian procurer at the moment of the adoption of the Template, with the production of the local specifications for the Tender, considering also to the set of outsourcing contracts already running in parallel and the in-house professionals that are available from the side of the procurer organisations, which will complement the outsourcing resources and services activated through the tenders. According to these criteria, each of the three procurers is expected to involve between 1500 and 2000 elderly patients.

B1.1.2 NHS Eastern Cheshire Clinical Commissioning Group (ECCCG)

ECCCG population is older than the England average and is the fastest ageing in the North West of England, with 1 in 5 people over the age of 65 years and 1 in 33 aged over 85 years. By 2033, it is projected that there will be a 72% increase in the proportion of people over 65 years of age and a 188% increase in the proportion of people over 85 years of age. Overall our population is relatively healthy, with female life expectancy being 83.6 years and 80.1 years for men. However this masks pockets of significant deprivation and a 12 year difference in life expectancy for men and 13 years for women.

The 2013/14 Annual Plan (https://www.easterncheshireccg.nhs.uk/About-Us/) identifies our commitment to delivering assistive technologies as part of our integration programme, Caring together.

The ECCCG will work up to **1250 patients** and committed to participate fully in the STOPandGO project (see letter of intent, Appendix 1c).

Figure 2. The 3MillionLives Project Plan
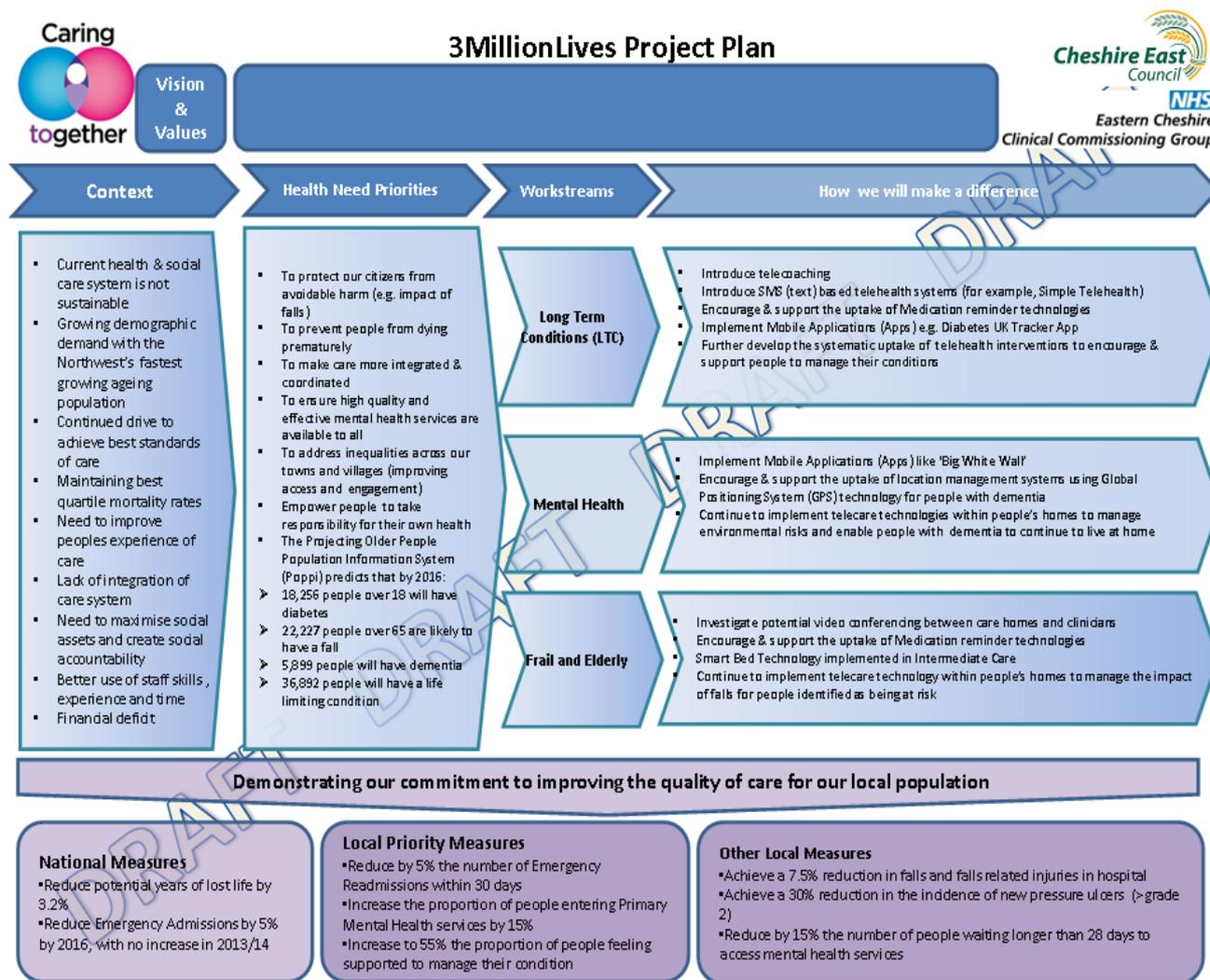
B1.1.3 Gemeente Helmond (GMH – municipality of Helmond)

In The Netherlands, there is an increasing trend in the responsibilities of municipalities in their the provision of social care, regulated by law in the Social Support Act. The Social Support Act (WMO) manages the integration of people with limitations in society. This makes municipalities responsibility for home care, supporting and activating care, as well as the regulations for transport, client support and various subsidies8. The City of Helmond sees - after years of dealing with innovative solutions and their suppliers - added value in joining hands with other regional municipalities, in selecting, buying, and implementing digital tools for social applications. This collaboration would have to lead to better pricing and conditions, to exchanging knowledge and experience in selecting and implementing tools, to a structured cooperative buying process, and to a form of cooperation/co-creation involving local end users as well as the manufacturers.

Helmond has therefore started a 'Joint Informal Care' project (Proeftuin Informele Zorg Peelregio), together with the municipalities of Asten, Someren, Deurne, Laarbeek, and Gemert-Bakel, with in total over 200,000 inhabitants in city and rural areas. In this 3-year project, initially, three innovative informal care tools (Zorgsite, Guido, and Zorgvoorelkaar) are planned to be bought, and implemented in the aforementioned municipalities, based on short-term (e.g. 2-year) contracts. This process should lead to a more or less standardised approach, which will then be used to cooperatively select, buy, and implement new innovative tools in the years after. The aim is also to in a later stage extend the collaboration to other municipalities in

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8 http://www.scp.nl/english/Topics/P_Z/Social_Support_Act_Wmo

Brabant, and share the approach on an (inter)national scale. Also, educational institutes and local health and welfare institutes will be highly involved in this project. Together with the other municipalities, Helmond aims to procure social services in STOPandGO to at least 1250 people.

~~B1.1.4 Junta de Andalusia (SAS)~~

~~Regional Ministry of Equity, Health and Social Policies (CISPS) of Junta de Andalucia (SAS) is the final responsible of providing public health and social personal care to >8M persons in Andalucia (over 13% > 65 years). There is currently a political strategy for integration of social and health care. Development of integrated personal health and social care model has to face great challenges in the functional, technological and organizational and managerial dimensions.~~

~~Elderly persons with multiple chronic conditions (MCCP) - 120.000 (prevalence: 1.5% general population) represents an relevant segment for health and social care services: 35.597 MCCPs generate 71.193 hospital admissions and 569.554 stays last year. Polimedication is a great personal and social burden for this group with a relevant impact in risk and adverse effects (average number of daily drugs taken by MCCP is 8±3). Dependent MCCP have a 64% adherence/compliance ratio vs. 43 % in autonomous.~~

~~CISPS-JDA provide through ASSDA, social services public agency , telecare service (SAT) to 178.454 per. (up to 268.259 users including key carers), 67 % of them >65 years, 30% > 80 32.4% disab. & dependent. The population receiving telecare from SAT have a high prevalence of chronic diseases: 119.961 users for HT; 57.544 for CHD; 25.995 for CRD; 54.180 for Diabetes; 16.289 for Alzheimer.~~

~~Health care needs and demands are managed through a coordination gateway to emergency (061) and health care demand management ptf (Salud Responde) .~~

~~Social and Health care authorities (actually in a formal process of integration) find a great opportunity (cost efficient) in widening the scope of services provided to new areas and scenarios of great (quantitative & qualitative) impact: poli-medication risks and adherence/compliance telemonitoring (Mobile option), user profile, identification process, risks assessment tools, alarms management, outcomes expected, etc .~~

~~Other needs and scenarios to be considered:~~

- ~~Out of hours tele-prescription~~
- ~~Out of hours telemonitoring for early discharged patients (mayor outpatient surgery and others early discharged)~~
- ~~Accessibility 24x7~~
- ~~Personal support~~
- ~~Information~~
- ~~Tele-alarm~~
- ~~Risk assessment~~
- ~~Emergencies~~
- ~~Installation and maintenance of equipments:~~
  - ~~Home based system: home station & remote control unit~~
  - ~~Central station and control centres~~
  - ~~Tele care Software support system~~

~~The target population that will contribute to the PPI pilot has to be defined more precisely but a sample of at least **1250 persons** should be covered.~~

B1.2 EU and national dimension

The STOPandGO consortium consists of public and private procurers in health care and independent expert organisations on interoperability and eHealth. All partners are actively involved in various telehealth and

telecare projects and pilots through Europe (e.g., European Innovation Partnership on Active and Healthy Ageing (EIP-AHA), e.g., the C2 Action Group, Ambient Assistive Living Forum (AAL), Competitiveness and Innovation Framework Programme (CIP)), have extensive experience in large-scale trials and procurement and are eager to extend the pilot successes to accelerate actual EU-wide scale deployment of telehealth and telecare. The partners involved in public procurement have a track record in supporting the market introduction of interoperable health services (e.g., Whole System Demonstrator[9], 3MillionLives[10,] and Slimme Zorg projecten[11]). The consortium will develop requirements and provide best practices on telehealth and telecare procurement, respecting and taking into account national and regional differences in legislations and technical infrastructure.

Results from larger scale trials have demonstrated patient benefits and efficiency savings to healthcare systems (Steventon et al., 2012). The dislocation of value barriers (where costs are carried by one agency but benefits accrue to another) is being lowered by integrated health and care service delivery and, in England, through health and care reforms that will give responsibilities to combined health and care agencies. Affordability is becoming pressing. The demand for services will increase disproportionately to the ability of economies to fund them unless significantly lower cost models are found to meet citizens' needs. The realization of this has led national administrations to promulgate collaborations to develop more service-based solutions, moving away from the traditional model of 'buying a box' (a single functionality appliance). These ideas are slowly being introduced to the market.

A critical barrier to adoption is an absence of robust and stable procurement specifications. Procurement practices lag market and service innovations. Isolated solutions undoubtedly exist that would meet various health and care needs, extend service reach and improve the economics of offerings but it is not possible to describe the new requirements by current product-oriented tender exercises. New business models, predicated on subscription and/or transaction charging rather than front-loaded procurement of equipment that may or may not be used, are encouraged and are emerging. These models rely on scale to be economically viable as they are inherently low margin activities.

Concerted service specification and procurement action across a range of Member States will yield the scale necessary to sustain services. Common specification, suitably validated and disseminated also through the EIP-AHA, will allow service component interoperability and robust solutions, preserving as possible the existing legacy solutions; assist in standards maturation, and lower barriers to entry to new suppliers, in particular SMEs with niche solutions which could fit within the overall design outlined by the common specifications. Specification based on health, care and life outcomes, rather than technology inputs, will allow for flexibility in implementing solutions and regionalization.

In Spain, in 2009 the former Ministry of Health and Consumer Affairs became the Ministry of Health and Social Policy, in an effort to move to the integration of health and social policies. This situation has been maintained with the actual Ministry of Health, Social Services and Equality (MSSSI). A common strategy for chronic care has been adopted by the State and all the Regions (Inter-territorial Council) in September 2012. The strategy has been jointly developed by MSSSI, the Regions, stakeholders and representatives of care professionals. The strategy also includes indicators on progress.

The Spanish Red Cross and The Institute of Health Carlos III (ISCIII), the latter a member of the STOPandGO Consortium, are conducting a study for the Ministry of Health, Social Services and Equity (MSSSI) to evaluate the effectiveness of the second generation of telecare technology about prevention of domestic accidents as compared with the former simple emergency "red button" systems. The study involves 2 groups of 2000 homes and intends to assess the decrease of morbidity and the economic impact on healthcare services.

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[9] https://www.gov.uk/government/publications/whole-system-demonstrator-programme-headline-findings-december-2011
[10] http://3millionlives.co.uk/
[11] http://www.smart-homes.nl/Innovatie/Nationale-projecten/Slimme-Zorg.aspx

Healthcare in Italy is managed by the Regional Authorities. However, the health systems of the three regions involved in the proposal have an excessive deficit and thus the healthcare ministries are at present under special governing rules, with a plenipotentiary appointed by the National government to drive a change management process. In addition, the Regions of Calabria and Campania fall under the Convergence Objective of the European Cohesion Policy[12] but they often find it difficult to effectively spend all the available European resources that could be available to enhance care and cure services by telehealth solutions, for a lack of guidelines and stable specifications in the sector.

They are receiving support from the National Agency for Healthcare (Agenas) about telemedicine within the Operational Programme 'Governance and Technical Assistance'. The aim of the support is to enhance the efficiency of public administrations involved in Regional Policy planning, implementation, monitoring and evaluation. Therefore their participation in the STOPandGO proposal is timely and appropriate.

In England the National Health Service and Local Authority responsibilities have significantly changed in line with the introduction of the Health And Social Care Act in April 2013. The Act requires health and social care commissioners to work more closely together to provide properly integrated care for everyone, and in particular for frail and elderly people. This integration of care provision is a central part of the STOPandGO procurement process, which stresses the need for integrated planning, which will lead to more cost-effective and yet personalised care.

Innovativeness and efficiency have been discussed as two success factors for affordable and high quality care[13]. A number of countries, like the Netherlands and the United States, implemented a system of regulated competition, in which healthcare purchasing is separated from healthcare provision. Healthcare providers compete to deliver healthcare services to people that are represented by the healthcare purchasers. Healthcare providers compete on a combination of quality and price, and are incentivized to provide high quality care at a competitive price, which should stimulate innovation and efficiency. Nevertheless, the separation of healthcare providers and purchasers creates a scattered health domain which – compared to the situation in England – makes it difficult to accelerate innovations on a large scale. STOPandGO is likely to contribute to the acceleration and potentially opens new possibilities for healthcare providers, in the end building a critical mass for telecare and telehealth in The Netherlands.

We have been working with our European Learning Network (ELN) to establish user, management, ethical and political views on requirements for urgent solutions to what is needed. The European Learning Network has already been formed by Maggie Ellis from LSE and will be further expanded during the project phases (see B3.2c).

The STOPandGO consortium is already in contact with coordinator Carole Gandon (PPI – HAPPI project), Gaynor Whyles (ECOQUIP), and Steven Browning (PPI – SILVER project) to learn from each other and to set up future meetings for the exchange of best practices.

The HAPPI project invited the STOPandGO participants to visit Paris for knowledge exchange or to organize a Telco or Skype in the near future. In addition, some of the project partners (e.g., Smart Homes) became a member of the Procurement Forum (www.innovation-procurement.org) and others will follow to exchange information with other procurers and experts in the field.

The impact of the STOPandGO PPI Pilot will be evaluated in verifiable and measureable economic, medical, social and individual utility terms (e.g., costs, number of re-admissions, Quality of Life, psychological wellbeing, need for informal family care). From this analysis, best practice recommendations will be developed and disseminated for a broader and sustainable application across the EU with the aforementioned groups.

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[12] http://ec.europa.eu/regional_policy/atlas2007/index_en.htm
[13] http://www.erim.eur.nl/research/centres/purchasing-supply-management/research/healthcare-procurement/

The consortium will build on and extend the existing (but fragmented) evidence base and leverage the experience of its members in the procurement and provision of care, technological developments in the health sector and the needs of the elderly in society.

B1.3. Innovative nature and near-to-market maturity of the technical solution(s)

There have been considerable resources directed at the research and development aspects of telehealth and telecare innovations over the past few years. The innovations support independent living and potentially reduce the increasing costs for health care. Electronic Healthcare Records (EHR) and telecare Personal Emergency Response Systems (PERS) have become commercially available, yet, telehealth/telemonitoring solutions still need to progress from pilots to market and are not available on a wide scale. The reasons for this vary. Most trials are additional to the usual course of business and therefore represent additional cost and complexity; knowledge of the benefits is not widely disseminated; sustainable business models have not been identified, and developed solutions cannot be scaled. Most importantly, across Europe, apart from the example of work done in Estonia, effective procurement policies and procedures are lacking for these types of innovative services.

Telecare services are on the rise, even without a clear and coherent strategic plan. In Sweden there are examples of higher distribution of these technologies. There are around 1.7 million users of the most affordable and simple telecare services in the UK, in The Netherlands around 80,000 (with a maximum market of approx. 240,000), in Italy approximately 100,000, and in Spain approximately 300,000. In addition, community based portals offer a suite of useful services from lifestyle and home monitoring to local social inclusion; e.g. in Noord-Brabant (The Netherlands). More complete telehealth services built on existing telecare service infrastructure could be a valid route to market to support the transformation of health services from within a healthcare context. This is more appropriate when services are delivered over consumer devices (TVs, PCs, laptops, tablets, phones) and provide a positive user experience – the thrust of much applied and industrial research within and across Europe. Although the penetration is steadily increasing, the percentage of first generation services like Personal Emergency Response Systems (PERS) is still in its infancy in most European countries apart from the UK.

The barriers in respect to the procurement of effective telehealth-enhanced care services are related to the complexity of the integration of multiple solutions fitting with novel organisational models, since the procurement is not just for a device or the software.

The novelty of the procurement process is not in the focus on a particular technological component, but in the integration and in the simultaneous improvement of the models of care and cure, to provide care and cure services i.e. managed services augmented by a coherent set of interoperable technological components. The development of a service oriented, technology agnostic, procurement specification will open the market to any industry players who can meet the STOPandGO specification.

Care pathways are evolving; different medical specialties are being increasingly integrated, resulting in large interoperability requirements, and the life cycle of the eHealth solutions. The STOPandGO consortium has in-depth knowledge and extensive experience in large-scale trials and public procurement of eHealth, and has a portfolio of best practices across Europe. The consortium will focus on care and cure service outcomes which are adaptable to various regions, enhanced by an appropriate selection of interoperable technological solutions, compliant to existing standards. The consortium has already developed an expert European Learning Network with representatives from users, industry, government, and knowledge institutes that will support the project through the various phases. Furthermore, the consortium already contacted other PPI projects (e.g., HAPPI & Silver) to exchange best practices and participate together in dissemination activities.

A principle of integrated health care systems is the comprehensive scope of health and social services covered. The adoption of integrated care systems is considered, at least in part, a solution to the challenge of sustaining healthcare systems. Moreover, integrated care is necessary to better meet the needs of frail older people and others with complex health and social care needs. The main suppliers assume the

responsibility to plan for, provide, purchase, and coordinate all core services along the continuum of care for the population served. This includes services from primary through tertiary care as well as cooperation between health and social care organisations. Thus, integrated care should be regarded as a complex ecosystem of organisations, relations, dependencies, professionals, caregivers, technologies and patients. But, the most important is that it is centred on the individual patient.

The central reason for integrated delivery systems is to meet patients´ needs rather than providers' needs, by ensuring the patient receives the right care at the right place at the right time. Accordingly, the concept of integrated care is closely related to continuity of care that emphasizes the patient perspective through the system of health and social services. This is why the concept of integrated care is particularly important to service provision to the elderly, as elderly patients often are chronically ill and subject to co-morbidities and thus in special need of continuous care. In this context, telehealth can play a key enabling role to implement integrated care by facilitating better continuity of care for all the actors (i.e., including the patient and caregivers).

In fact, another relevant aspect to consider is patient empowering. Integrated care focuses on coordination and communication not only between healthcare professionals but also with the patients, and caregivers at the centre of the care team. Moreover, self-care and care provided by families and friends are further considerations for integrated services addressing the actual needs of the patients. As Rogers et al[14] said "A truly integrated model of care services needs to respond to the actual types of self-care undertaken by people prior to and in addition to contacting services; and to the reasons for and ways in which people actually access formal healthcare". Regarding that, telehealth offers the potential for patient-empowering applications and services providing patients the support they need to actively self-manage their condition.

We have not identified a unified or commonly agreed conceptual model for health systems integration in the literature. However, in spite of the variety of approaches proposed, successful integration models for health and care systems integration show a number of common principles[15]. A recent study[16] conducted by the IS Unit of the Institute of Prospective Technological Studies (IPTS) of the EC-JRC in cooperation with DG CONNECT/H2, on Integrated Personal Health and Social Services in Europe, has identified eight key factors for success: reorganisation of services; patient focus; governance mechanisms; interoperable information systems; policy commitment; engaged professionals; national investments and funding programs, and incentives and financing.

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[14] Rogers A, Sheaff R. Formal and Informal Systems of Primary Healthcare in an Integrated System: Evidence from the United Kingdom. *Healthcare Papers*. 2000;1:47–58

[15] Suter E, Oelke ND, Adair CE, Armitage GD. Ten Key Principles for Successful Health Systems Integration. *Healthc Q.* 2009 October; 13(Spec No): 16-23

[16] The Strategy Intelligence Monitor on Personal Health Systems. IPTS-JRC-EC,IS Unit. http//is.jrc.ec.europa.eu/pages/TFS/SIMPHS2.html

Section B2. Impact

B2.1. Target outcomes and expected impact

This STOPandGO proposal offers a very practical answer to a question that is prevalent across all advanced economies. The patient groups have already been identified by STOPandGo Procurers and details are included later. The cost of caring for people living with long term conditions consumes a high proportion of the healthcare budget – e.g. in the UK it comprises 70% of the overall budget. Fortunately people are enjoying increasing longevity, but unfortunately for many they live with multiple co-morbidities , which require them to make frequent visits to hospitals and primary care, placing further strain on healthcare providers and adversely affecting their quality of life. An additional complication is the decreasing number of trained and experienced healthcare workers available to care for these people.

This scenario presents a worrying picture for many advanced healthcare economies, which could face bankruptcy in a relatively short period of time if measures are not taken now to reduce expenditure in this sector. Reducing expenditure is not the only concern – it should be coupled with an opportunity to increase people's health and well-being by enabling them to live independent lives in their own homes rather than in hospital i.e. independence with dignity and confidence.

The European Union is promoting the Digital Agenda and in particular the European Innovation Partnership on Active and Healthy Ageing (EIP-AHA), e.g. the action groups A2, A3, B3 & C2. In this context, it could be appropriate to consider the effort done in England leading to the 3millionlives initiative.

In the UK, the Government's response to this challenging scenario was to examine, through the rigours of a Randomised Control Trial (RCT), the effects of telehealth and telecare intervention in caring for frail, elderly and those living with long term conditions. The trial was called the Whole System Demonstrator (WSD) and was conducted at three sites in England, Newham (East London), Kent and Cornwall, which represented an accurate spread of different demographics. It ran from 2008 through 2010 and included over 6,000 people, making it the largest RCT of telehealth and telecare anywhere in the world to date. The academic scrutiny of the trial's data was conducted by a number of academic institutions under the leadership of Professor Stanton Newman from City University and included staff from the London School of Economics. The headline findings from the trial were announced in November 2011 and showed the following encouraging reductions:

- Emergency hospital admissions by 20%
- Accident &Emergency Department visits by 15%
- Hospital in patient bed days by 14%
- Elective hospital admissions by 14%
- Mortality by 45%

However, while the efficacy of the solutions was proven, the cost effectiveness of the provision of telehealth and telecare equipment was a negative observation. So, in recognition of this, the UK Government announced the inception of the 3millionlives initiative, which was specifically tasked with finding ways of increasing the use of technology in the care provision for people living with long-term conditions, while at the same time tackling the lack of cost effectiveness of technology available at the time of the RCT.

Under the leadership of Stephen Johnson, then Head of Long Term Conditions at the English Department of Health (3millionlives is an English initiative rather than UK-wide), a collaboration was created between the telehealth and telecare Industry, Department of Health, NHS and social care and other stakeholders to embark on a programme of work that would find a new way of implementing technology in service provision. Implicit in this approach was the understanding that the 'old' way of providing technology – capital upfront purchase of 'boxes' with little or no regard to their appropriate integration into care pathways – was one of the principle barriers to uptake at scale. A new way of implementing technology was

agreed: to put service design or redesign first; to ensure proper engagement and buy-in from clinicians; to ensure proper and cost-effective integration with social care colleagues and other stake holders; and for industry to offer their product and services on more of a leasing basis, and geared where possible to payment by results.

The ethos of the 3millionlives approach is therefore to put service design first, and make technology considerations second. In this way the design of the service will identify the desired outcomes for patients, and commissioners will commission services that achieve those outcomes, with the provision of technology within the care pathway only relevant as and when it enables the achievement of those outcomes. If 3millionlives is innovative in any way it is in the way in which it proposes a new model for the introduction of technology of any kind into healthcare provision. That introduction should only be considered as an integral part of service provision, and when used should be subject to clear benefits realisation and measurement to ensure appropriate return on investment.

The NHS also recognised in 2011 that effective, streamlined procurement is another key enabler in introducing technology into healthcare provision at scale. In England revision and streamlining of procurement processes, within the confines of EU legislation, is underway. The 3millionlives Way of procurement, a practical step-by-step guide for commissioners, is embedded in Work Packages 2 and 5 of this proposal. That model is also firmly embedded in a number of exciting scale deployments in England right now, and the purpose of STOPandGO is to further test the applicability of that model across the EU, with the overall ambition of showing that its portability can positively impact on the challenge of an increasing population requiring the kind of healthcare intervention that the WSD trial showed can be very effective.

Furthermore the possibility of four EU Member States working in harmony in STOPandGO - in close cooperation with other EU PPI projects (e.g., Silver, HAPPI) and the EIP-AHA action groups - will enable greater experience, a wider collection of data, greater exploitation and dissemination of our main concepts and practice to a wider audience of users, stakeholders, policy makers and alternative purchasers.

B2.2 Wider deployment and use

STOPandGO will contribute to the sustainability of best practice tendering procedures during and after the project end. Furthermore, in conjunction with other EU PPI projects and the EU Learning Network, the findings on public procurement based on the specifications for care and cure services augmented by technology, will be shared during a number of events (e.g., AAL Forum, EKTG meetings, etc.) and

disseminated via the STOPandGO website, Twitter, newsletters. The challenge addressed by PPI procurement in the STOPandGO project has high relevance to other European member states, for a variety of 'end-users', e.g., - among others – older people, service providers, service developers, care providers, insurance companies, municipalities, counties, and national governments. As described in B1.1.1 to B1.1.4, procurers – as the other partners – are highly involved in national and regional initiatives in procurement and assisted living.

Figure 3. Age-related expenditure in EU27
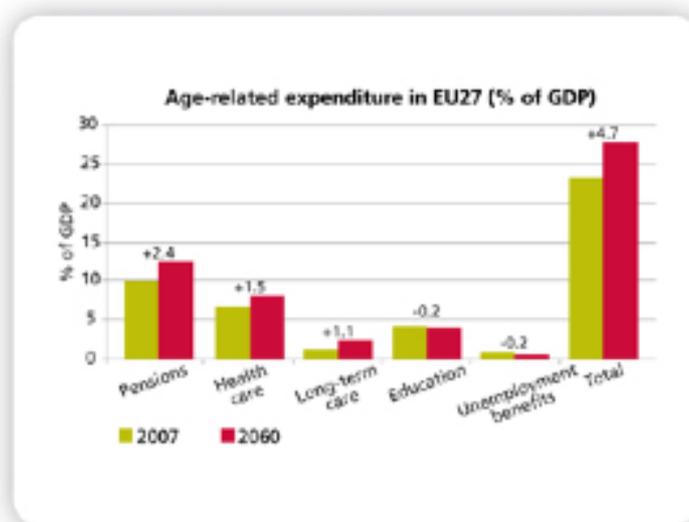
European average public health expenditure related to the ageing population is expected to rise from 1.7% to 3.7% of the GDP by 2050. It will become increasingly relevant in the EU to achieve value for money for the goods and services needed to deliver health care and services. In the EU, health is paid by **public** tax and social insurance, and **private** health insurance, out-of-pocket (OOP) payments, cost sharing (user charges) and informal payments.

Competition among purchasers is still premature in many EU health systems. Competition exists in Belgium and was introduced in Slovakia and the Czech Republic to the whole population in The Netherlands and Germany[17].

Older persons will directly benefit from the STOPandGO project results, since this will stimulate real deployment of telecare and telehealth services, in particular through the amplification within the EIP-AHA milieu. The service allows people to continue living in the known environment of their houses, which is an important factor influencing the perceived quality of life for older persons.

It should be noted that most older persons are not the direct buyers of the services, since care in the EU for older people is mainly funded with public money coming from health and social insurance contributions and general taxation. STOPandGO will further result in benefits for the purchasing market structure across Europe.

For example, the results in The Netherlands from the Public Procurement of Innovation will be relevant for EU member states with a similar market structure.

In The Netherlands, there is a central collection and competing funds purchase on a national level, similar to Belgium and Luxemburg, who will certainly benefit from the STOPandGO outcomes in The Netherlands[18].

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[17] http://www.euro.who.int/data/asse ts/pdf_file/0009/98307/E92469.pdf
[18] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/62060/introduction-public-procurement.pdf

Health and Social Authorities are responsible for achieving value for money in public procurement and resulting in the optimal utilisation of decreasing budgetary resources13. The participating STOPandGO procurers and supporting parties will make use of their network of contacts and their membership in National and European associations and projects (e.g., CASA, 5 stedenoverleg Noord Brabant, EIP-AHA action groups, PPI projects, Slimmer Leven 2020, AAL, etc.).

In addition, the uptake and acquired knowledge will be further disseminated via the STOPandGO European Learning Network (ELN). The Network will include members for public procurement bodies (e.g., national and regional public bodies, health care services, etc.) and a member from each STOPandGO partner and will be extended during and after the project phases by relevant stakeholders in the field of eHealth and procurement.

To further ensure wide deployment of the results, the STOPandGO consortium will produce the specifications (IES) and validate them through an Open Market Consultation. Moreover, it will develop an education and training programme to support businesses and government agencies on (e)Health procurement and large-scale evaluations which will be updated as part of the project using the accumulated advancing insight, knowledge and experience.

Overall, the Consortium will be the leading force behind the deployment of the STOPandGO findings beyond the boundaries of the participating regions as part of their commercial strategy and EU wide dissemination and exploitation responsibilities, especially within the EIP-AHA milieu.

This work will benefit from the collaboration with the contribution from the Advisory Board and European Learning Network members in the regular meetings and exchange of ideas.
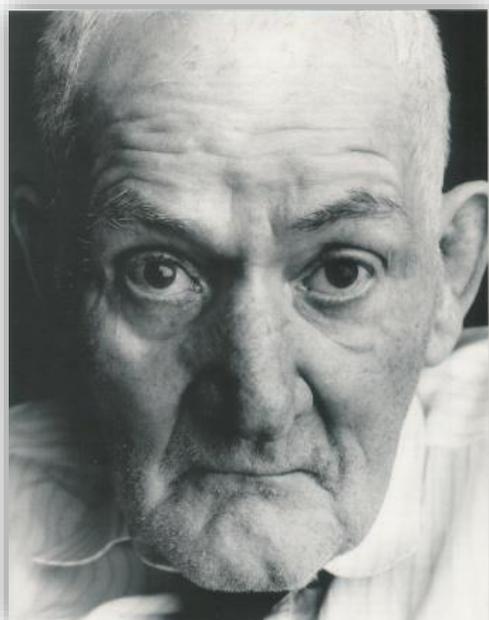
Section B3. Implementation

The organisation of the STOPandGO Project

STOPandGO is organised around the following management entities:
- Executive Board
- EU Learning Network
- Advisory Board
- Project Coordinator
- PPI Coordinator
- Administrative Coordinator
- Work Packages (WP)

The overall organisation and management of the project is shown in Figure 1 and further detailed in section B3.2c.

Figure 4. STOPandGO Organisation
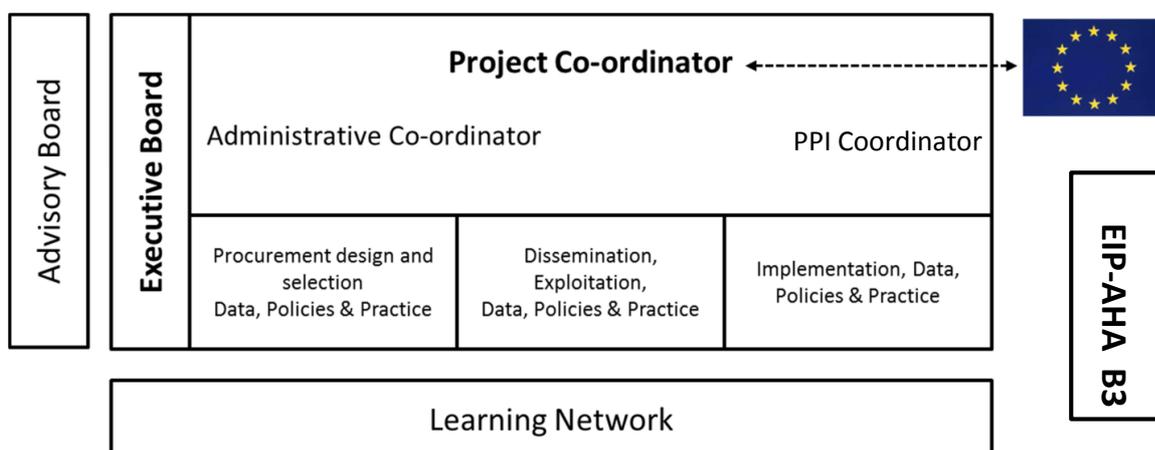
The STOPandGO consortium comprises a select group of independent public and private organisations from the UK, Spain, Italy and the Netherlands that have expertise and experience in the telecare and telehealth arena. The consortium includes public and private healthcare buyers from the four countries, including the North West Coast Academic Health Science Network in England, a new type of organisational structure, reflecting the need for the NHS to have stronger relationships with the academic communities and industry.

In addition, the group includes the Telecare Services Association (TSA), with its expertise in standards (Telecare and Telehealth Code of Practice), representing industry, as well as independent organisations with experience in innovative care and cure solutions, as well as the Eastern Cheshire Clinical Commissioning Group (ECCCG, England). In Spain, the Andalucía will coordinate the tender processes with two other regional authorities (Cantabria and INGESA) and the Health Institute "Carlos III" will be responsible for the interoperability aspects of the whole project. In Italy, the Federsanita ANCI will organize two Mirror Panels (respectively made of procurers and of providers) to support and advise the Italian procurers. Furthermore, in The Netherlands, Smart Homes, has many years of experience in EU eHealth projects, expertise in standards, and also in tendering processes.

The group has an unparalleled knowledge of state-of-the-art services, technologies and procurement processes.

The procurers that will actually commission the local tenders and run the PPI pilot are:
- ARSAN, the Regional Agency for Healthcare in Campania, Italy;
- the Local Healthcare Trust of Catanzaro, Italy;

- the Local Healthcare Trust ASL RMD, in Rome, Italy;
- NHS Eastern Cheshire Clinical Commissioning Group (ECCCG), UK;
- Junta de Andalucia, Spain;
- Gemeente Helmond, The Netherlands;

The procurers fully committed to the STOPandGO project and a number already provided an overview (per procurer – see B1.1.1-B1.1.4) of the patient group they will target, the number of patients, the types of products and services, and possible companies that could deliver these products and services. See B3.1 for a description of the competencies and key personnel of the STOPandGO partners.

B3.1. Capability and Commitment of consortium and key personnel

The STOPandGO consortium comprises a selected group of independent public and private organisations from the UK, Spain, Italy and the Netherlands that have expertise and experience in the telecare and telehealth arena. The consortium includes public and private healthcare buyers from the four countries, including the UK Department of Health (NHS England) with its invaluable experience from the 3millionlives programme. In addition, the group includes the Telecare Services Association (TSA), with its expertise in standards (Telecare and Telehealth Code of Practice), representing industry, as well as independent organisations with experience in innovative care and cure solutions (e.g., Stichting Smart Homes). The group has an unparalleled knowledge of state-of-the-art services, technologies and procurement processes; see the profiles of the partners below.

Profiles of partners

1. Stichting Smart Homes (SMH, NL)

Smart Homes will coordinate the STOPandGO project and is the only expert centre on smart home technology and smart home living in the Netherlands. Smart Homes is highly interested in the results of STOPandGO in order to further expand the market of smart houses and smart services. The ultimate goal is to enable people to live longer in their own dwellings in a safe and pleasant manner. Smart Homes has participated in IP projects on ambient assisted living: NETCARITY, SOPRANO (FP6) and CompanionAble (FP7) and is involved in the CommonWell, Independent, ReAAL, SmartCare, and CAALYX-MV CIP projects. Smart Homes is involved in one STREP (Specific Targeted Research Projects) project named Mobiserv and one Coordination Actions (CA) called CARDIAC. Furthermore, Smart Homes participates in the LEAGE project (EU Lifelong Learning Programme). Most of these projects deal with context aware software based services, built around many different sensors and smart technology in the house.

The exploitation purposes are to achieve a higher level of knowledge and experience, also for the members of the Smart Homes partner community. This community consists of more than 150 organisations, varying from service and care providers, housing associations to manufacturers and installers of smart home technology. Exploitation of the results means that individual members of this community, as well as user and care organisations will make use of the STOPandGO findings. Furthermore, Smart Homes will integrate the knowledge and results of STOPandGO in new courses for education and training. Finally, the project results will strengthen Smart Homes' image in The Netherlands and Europe as an expert centre of smart houses and smart living. Smart Homes' end user group will further grow and build experience with technologies from this project. Dissemination will be done via many channels: its own newsletter, website, yearly conferences and big yearly trade fair on smart living, all in the Netherlands. A particular role will be played by the Smartest Home of The Netherlands, in which the results of the project can be demonstrated. Furthermore, Smart Homes is involved in multiple journal and conference papers on the topic of domotics & smart living. Exploitation and demonstration activities will focus on the care sector in the Netherlands.

Ad van Berlo, Ph.D., M.Eng., M.A. Ad van Berlo is both mechanical engineer (1980) and psychogerontologist (1997). He has a Ph.D. in biomedical technology (1985). He worked in industry in R&D and marketing up to

1991, in the field of biomedical technology. In 1991 he returned to the Eindhoven University of Technology as lecturer in the new area of technology and ageing. In 1993 he built a demonstration house, which also served as "test lab". Currently Ad van Berlo is manager R&D of Smart Homes.

Henk Herman Nap, Ph.D., M.Sc. has a background in cognitive ergonomics, with a M.Sc. degree in psychology (Utrecht University). His main interest is on reducing the complexity of current technology interfaces by cognitive support systems, with a special interest in user groups that face the most difficulties interacting with current media (e.g. seniors). His PhD (Eindhoven University of Technology) focused on stress in senior computer interaction and worked as a Postdoc research fellow on senior gamers in the European FP6 Games@Large project. Since 2011, he works as a project leader and research scientist at Stichting Smart Homes. Henk Herman is continuously involved in various research proposals in the field of supported living, playful persuasion, and UX design (FP6, FP7, CIP, AAL, etc.), for example in the LEAGE project (learning games for seniors), E-NO FALLS (fall prevention & detection), ReAAL (eHealth & interoperability), SmartCare (Integrated Care), and UseITSmartly (Persuasion, Energy & Young Adults). In addition Henk Herman coordinates two Dutch IPC projects for approx. 30 SMEs in the field of domotics & smart living.

Ilse Bierhoff, M.Sc. is a research project manager whose expertise is applying knowledge from social sciences to problems related to the introduction of new technologies. In 2002 she joined Smart Homes and her main activities are in the field of the use of smart home technology in the care and cure sector. Research activities can be divided into three main areas. The first area is the implementation of the user centred design approach with a focus on the gathering of user requirements with innovative methods that allow an equal and creative interaction between user and experts. The second area focuses on advising the process of installing and evaluating smart home technology.

Richard Pasmans, M.Eng. is an electrical-engineer who graduated in 2008 in the field of telecommunications. He works for Smart Homes since 2010 as a project manager for the Smartest House of the Netherlands, a realistic demonstration house located in the smartest region of the world, Eindhoven. Currently he supervises the technical and integration parts in various European and national research projects on domotics and Telehealth.

2. Telecare Services Association (TSA, UK)

The Telecare Services Association (TSA) is the UK industry body for telecare and telehealth and as such is recognised as the source of independent and objective sector specific information by all, from service users/patients to government departments. TSA is a membership based, not for profit organisation, formed in 1995 whose members (360+ organisations) provide telecare and telehealth to over 1.7 million customers within the UK and many more abroad. TSA draws support from providers (who deliver 24/7 monitoring and response services), suppliers (who manufacture equipment, sensors and software systems), third sector and other associated organisations such as those that provide professional and consultancy services. TSA drives quality throughout the sector in two ways:
1. By accreditation to its internationally recognised Telecare and Telehealth Code of Practice; the only bespoke fully audited quality standard available for telecare and telehealth services. This Code of Practice is for consumers (both individual consumers and corporate customers) of telecare and telehealth services. It is a voluntary Code that sets high quality, guaranteed, challenging and audited standards for delivery of telecare and telehealth services in the UK by:
   - ensuring best practice in the provision of telecare and telehealth services
   - providing a clear framework within which service providers should be working
   - informing commissioners, consumers and corporate customers of the service and behaviour to be expected from their telecare and telehealth providers
2. Code of Conduct for supply members

The UK government has signalled a clear intent to embed both telecare and telehealth as a mainstream service within its vision for the NHS. TSA is working, on behalf of its members, with the Department of

Health to support this endeavour by being a lead-partner in the 3millionlives campaign, launched by the Prime Minister in December 2011.

Trevor Single, prior to taking up the position of TSA Chief Executive in 2011, worked for over 30 years in Central Government, with the Department of Trade and Industry (now BIS), heading up a number of policy and legislative initiatives, and with regular engagement with Ministers and other key stakeholders. His work included directing the UK's first major reform of consumer credit legislation for over 30 years, and leading the UK delegation for three years in work with the European Commission and member states on the development of a new Consumer Credit European Directive in Brussels. Trevor left the DTI in 2006 and joined Choose Independence in providing telecare consultancy advice and support, which included working with the TSA on the 2009 revision of its Telecare Code of Practice.

Clive Noak is the Business Development Manager of the Telecare Services Association (TSA) responsible for membership retention, growth and development of added value services. Clive has spent most of his career in pharmaceutical sales and marketing in the UK and overseas (Merck & Co. Inc.), where, as Director of Program Management, he was responsible for supporting the needs of more than 30 countries across Latin America, EMEA and Asia-Pacific markets with regard to sales and marketing applications (especially Customer Relationship Management (CRM) systems). In more recent times Clive has specialised in UK health informatics and patient experience programmes (Dr Foster Intelligence) and Business Development within the health consultancy arena (Tribal Health and Capita Business Services Limited).

3. The Institute of Health Carlos III (ISCIII, ES)

ISCIII is a public research organisation and the national reference centre on scientific research and technological development for health in Spain. The staff of around 1,700 covers all aspects of health, from basic research, to policy formulation and education and training. ICT for Health is implemented through the Telemedicine and eHealth Unit that has a staff of 25 researchers. The main research lines are: mobile health; AAL (Ambient Assisted Living); information systems in healthcare; standardization and semantic interoperability in EHR; PHR and Archetypes; development of open platform (hardware and software) for the follow up of patients (chronically sick, elderly and dependent persons care); security and safety of telemedicine applications and evaluation of new mobile telehealth services and their integration in the public healthcare system. The unit has extensive experience in European projects on ICT for Health under the 4, 5, 6 and 7FPs, including: CARE (Pharmacovigilance European Network); TECN (transplant data network); HECTOR (Health Telematics in Emergencies) and many others, as well as being the leader of the national project PITES, a network of research groups focusing on chronic and dependent people supported by a technical and human platform developed by the Unit. The Unit is actively participating in the EIP-AHA Partnership and has declared its commitment with the activities of B3 action plan.

Carlos Hernández Salvador is the Project Director of the Telemedicine and eHealth Unit. He established the Bioengineering and Telemedicine Research Service at University Hospital Puerta de Hierro in Madrid, participating since then in more than 50 projects (national and European) on subjects such as Telemedicine, Health Information Systems, Semantic Interoperability, Chronic Care and Dependency. He is Technical Secretary of the Executive Committee of the Standardization Forum of the Centers of Technology and Research in Health Care, Spanish Society of Computing in Health Care (SEIS) and Coordinator of the Telemedicine Forum of the SEIS.

Adolfo Muñoz Carrero is a tenured researcher of the Telemedicine and e-Health Unit. Since 1990, he has participated in several European R&D projects. He is a Spanish representative at the CEN TC251- WG1. He is the Secretary of the Committee 139 "Health Informatics" of the Spanish Normalization Agency and participated as a member in the Consultant Group on Semantic Interoperability of Electronic Healthcare Record for the Spanish Ministry of Health. Head of the Information systems and Interoperability Section of the Telemedicine and e-Health Unit (ISCIII), he is now participating in the EIP-AHA B3 Action Group.

4. North West Coast Academic Health Science Network (NWC AHSN, UK)

The Department of Health has overall responsibility for the commissioning of healthcare services and NSH England is specifically for England. All commissioning organisations in England, the Clinical Commissioning Groups (CCGs), come under NHS England. The CCGs will be responsible for directly spending the majority of the £95billion annual budget for the NHS in England, but NHS England will assume responsibility for commissioning specialist services to the value of about £30billion.

While NHS England is the overall partner for the STOPandGO project, the Eastern Cheshire Commissioning Consortium (comprising Eastern Cheshire CCG and Cheshire East Council) will fulfil the role of procurer for England for the project, as they are embarking on a procurement project that exactly fits the requirements of the pilot project as defined by STOPandGO.

Rachel Cashman, Head of Innovation Strategy and Programme Development, NHS England is the newly appointed Head of Innovation Strategy, but she has effectively filled this post for the last 4 years on a secondment basis from Pfizer. Rachel has been working at the highest level of state healthcare and government to oversee the introduction of a variety of leading edge technology innovations.

5. ESP Central Ltd (ESP KTN, UK)

ESP Central was established in November 2009, and has grown from a company with one contract with one customer, to a company that works with a number of different organisations across both the UK and Europe, with occasional forays into the rest of the world. We pride ourselves in working harmoniously with other organisations to achieve the goals of various projects. ESP Central is a company limited by guarantee that exists to promote collaborations the sharing of knowledge to enable successful exploitation of Electronics, Sensor and Photonics technologies. We currently run the Electronics, Sensors, Photonics Knowledge Transfer Network (KTN) and a number of Special Interest Groups (SIG), cross-domain communities run in association with other KTNs for the UK's principal innovation agency, the Technology Strategy Board. ESP Central also runs a number of projects for the EU, the UK Research Councils and the UK Department for Business, Innovation and Skills. ESP Central maintains a core KTN community of around 6,000 stakeholders to which it communicates relevant technological and business with the objective of encouraging adoption of new solutions in the market place, typically those addressing major societal challenges characterized by the SIGs. A further objective is the encouragement of future collaborations by showcasing successful innovation.

Richard Foggie leads on 'digital' for ESP. He trained as a device physicist at the GEC Hirst Research Centre before spending 24 years in the UK Department for Business, Innovation and Skills where he led on electronics innovation including responsibilities for eHealth and Assisted Living. He was contributing editor to the first EU eHealth Action Plan (2004) and latterly led on the business implications of promoting Independent Living in the UK Growth Plan (2011). He is also a director of HoIP Community Interest Company, a 'not for profit' dedicated to advancing the knowledge and practice of Independent Living using familiar consumer ICT. This involves leading and partnering in UK and EU collaborations exploring viable economic and business models.

6. London School of Economics Enterprise Ltd (LSEE, UK)

LSE Enterprise was established by the London School of Economics (LSE) in 1993 to enable and facilitate commercial application of its expertise and intellectual resources. A wholly-owned subsidary of the LSE, the company offers a professional interface with the academic community via services such as Executive Education and Consultancy - its two main activities. Consultancy projects constitute a large proportion of the company's business, with Project Managers sourcing LSE academics according to client needs, and supporting faculty working on research and advisory projects with our clients.

Our client list includes UK government departments and agencies (for example the Department of Trade and Industry, National Audit Office, Foreign and Commonwealth Office, Corporation of London and London

Development Agency), international and supranational organisations (including various institutions of the European Union, the United Nations, Commonwealth Business Council and World Trade Organisation), and major businesses and financial institutions (for example Citigroup, British Petroleum, Pfizer Pharmaceuticals, British Bankers Association and Deloitte & Touche).

Margaret Ellis is a Senior Research Fellow at LSE. She has been involved with two EU Research Projects, the MonAMI project on assistive technology and the SOCIONICAL project using technology for crowd dynamics at times of contingency. She originally graduated as an occupational therapist, managed physical disability and mental health services, and has been a Member of many university and research boards, including the Royal London Hospital, King's College Medical. She has been in charge of project management, structures and finance for health and welfare systems in the UK and in Japan, as well as being involved in various research projects with responsibility for grant holding and supervisory roles including: applications to assist with independent living of older people at home; accident prevention and falls reduction, use of vitamin D with elderly people; healthcare and disability equipment; product evaluation by users for UK Department of Health. Membership of CEN/CENELEC and ISO Technical Committees brought wider experience. She is a Committee Member for European Knowledge Tree Group. Other recent projects undertaken have reviewed SFT methodology and process for Scottish Government Services.

David McDaid is Senior Research Fellow in Health Policy and Health Economics at LSE Health and Social Care and the European Observatory on Health Systems and Policies. He is coordinator of the Mental Health Economics European Network. David's principal research activities focus on mental health policy in Europe. Recent research has included evaluation of the first phase of the National Suicide Prevention Strategy in Scotland, the UK wide Healthy Living Centre Initiative, and undertaking a review of the extent to which economic evaluations have been used in public health for the Welsh Assembly Government.

Steve Smithson is a Senior Teaching Fellow in the Department of Management at the LSE. His research interests are in information systems management, e-commerce and the evaluation of information systems. He is a past President of the UK Academy for Information Systems. He chairs various committees at the LSE and within the University of London International Programme as well as chairing a number of local community associations. He is a Committee Member of the European Knowledge Tree Group.

7. Federsanità Servizi (FSA, IT)

Federsanità Servizi is a wholly owned subsidiary of Federsanità-ANCI, which is the institution that collects Local Health Trusts and Hospitals Trust together with the Conferences of Mayors (through ANCI, the National Association of Italian Municipalities). Federsanità-ANCI provides support to health trusts and municipalities to ensure the paths of integration of socio- health care and welfare. Federsanità-ANCI was founded in October 1995, as a federation of Local Health Trust, Hospitals Trust and of Municipalities with the intent to contribute actively to the process of corporatization and integration of services triggered at the beginning of the 90s. In October 2006, during the first National Congress, Federsanità-ANCI turned itself into a confederation of regional federations. The Confederation is currently composed of 17 regional federations and counts among its members 166 Trusts and Conferences of Mayors.
Federsanità ANCI, through Federsanità Servizi, is running an initiative, named "CATALIS", to support a community of public and private stakeholders about care&cure services augmented by technology, providing a portal, a newsletter, a documentation centre, a discussion forum, face-to-face workshops involving also industry and top management of the local trusts and municipalities. Through CATALIS, FSA is setting up the National panels of procurers and providers to support the activities of STOPandGO.

Massimo Mangia is a senior consultant at Federsanità ANCI, where his activities are in the field of strategic planning for the enactment of e-Health and Connected Health where he has experience of over 20 years. He has been very committed to the promotion and launch of e-Health in Italy and contributed to the birth and development of a community of ICT operators in the sector. He founded and is past-president of HL7 Italy, the Italian affiliate of the most important global association that defines the protocols for the world

of health information technology, he is also associate of ProRec Italy, a committee for the promotion of electronic medical record within the European consortium EUROREC. He collaborates with the eHealth Unit of the Institute of Biomedical Technologies, CNR as well as with the weekly "Il Sole 24 Ore Health", and the "Il Welfare dell'Italia" and "e-Health" magazines.

Angelo Rossi Mori is a senior consultant at Federsanita-ANCI. He is also a researcher at the Institute of Biomedical Technologies of the National Research Council, in Rome, and a senior consultant at AGENAS, the National Agency for the Regional Healthcare Services. The focus of his activities is on comparative studies about design principles of National and Regional eHealth strategies and evaluation of their impact. He is developing methodologies to deploy ICT-enhanced health policies at National or Regional levels, for a balanced diffusion of ICT across the health sectors. He is currently assisting the Health Regional Authorities of Sicilia, Campania, Calabria about a sustainable approach to eHealth and modern telemedicine. Other research topics involve the semantics of clinical terminologies, clinical datasets, EHR. He was or is involved in several EU Projects (including GALEN, KAVAS, IREP, GALEN-IN-USE, TOMELO, C-CARE, PROREC, WIDENET, EHR-Q-TN, eHealth ERA, RIDE, ANCIEN, UNITEDforHEALTH). He was active in the standardization on health informatics, contributing to the creation of CEN/TC251 and ISO/TC215 and leading the Project Teams which developed EN 12264 "Model of Semantics", the part 2 of EN13606 on EHR semantic interoperability and ISO-CEN EN 13940 on the system of concepts to support the continuity of care. In HL7 he was member of the Technical Steering Committee and co-chair of the Templates SIG.

8. Agenzia Regionale Sanitaria Della Regione Campania (ARSAN, IT) – procurer

ARSAN is the Healthcare Agency of the Campania Region, the Italian 2nd most-populous and 1st most densely populated region, with 5.8 million inhabitants. ARSAN is a technical body providing support to the Regional Government. More in detail, it is in charge of: the performance monitoring of the Regional Health System (RHS) and the quality evaluation of the public healthcare services; as well as the assessment of population needs. These activities are particularly relevant for the periodic revision and planning in the medium-term of the RHS offering. ARSAN has been involved in several scientific, education and coordinating initiatives targeting primary and community care, both at a regional and national level. In particular ARSAN has a strong expertise in the organization and management of proactive and integrated care, with special regards to diabetes, achieved by actively participating and significantly contributing to the IGEA Project, coordinated by the National Institute of Health.   ARSAN is currently involved in the European project United for Health, whose aim is to reaching new frontiers in the evaluation and deployment of ICT services for the management of people living with chronic diseases in home settings, on a large-scale.

Giuseppe Longo, MD is an executive manager, responsible for the Office of the Cabinet of the ARSAN General Directorate. He has been member of several national and regional working groups including the Team for the Evaluation and Verification of Public Investments established by the Ministry of Health, the Ministerial committee on the management of the waiting times for accessing healthcare services, the inter-ministerial committee for the Management and Implementation of the Framework Program for the health investments, the Technical Commission for the development of regional accreditation criteria, and several other regional technical and scientific committees in the field of quality of health care. He worked as a lecturer in university and advanced courses at the University Federico II. He also taught in various master courses, specialized in economics and business topics in health care. In 1999 he was sub-commissioner at the ASL Napoli 2 Nord Health Trust.

Massimo Di Gennaro is Head of the ARSAN Bursar since 1998. He has coordinated and actively participated in the preparation and execution of several calls for tender for the acquisition of goods and. He also has taken part in committees for procurement and testing. He was involved in the computerization of several business processes as well as in the functional design of the ARSAN information system and website. He is member of the Commission for the design and implementation of the Regional Accounting Information System for Healthcare. He is also member of the Regional Commission in charge of the control and supervision of the

activities and services for the operation, management and maintenance of the regional Electronic Health Record Systems and its adoption on a regional scale in Campania. He is actively involved in the activities of the United 4 Health project.

9. Azienda USL Roma D (RMD, IT) – procurer

AUSL RMD is the Local Health Trust serving the south-east area of the city of Rome, the most populated municipality of Italy and the fourth-most populous city in the European Union by population within city limits, as well as the municipality of Fiumicino, in its immediate vicinity along the Tyrrhenian coast.

As part of the National Health System AUSL RMD is in charge of the organization and management of public health as well as of the provision of healthcare services to the population under its jurisdiction.

The total geographical area covered by ASL RMD is of 517 km2. It is operationally divided in four independent districts, which respectively coincide with the Municipalities X, XI and XII of the City of Rome and with the Municipality of Fiumicino (see Figure 1).
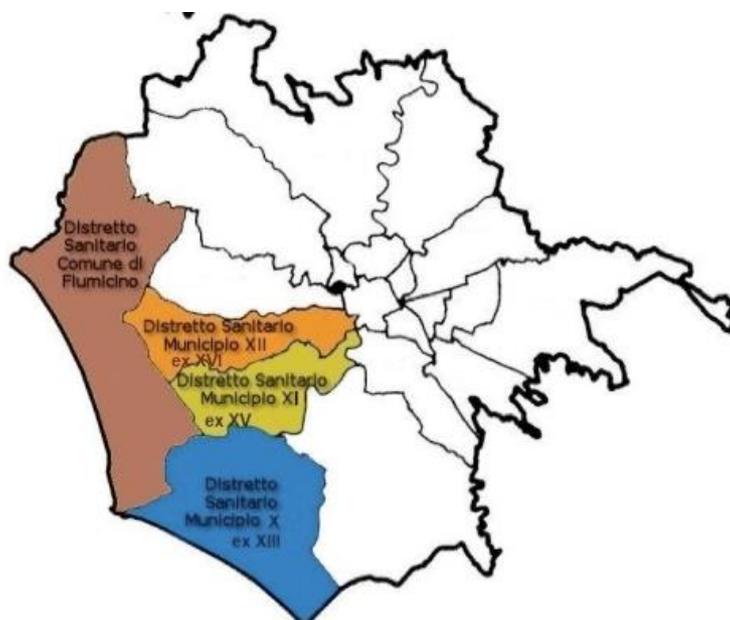
Figure 1: Map of the Municipalities of Rome and Fiumicino, with the four districts of ASL RMD

The resident population is approximately of 593.000 inhabitants, with geographical and demographic characteristics rather uneven, because AUSL RMD includes both:

- urban areas highly populated and characterized by a rapidly aging population (District 3 and District 4 respectively corresponding to the municipalities XI and XII of the City of Rome); and
- peripheral areas, a part of which rural, with a younger population also due to the development of new and extended settlements in the last decade (District 1, corresponding to the Municipality of Fiumicino, and District 2, corresponding to the municipality X of the City of Rome).

While occupying an area of less than one-third of the total AUSL RMD, District 3 and District 4 together account for 50% of the total population, with a population density much higher than the other two ones.

The Table below shows the distribution of the elderly population residing in the AUSL RMD territories in 2010: the elderly population constitutes 20% of the total population.

Table 1: Elderly population of ASL RMD by age groups in 2010

Age range	Population	% Total Population
65-69	32,027	5,40%
70-74	32,158	5,43%
75-79	24,517	4,14%
80-84	16,656	2,81%
85+	14,131	2,38%
all 65+	119,489	20,16%

	all ages	592,752	100,0%

ASL Roma D has a particular organization, strongly focused on primary and community care, operationally managed and delivered throughout its Districts, who have economic, financial and managerial autonomy, with specific budget for protecting the health of resident citizens and for the production and delivery of care and cure services. Actually, the districts assume the programmatic and operational initiatives for the integration of the territorial, departmental and hospital units and points of care, with the aim of achieving an efficient and coordinated response to health needs from the Territory. Districts also represent the frame of reference for an integrated response to the health and social needs of the citizenship, thereby working in close cooperation with the Municipalities and the other local authorities involved to deliver residential, semi-residential or home-based integrated health and social care.

In the provision of care to frail elderly the most important services provided by AUSL RMD are: the "Punto Unico di Accesso", a service of takeover for frail elderly, persons with disabilities, with specific or chronic diseases, with difficulties or complex hospital discharge, or which require specific care from the point of view of social welfare. The service consists of "customized" packages treatment provided for prolonged periods, and with different intensity in the path of life. It is provided through strong cooperation between the Districts and the Municipalities on home care and residential care, provided at home or in nursing homes, hospices, etc. for patients who are permanently or temporarily unable to move. The services are activated on demand by the General Practitioner (GP) or at the request of the family of the patient, according to a plan of care established by the Home Care Centers (CAD), with a strong cooperation of GPs, specialists and the other healthcare and social care professionals: The services include aslo prosthetic assistance, with the provision of Medical Device, Aids and and Assistive Technology (incontinence aids, wheelchairs, orthopedic shoes, etc..).

As consequence of a general reorganization and the closure or conversion of many hospitals in the Lazio region, emergency and inpatient care are now only partly directly managed by ASL RMD with the three hospitals: (i) the P.O. Giovan Battista Grassi in Ostia, providing services for acute wih medium-high complexities and headquarters of the 1st level Emergency Department; (ii) the P.O. Centro Paraplegici in Ostia (CPO), specializes in rehabilitation and home of a spinal unit; and (iii) the P.O. Integrato Luigi Di Liegro Rome, for acute care and rehabilitation of patients with medium complexities. Emergency and impatient care services to the resident population are also guaranteed by other autonomous hospitals present in the area, among which the more relevant is the Azienda Ospedaliera San Camillo-Forlanini. Finally, outpatient specialised services are also provided by many clinics and ambulatories distributed on the territory.

Antonio Mastromattei is an executive manager of the Health Department of the AUSL RMD as well as of the Directorate of District XI. He is a medical doctor with a specialization in Geriatrics and Gerontology, and in Hygiene and Preventive Medicine. For many years he manages and supervises projects in the area of frailty, territorial assistance and integration of health and social care, with particular reference to methods and procedures for the multidimensional assessment of needs and to the definition / adoption / improvement of care pathways for the elderly and patients with dementia. In the past, he held executive positions at the Local Health Trust ASL RMA, as well as Laziosanità-ASP, the Public Health Agency of the Lazio region. He is member and delegate for the Lazio region of the Italian Society of Gerontology and Geriatrics (SIGG), and member of the Italian Society of Hygiene (SITES). Since 2002 he is lecturer in Master and High Specialization courses at the University "La Sapienza" and "Tor Vergata" in Rome.
He is author of numerous publications in national and international journals.

10. Azienda Sanitaria Provinciale of Catanzaro (CZ, IT) – procurer

The "Azienda Sanitaria Provinciale di Catanzaro", hereby ASP Catanzaro, is the Local Health Trust for the Province of Catanzaro. Its mission is the promotion and protection of health of the resident population, both individual and collective, to enable the best possible quality of life, and to ensure basic levels of care (in accordance with the Essential Level of Assistance (LEA)). Actually ASP Catanzaro operates in the context of the Italian National Health Service and, more specifically the Regional Health Service of Calabria. The Province of Catanzaro has a resident population of about 360.000 inhabitants, with about a 10% of people

aged between 65 and 74, and another 10% aged 75+. The ASP Catanzaro is in charge of the provision of caring, rehabilitative and preventive services, which are operationally managed and delivered by 5 geographically distinct healthcare districts, in close connection with public and private health and care providers, in a logic of trust and cooperation. In particular Home Care Services are currently delivered to many different categories of patients among which frail elderly with long term conditions and major limitation in their autonomy, patients affected by degenerative diseases (e.g. Multiple Sclerosis), patients at an advanced stage and /or terminal incurable diseases (e.g. cancer and AIDS), patients with "protected discharge" from hospital wards. The protection of all the citizens' rights of accessing health services and socio-health services and of transparency on the ASP Catanzaro activities are guaranteed by the Charter of Social and Health Services and the Annual Conference of the Services.

Gerardo Mancuso is a Doctor of medicine and surgery. His current position is Director General of the A.S.P. Catanzaro. He holds a specialization degree in Internal Medicine from the University of Reggio Calabria. He was Medical Director at the Research Unit Department of Internal Medicine at the "Mater Domini" University Hospital, with clinical and managerial responsibilities for the department activities. He was Director of the Medicine Unit of the Hospital of Lamezia Terme. He has been an adjunct professor at the School of Specialization in Internal Medicine, University of Reggio Calabria and coordinator for educational activities of the Postgraduate School of the Faculty of Medicine, University of Catanzaro.
He is a National Councillor of the Italian Society of Internal Medicine, and contributed to the drafting of many Italian guidelines. He is also a member of the Federsanità-ANCI board of directors.

Giuseppe Romano has a laurea degree and a PhD in physics. He also has several diplomas and three distinct master's degrees in healthcare management topics. He is the Chief Information Officer at the ASP Catanzaro. He has been responsible for the development and evolution of the current Healthcare Information System. In its role he actively participates to the decisions and activities of the strategic management of ASP Catanzaro. He is also a consultant of the Health Department of the Calabria Region, directly cooperating with the Director General for what concerns the e-Health and more in general the development of the information society in the public administration. In the period between the 2005 and 2010 he has been a lecturer of Business Administration at the University of Pisa.

11. NHS Eastern Cheshire Clinical Commissioning Group (EC, UK) – procurer

ECCCG is based in the North West England. Its purpose is to commission, plan and monitor health services on behalf of the 201,000 people of Eastern Cheshire with a budget of £222 million in 2013/14. It is a membership organisation that is composed of 23 general medical practices located across 11 towns. It is responsible for commissioning a broad range of services including: urgent and emergency care; planned hospital care; community health; maternity and newborn; children's healthcare, services for people with learning disabilities; mental health; continuing healthcare and long term nursing care. Our vision which is embedded in all that we do is to "inspiring better health and wellbeing". Our way of working is guided by our values of: valuing people; working together; innovative; quality; and investing responsibly.
ECCCG population is older than the England average and is the fastest ageing in the North West of England, with 1 in 5 people over the age of 65 years and 1 in 33 aged over 85 years. By 2033, it is projected that there will be a 72% increase in the proportion of people over 65 years of age and a 188% increase in the proportion of people over 85 years of age. Overall our population is relatively healthy, with female life expectancy being 83.6 years and 80.1 years for men. However this masks pockets of significant deprivation and a 12 year difference in life expectancy for men and 13 years for women.
We were successful in being identified as a "Fast Follower" as part of the UK 3millionlives programme. To date we have limited experience in the use of Telehealth but are enthusiastic to develop a wide range of technology to support health and wellbeing as a core enabler in our integrated services. The 2013/14 Annual Plan (https://www.easterncheshireccg.nhs.uk/About-Us/) identifies our commitment to delivering assistive technologies as part of our integration programme, Caring together.

Caring together – Integrating Care in Eastern Cheshire

Commissioners (including ECCCG and CEC) and providers across health and social care in Eastern Cheshire are committed to radically reshaping the delivery of care to the population. The aim is to improve the health of people in Eastern Cheshire by driving up standards of care to meet future challenges, to improve outcomes and experience of care received, to do so within the resources available.

The Caring Together Programme through major cultural change has the potential to dramatically shift the current system from reactive, acute care to proactive care closer to home, to improve patient experience and outcomes, achieve better staff experience by significant engagement with our citizens and staff to co-produce the pillars of care. It also has the potential to do much to support commissioners and providers in Eastern Cheshire in addressing the financial challenges they face. The programme is comprised of three interlinked and inseparable strategies: integrating care, redesigning acute services to deliver specialist care, and increasing productivity across the system. These strategies will be delivered via empowered and responsible patients, multi-disciplinary neighbourhood teams including primary care who are responsive to risk assessed needs in their populations and responsive acute care in times of crisis. The use of technology across the pillars of care, is key to empowering people to take greater responsibility for their own health and wellbeing, supporting people to live well in their own homes, shared clinical care across primary, community and secondary care, shifting care from hospital to the community, and increasing productivity across all services. Further information can be found at: http://caringtogether.info/

Bernadette Bailey is a Transformation Manager leading on the commissioning of integrated services for Eastern Cheshire Clinical Commissioning Group, as part of the local whole system integration programme, Caring together. She graduated as an Occupational Therapist and has worked in the National Health Service in a number of clinical and operational management roles across hospital and community health services. She has held a number of commissioning roles with a focus on older peoples care and partnership working, including working in a joint health and social care commissioning unit. In 2010 she established the whole system Ageing Well programme for Cheshire East and continues to lead the programme http://www.cheshireeast.gov.uk/social_care_and_health/health_advice/ageing_well.aspx.

12. Junta de Andalucia / Servicio Andaluz de Salud (SAS, ES) – procurer

CISAPS JDA

The Regional Ministry of Equality, Health and Social Policy (CISAPS) is a public body of the Regional Government of Andalusia (JDA) which is responsible of health and social policies in the region, as well as the direction of their dependent care provision bodies, among which are the Andalusian Health Service (SAS), the Agency of Social Services and Dependency of Andalusia (ASSDA) and EPES ("Public Company for Sanitary Emergencies").

The CISAPS currently manages the greater volume of budgetary resources of the regional government (45.5%, 9.982 M€ for 2014). This facilitates the deployment of a network of services for the population (8.449.985 inhabitants; 4.169.634 men; 4.254.468 women. 1.3 million are 65+).

The institutional integration process of health and social services will impulse previous initiatives that have been implemented in previous years some of them very significative in terms of impact and efficiency- in the area of health and social tele-care dealing with emergency and chronic patient support for elderly and disabled people at home (INDEPENDENT http://independent-project.eu/consortium/ ; COMMON WELL http://commonwell.eu/commonwell-home/). The telealarm system (SAT) is currently providing services to 268.259 (67% > 65, 30% > 80, 32.4% disab. & dependent).

Integration is faced with the challenges of organizational, professional, process and ICT support systems change as well as with the development of new ways of relation with technology and services providers in context of public budget restriction, recession and the need for improved new and more efficient services deployment. Actual systems and services platforms for elderly and persons with chronic diseases (being

managed and supported by SAS, ASSDA, EPES and also by local authorities) is an opportunity for a quick development of such new services, demanded as a fact for sustainability and improved outcomes, taking for granted that financial issues are overcome and that the benefits o new procuring tools (such as PPI) are demonstrated. PPI is one of the tools and strategies being considered as central part both in Health and Social Services innovation strategy as well as in Regional and National innovation strategies.

Regional commitment with EIP-AHA (both E-Health and Active Ageing Programme have been very well evaluated in the reference site initiative http://ec.europa.eu/digital-agenda/en/news/excellent-innovation-ageing-european-guide-reference-sites-european-innovation-partnership) will facilitate dissemination and scaling of new services solutions in and public procurement procedures.

Servicio Andaluz de Salud – SAS

The Andalusian Health Service (Servicio Andaluz de Salud – SAS) is an autonomous public body responsible for health care provision in Andalusia, attached to the Ministry of Equality, Health and Social Policies(CISAPS) of the Government of Andalusia (JDA). Its mission is to provide high-quality public health care to the citizens, ensuring its accessibility and the satisfaction of its users, and seeking efficiency and optimum use of resources. Healthcare services are provided by SAS through a network of integrated healthcare facilities organized to ensure the accessibility of the population: 1.514 primary care centres, 29 hospitals and 84,753 employees. Its budget for 2014 is 7.5 billion euro.

Andalusia has more than 8.4 million inhabitants. SAS provides a wide range of health services portfolio, from preventive and public health activities to highly specialized services, in a system with universal coverage and funded by taxes. Primary health level provides comprehensive care including health promotion and community health, and is the gatekeeper of the system. Specialized care is provided by hospitals (93% of all hospital beds are managed by SAS) and outpatient clinics.

Since the 90's, SAS has incorporated the use of information technologies into healthcare services. In 2000, the implementation of an electronic health system called Diraya started. Diraya integrates all the health information on each citizen into a single electronic health record, ensuring that all relevant information is structured and accessible. At the beginning of 2011, 100% of the population is covered at primary healthcare leve.l Electronic prescription is accessible for 99.4% of the population, and 99.5% of all pharmacies in the region. After assuring its use at primary care settings, with more than 38 million consultation sheets at this level, Diraya spreads to emergency units and outpatient specialised care. The eHealth strategy fits the overall health strategy; it is part of the process supporting strategic initiatives that improve healthcare in the region.

Chronic care model deployment based on PHC supported by specialized care units within hospitals and 24x7 ICT platforms such as SAT, "Salud Responde" and Emergency Care Control Units is part of the Integrated Care for Persons with Chronic Diseases Regional Strategy (PAAIPEC).

SAS is the main public procurer of goods and services in the Andalusia region (up to 2b€/year) and is participating in PPI (pre commercial) initiatives of national reference supported by the Spanish Ministry of Economy and Innovation (MINECO)

SAS has an extensive experience in EU project, currently SAS participates in several ICT European projects as epSOS, REWIRE or GIRAFF and coordinates PALANTE project. SAS aims to procure services in STOPandGO to at least **1250 people**.

Martín Blanco García. Economics and Business Administration graduate. MSc in Health Care Administration. Planning and Economic Evaluation General Secretary of the Regional Ministry of Health and Welfare of Andalucia . Long experience in Health Care Administration in PHC and Hospitals (University Hospital V Nieves, Granada), he has also been general manager of the Andalucian Public Health School (EASP) and general director of Human Resources of the Andalucian Health Service (SAS).

~~**Jose Maria de la Higuera** MD MsC. Innovation adviser in the Regional Ministry of Health and Welfare of Andalucia. Specialist in Family and Community Medicine. MSc Health Economics and Health Services Administration. Involved in Primary Health Care and Community services radical reform, including the development and implementation of the first great scale EHCR in a Spanish PHC regional service. Strategy and innovation directorate in University Hospital Virgen del Rocío in Seville and after that involved in evaluating and developing new approaches of the Health and Social Research+Development+Innovation plan and strategy for the regional Ministry of Health and Welfare of Andalucia.~~

~~**Manuel Ollero Baturone** MD PHD. Specialist in Internal Medicine. Director of the Integrated Medical Care Unit (UCAMI) of University Hospital Virgen del Rocío in Sevilla, unit of reference in Andalucia and Spain for its deployment of chronic care model approach. Director of the Integrated Care for Persons with Chronic Diseases Regional Strategy (PAAIPEC).Leader of chonic multimorbidity patient care model approach at national and regional levels.~~

13. Gemeente Helmond (GH, NL) – procurer

With nearly 90,000 residents, Helmond is one of the five largest cities in the Dutch province of Noord-Brabant. The city has always given priority to initiating, and implementing innovative solutions that directly benefit its citizens, and is in more than one way considered a front runner by other Dutch cities. It has actively participated in innovations programmes, such as the Smart Health (Slimme Zorg) programme from Provincie Brabant, and is currently involved in a.o. the longitudinal research project 'Ageing at Home with Technology', part of the Dutch national RAAK programme. The latter research project fully takes place in Helmond, as well. Helmond plays an important role in the Brainport Region (World's smartest region 2011), with a.o. Automotive NL, the Dutch automotive knowledge center focused on Smart Mobility and Future Powertrain, and the Food Tech Park. The City of Helmond has a very strong social policy programme, supporting participation, autonomy, self-care/self-help, and informal care/volunteers. There is a strong cooperation between the city and local institutions that are involved in housing, health, welfare, elderly, and informal care. Over recent years, the City of Helmond has implemented some innovative social tools, such as Zorgsite Helmond (Caresite, a product of Simac Sharecare), and Guido, an online demand-driven guide to Health and Welfare (a product of MetaObjects).

After years of dealing with innovative solutions and their suppliers, the City of Helmond sees added value in joining hands with other regional municipalities, in selecting, buying, and implementing digital tools for social applications. This collaboration would have to lead to better pricing and conditions, to exchanging knowledge and experience in selecting and implementing tools, to a structured cooperative buying process, and to a form of cooperation/co-creation involving local end users as well as the manufacturers.

Helmond has therefore started a 'Joint Informal Care' project (Proeftuin Informele Zorg Peelregio), together with the municipalities of Asten, Someren, Deurne, Laarbeek, and Gemert-Bakel, with in total over 200,000 inhabitants in city and rural areas. In this 3-year project, initially, three tools (Zorgsite, Guido, and Zorgvoorelkaar) will be bought, and implemented in the aforementioned municipalities, based on short-term (e.g. 2-year) contracts. This process should lead to a more or less standardised approach, which will then be used to cooperatively select, buy, and implement new innovative tools in the years after. The aim is also to in a later stage extend the collaboration to other municipalities in Brabant, and share the approach on an (inter)national scale. Also, educational institutes and local health and welfare institutes will be highly involved in this project. Together with the other municipalities, Helmond aims to procure services in STOPandGO to at least **1250** people.

Wytske Teeuwen-Besseling - Wytske Teeuwen is policy advisor, specialised in Innovation in the social sector at the City of Helmond. She has directed all the innovation projects that the City of Helmond initiated over the last five years and coordinates the efforts of Helmond in projects where the city acts as participant. The 'Joint Informal Care Peel Region' project started out on her initative, and will be carried out under her supervision.

Stephan Roijers - Stephan Roijers has worked for the last 12 years as an innovation consultant, and focuses on technical innovations in the social realm. He has been a project manager for a.o. three 'Smart Health' projects on Dementia, is project manager of the Zorgsite project in Helmond, coordinates the 'Ageing at Home with Technology' research project with 19 partners, and will also be the project manager for the 'Joint Informal Care' project.

B3.2a. Chosen approach

Preparation for Procurement

According to the Public Procurement of Innovative (PPI) solutions document, "PPI Pilots are centred around a commitment from procurers to buy/deploy innovative solutions on condition the market can provide solutions that meet predefined price/quality requirements by a given point in time." (ICT PSP Guide for Applicants 2013 – PPI pilot, 2.3.1. Objectives)

In order to deliver the PPI pilot for a given locality (which at its highest level of definition could be a country and its lowest a small group of consumers) the design phase of the procurement must abide by all current European Union (EU) rules and regulations through to the end. In addition, the procured products and services should be innovative, sustainable and capable of robust evaluation. Therefore the procurement must by compliant to the European Specification Template (EST) that will be produced by the project and should also specify:

- Awareness and advice on standards (e.g. TSA Integrated Telecare and Telehealth Code of Practice) to be delivered at the level of the consumer (older persons and their carers) within their locality
- The ramifications of the available budget and any public/private arrangements regarding the procurement (e.g. does there need to be a sub-division at the level of the tenders to deliver the totality of the procurement proposition)
- The socio-demographic aspects of the locality in isolation and relation to its surroundings
- The presence of technological solutions already in use, including their infrastructures (e.g. broadband)
- The readiness of the locality with respect to new technological solutions
- The presence within the locality of motivated and knowledgeable managers dedicated to the delivery of the solution
- The capabilities and culture of the professionals and citizens involved (e.g. regarding the usage of computers and smartphones) relative to the innovative care and cure services, as well the technology, to be deployed
- The overall locality action plans around the procurement, i.e. the complementary activities that are being deployed (e.g. reallocation of resources, training of professionals)
- The means by which the deployment will be evaluated against each and all of these criteria to generate requirements and best practices on PPI capable of use with subsequent deployments
- The fully approved business case for the pilot as a final deliverable prior to the advertisement of the tender

Input for the EST will come also from other significant European Projects dealing with the systematization of care and cure services augmented by telehealth and telecare, as for example Momentum, BRAID, K4care, ANCIEN.

The design phase of the procurement for a PPI Pilot will follow EU regulations on PPI and will be overseen by the Executive Board with input from the Advisory Board and will abide by all of the steps detailed within the Guide For Applicants.

The open market dialogue is already underway in an informal way as part of the discussions leading to the creation of this document but will be further enhanced by inputs from the Action Group B3 of EIP-AHA (also through their platform on Yammer), the Advisory Board, other EU PPI projects, and the Learning Network.

In addition a formal consultation will be encouraged through an open meeting arranged by the Project Coordinator, announcement of a Prior Information Notice (PIN) published in the OJEU and a webinar to ensure all inputs have been received and properly taken into account.

Dissemination of the total information gathered in this way will commence immediately i.e. not await the PIN, to ensure transparency, facilitate evaluation and generate long-lasting gains for all outside of the PPI Pilot.

The output of the design phase will be the EST to be applied in the PPI Pilot (including business case) that takes note of all the above points and in addition the inputs from all other available knowledgeable sources, especially those associated with the locality for the pilot.

It is important to recognise that there will be continual modification/improvement of the procurement specification design for the Pilot based on the learning's of the locality procurement teams and information derived from any implementation, as well ass from input by the eHealth community at large, solicited by the project. Hence evaluation will be continual and at all levels, not only that of the implementation outcomes.

Critical to addressing the innovative aspects of the PPI Pilot will be the need to embrace both existing (including the findings from other PPI projects) and new commercial models, such as those currently referred to as "Capital Purchase" (e.g. up-front purchasing of the equipment to be deployed) through to "Outcomes Based" (e.g. Payment by service delivery results) and their inclusion within patient pathways where applicable.

Figure 5. Project Management Structure
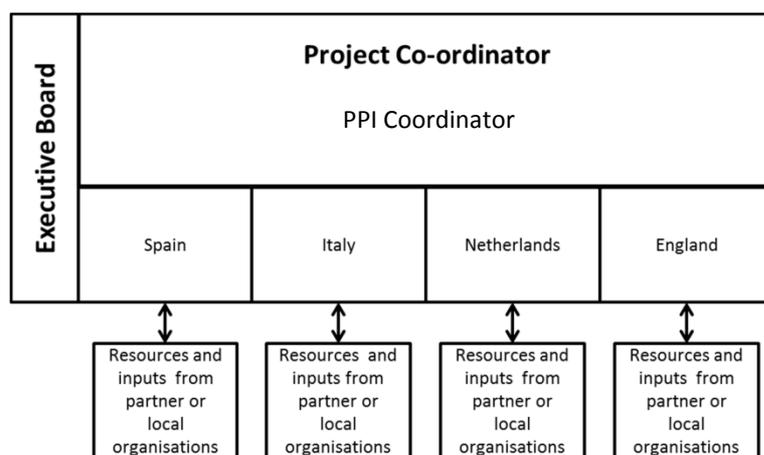
Procedures for Procurement

The outcome of the Preparation for Procurement phase will be a set of local Tender Specifications (compliant with the EST) by which the process to identify the most suitable provider/consortium of providers for each locality will be concluded. All actions must comply with European Union legislation regarding public procurement exercises and timings as illustrated in Figure 2. This phase will end with the award and sign off the contract[s] to deliver the identified PPI Pilot.

Procurement will take place according to EU guidelines for an Open Procedure. For the PPI Pilot the WP5 leader, assisted by the PPI Coordinator will call on the procurement expertise within the partner organisations and the associated localities to assist with the activities associated with the specification and publication of the tender.

The locality procurement professionals will evaluate all bids received against the criteria set out for that locality. The contract will be awarded to the most economically advantageous tender, considering a series of criteria including:

- Lowest price
- Deliverability of the services within the agreed time scale
- Technical merit
- Innovation
- Level of risk accepted by the bidder
- Proposals relating to health and safety
- Proposals for dealing with environmental issues (protection of the environment)
- Service assistance
- Certain social considerations such as positive action towards disabled persons, promotion of equality between men and women and promotion of ethnic/racial diversity. "Buy local" is not acceptable as a social consideration.

Following the award of the contract there will be the obligatory "Standstill Period" to allow unsuccessful bidders or other interested parties an opportunity to challenge the decision. This stage of the work will be managed by the procurement professionals in each locality, working with the Executive Board, to ensure compliance with all European regulations regarding formal notification of the decision to award the contract and the reasons why the successful bidder in the locality was selected.

The PPI Coordinator and procurement professionals in the locality, working with the Executive Board, will ensure that there is compliance with European regulations regarding submission of the formal OJEU Award Notice within the statutory 48-day period.

Figure 6. Guide for Applicants Alignment – Section 2.3.3 Types of Activities
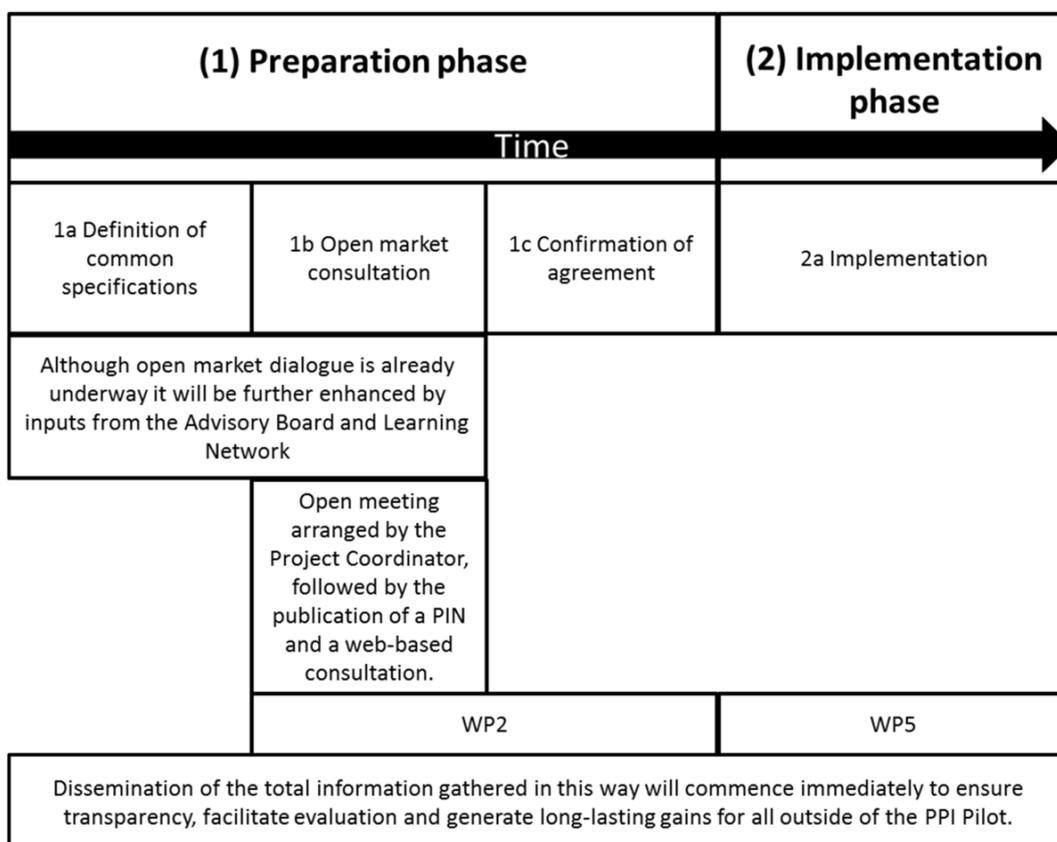
General interoperability aspects[19]

As the European Commission recognises the Interoperability of European public services is a necessity, identified in the Digital Agenda for Europe, which is essential to maximise the social and economic potential of information and communication technologies. In the case of the healthcare services, the necessity becomes an urgency in order to cope with the new challenges to be faced regarding continuity of care and sustainability of the public systems, as is established in the eHealth Action Plan 2012-2020. In this action plan is stated that by 2015 the Commission will propose an eHealth Interoperability Framework (EIF). The EIF will be based on the results of studies, pilots and research projects, and STOPandGO will play an important role in this process.

According to the European Interoperability Framework proposed in annex 2, Interoperability can be divided into several levels: technical, semantic, organisational and legal. This proposal deals with all these levels.

Currently, technical interoperability can be achieved: transferring data from one system to another in a way that they can be represented and they can be understood by a human operator is achieved using the existent standards such as xml to codify files or using the appropriate communication protocols.

Achieving semantic interoperability, i.e. a system can correctly and automatically interpret received information, preserving its whole meaning and context and it can act in consequence, is a much more complex task. In recent years as a consequence of a number of different initiatives promoted by national administrations, from international standardization organisations and from different research entities a change in the design of information systems for normalization in the healthcare field has been proposed, as a solution to the semantic interoperability problem. This change is mainly based on using a new paradigm which isolates information from knowledge and entailing the use of a dual model in contrast to the single model used in traditional developments. The use of this dual model strategy has been supported by the European Commission in two different reports. The first one is the SemanticHealth project report of January 2009; it establishes a route map recommendation to achieve semantic interoperability in Europe; with respect to electronic healthcare information communication the route map recommends to adopt a common generic model considering the ISO-EN 13606 standard (which was developed with the active contribution of a partner of the present Consortium) as a short term action; and to adopt a normalized approach to represent and share healthcare data structures specifications through the use of archetypes. The second report has been published by the three European normalization organisations (CEN, CENELEC and ETSI) as a response to the first phase of the European Commission M403 mandate about interoperability in the healthcare field. This report recommends data structures to be communicated to use common terminologies and to be compliant with the appropriate archetypes and templates.

Archetypes are mechanisms to formally represent medical concepts which can be automatically processed by information systems. Archetypes not only permit to represent the structure of information but also its meaning, binding it to medical terminologies and ontologies such as SNOMED CT. Moreover they enable its automatic interchange between systems, since they define a formal representation of knowledge.

The use of a standard based upon the dual model and its embodied archetypes mechanism such as the ISO-EN 13606 standard is an ideal tool to achieve semantic interoperability for a number of reasons:
- It permits to transfer information preserving all its meaning and context.
- It protects information systems from changes in knowledge: if knowledge changes new archetypes modelling the new concepts will be used, but the system will not need to be updated since the reference model upon it is based remains unchanged.
- By using it, every organisation can define its own concepts (as archetypes) keeping the semantic interoperability of the information. This is especially adequate in the STOPandGO scenario, because the regions will be able to communicate in an interoperable way without the need of a previous agreement.

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[19] [see Bibliography for references]

- Archetypes are also an integration tool, as they can act as bridges between legacy systems (HL7, proprietary ...) using generation applications like LinkEHR.
- It facilitates the inclusion of new entities to the communication process since they will only have to use their new archetypes.
- It isolates responsibilities on very different tasks: domain knowledge experts (healthcare professionals) will define concepts and technologies professionals will define the managing systems.

All these characteristics will be used by STOPandGO to allow the automatic interchange of information of its systems around Europe and will contribute with its experience to the definition of the eHealth Interoperability Framework (EIF) proposed by the Commission. Therefore particular attention will be devoted to the harmonisation across the PPI pilots of the adoption of archetypes compliant with CEN EN 13606 and to their mapping to the most widespread coding schemes, e.g. LOINC, as well to the definition of document templates, based on HL7-ANSI CDA and CCD, for the exchange of context-specific datasets in predefined situations.

Healthcare information systems interoperability is not exclusively based upon technical and semantic interoperability. The European Commission recommends (COM (2008)3282 recommendation) Member States to act at different levels, including the organisational interoperability level, to achieve trans-border semantic interoperability of healthcare information in Europe. Likewise, in the final report of project SemanticHealth, where a roadmap to achieve semantic interoperability in Europe is proposed, organisational interoperability is mentioned as one of the necessary factors to accomplish it. Standardisation organisations are taking the organisational level interoperability first steps in standards like ISO-EN 13940 (system of concepts to support the continuity of care).

The EN 13940 standard was developed by WG1 in TC251 from CEN with the active contribution of a partner of the present Consortium. Publication of its first part (the European version of the standard consisted of two parts) caused enough interest among the healthcare community and is being adopted by ISO as an international standard. The system of concepts supplied by EN 13940 may be used at different levels, from the establishment of healthcare politics to the development of products by industry, including the work flows and the services of organisations, a common context can be generated that would facilitate interoperability greatly.

The use of this standard in the definition of the services proposed by STOPandGO will greatly facilitate the common definition of the services to be procured and will be the cornerstone in which its interoperability will be based.

Additional input to the organisational interoperability will be provided by the ontologies and the systematisations about the care and cure processes, the domain concepts and the related technological solutions, produced by international organisations (e.g. ICF, suite interRAI/RUG/MI Choice [20]) and by several European projects, including for example: Momentum, BRAID, K4care, ANCIEN.

The conclusions obtained by STOPandGO will be contributing to the definition of the EIF.

One of the tasks to be carried out by this proposal is the analysis of the national legislations in order to establish a common base of legal interoperability to develop the specifications of the coordinated procurements. As result of this process a report will be produced that, again, will contribute to the elaboration of the EIP.

STOPandGO is not only going to use and promote the interoperability of eHealth European Services, it also will contribute to the European Normalisation Process and to the development of interoperability standards. This task will be easily carried out due to the direct involvement of some of its partners in the CEN Technical Committees.

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[20] for a glossary, see http://www.interrai.org/104.html

In the following figure (Figure 5) a schematic representation of the information flow for interoperability related tasks can be seen. The IWG will be fed by the experience of its members and of other external consultative groups like the EU Learning Network, the Advisory Board and the EIP-AHA. Its works will be based on the EU Interoperability Framework and the products of the standards development organisations and will take into account the opinions of the standard implementers from the Industry.

The first product of the IWG will be the STOPandGO Interoperability Framework that will serve as the basis to develop the Interoperability Specifications, as well as the source of criteria for the Procurement Interoperability Assessment and for the Evaluation of the level of Interoperability reached by the pilots. The experience gathered from these activities will be used to refine the definition of the Interoperability Framework in order to obtain the definitive version.

To close the circle, the experience gathered and the knowledge generated during this process will be fed back to the SDOs and the Industry, contributing to the European Normalization Process, and within the EIP-AHA milieu.

Figure 7. STOPandGO Interoperability Model
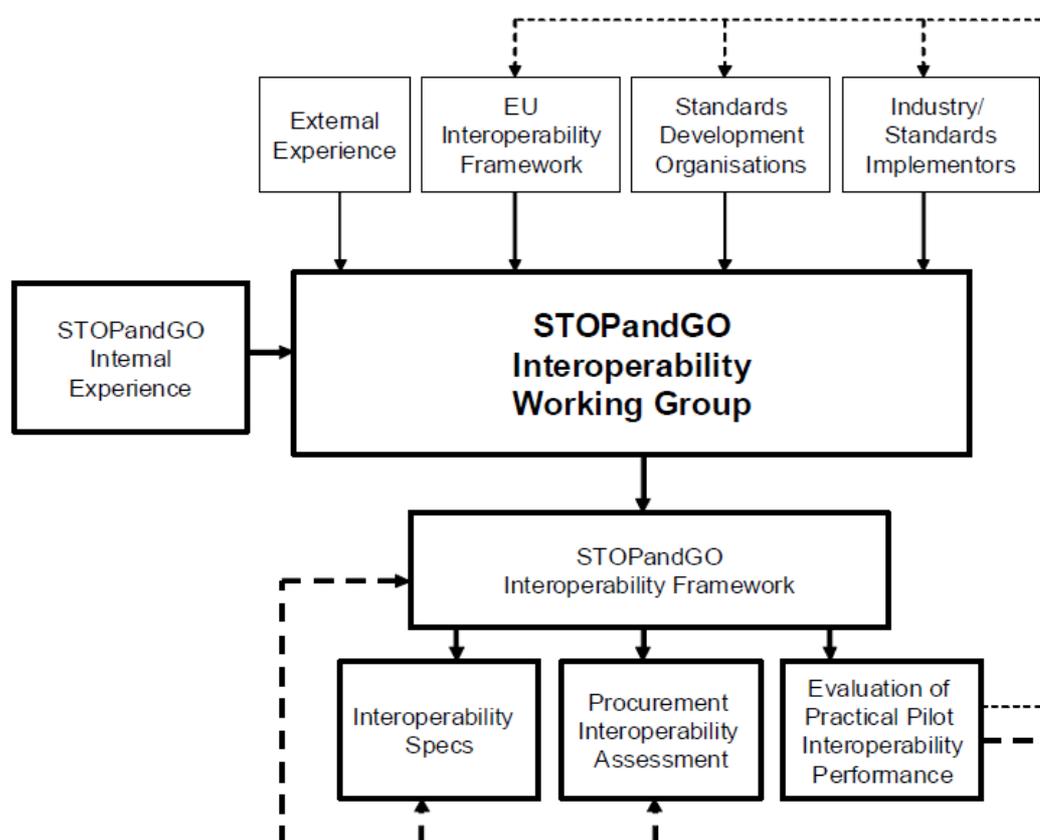
Legal & ethical aspects

Legal and ethical topics are run in order to safeguard the users, their families and carers as well as the health care staff and industry who are involved in the work of this scheme. For years there has been inadequate cover of these topics especially where we staff are working away from their normal site of normal work.

During the endeavour our group will review the listed items, the STOPandGO Checklist of topics, currently thought relevant and give special consideration to items known to be under review by officials and committees elsewhere, as is the current situation with the Radio Equipment Directive included in the checklist.

In addition in STOPandGO we have to address legal and ethical issues concerning the procurement and implementation laws. These are addressed in greater detail in other sections of the submission. They are outlined in the EU Single Market (ref Public Procurement - European Commission, ec.europa.eu › European Commission › The EU Single Market), where the section on Public Procurement Rules give guidelines for current rules for contracts, Government procurement agreements, World Trade Organisation, and Free trade agreements.

In STOPandGO some of the Legal and Ethical items specifically address the welfare of the user, family and carers, whilst others may well have greater significance for the workforce. We will agree a general policy and practice and follow EU guidelines in main areas.

These include :

1) Nuremberg Code (See Attachment 1) The Nuremberg Code

The main points of the Nuremberg Code which need to be considered in STOPandGO but as the work is not research we will note the main elements and check that we have applied the sentiments of the code to our work. The points are, (all from United States National Institutes of Health)

2) EU **GUIDANCE FOR APPLICANTS INFORMED CONSENT Directive 2001/20/EC**

It relates to the implementation of good clinical practice in the conduct of clinical trials on medicinal products for humans. Although STOPandGo is not a research project, because we are working with the cooperation of health and welfare organisations we must meet any ethical aspects as they are identified. Again, we will review this EU Guidance and include any aspect we believe to be essential.

3) Data Protection Action

An EU wide regulation that is regularly being updated. Some variables occur in different countries. It is wise for researchers and policy makers to be alert to the Act as some times it is miss-quoted and wrongly used as a deterrent to practice. Issues which need to be defined include collection of data, storage of data, where, by whom, how (electronic, hard copy etc) access to data (who, when, how) length of time data kept, methodology and security for destruction of data etc.
Professional indemnity – Is the person covered by their own insurance in case they cause accident or injury to themselves or others. Rules about this vary from organisation to organisation and do need to be checked. In some countries individuals may well be not covered by their usual insurance, e.g. undertaking work that might be deemed experimental or research orientated or in some countries, eg. USA.

4) Health and safety

Regulations vary in Member States, however the EU is now tightening the regulations, again these need checking for each event.

5) Public liability

This aspect is the insurance required to cover individuals undertaking work off site in case they are involved or cause an accident, injury, or damage to buildings and things by the activity they are undertaking on behalf of the organisation.

6) Personal liability

This aspect is the insurance required to cover individuals undertaking work off site in case they accident, injury, or damage to buildings and things by the activity they are undertaking on behalf of the organisation. For example they may not follow regulatory requirements but need to be covered.

7) Employment contract and laws

This is a requirement in Employment Law that the actual contract for the worker does need to state they are expected to undertake this work, mention this includes off site working etc. Many contracts also state that the individual must be trained for specific aspect of the work, e.g., Health and Safety on and off site. During the project we will identify issues through our checklist and address these.

8) CE Marking Directive (93/68/EEC)

This EU regulation requires that checks be made about specific equipment used whether this has identified CE Marking or is research model stuff only, etc. It is known that when some equipment is used for slightly different purposes, eg. A Mobile phone used to gather healthcare data that possible additional checks and agreements are needed. Each Member State has a Regulatory Body (MRHA in UK) dealing with these matters and may have variable requirements.

9) EU Medical Device Directive (EN60601)

Another EU Directive where the work may include emergencies with accident/injury work included. Each Member State has a Regulatory Body (MRHA in UK) dealing with these matters and may have variable requirements. Again if the use of main purpose of the equipment is changed from that it was designed for specific approval maybe required.

10) Radio Equipment Directive (199/S/EC)

This EU Directive requires organisations to check that equipment they are using meets this regulation, especially as some new items may interfere with Radio systems elsewhere. Each Member State has a Regulatory Body (MRHA in UK) dealing with these matters and may have variable requirements. Currently there are reviews of this Directive being undertaken and changes may well be implemented during the lifetime of STOPandGO. Preventing interference with the local telephone line interface IEC 950-EN 60950 (BABT) UL 1950/CSA 950 - This EU Directive requires organisations to check that equipment they are using meets this regulation, especially as some new items may interfere with telephone systems elsewhere. Each Member State has a Regulatory Body (MRHA in UK) dealing with these matters and may have variable requirements.

11) EU General Product Safety Directive (GPSD 2004)

This EU Directive requires organisations to check that equipment they are using meets this regulation, especially as some new items may interfere with technology systems elsewhere. Each Member State has a Regulatory Body (MRHA in UK) dealing with these matters and may have variable requirements.

For the purposes of the Ethics Review process, the definition of Informed Consent given in the Directive 2001/20/EC relating to the implementation of good clinical practice in the conduct of clinical trials on medicinal products for human use is adopted. The principle of "informed and free decision" remains valid for any other kind of research.

Quality assurance and evaluation

The PPI is a novel instrument promoted by the EU, and the experience within the STOPandGO project will be usefully systematized according to different perspectives, to facilitate the further applications of this instrument to other topics in the eHealth field.

The project will perform quality assurance and evaluation according to three major perspectives:

1. To monitor and evaluate the advancement of the process carried on by STOPandGO to prepare and run the PPI, i.e. to answer the question: "what are the preconditions for an appropriate usage of the PPI instrument in the eHealth field?"

2. To discuss the quality and evaluate the usability of the EST, i.e. to answer to the question: "are the specifications on the care&cure services augmented by technology able to fit with the intent of promoting the improvement of the care provision and a coherent development of the market across Europe?"

3. To monitor and evaluate the local tendering processes and the related deployments, i.e. to answer to the question: "what is the impact of the local deployments on the care&cure system and on the benefits for the patients in the target population?".

The first perspective regards the suitability of the application of the PPI instrument to the topic of this proposal. The lessons learned by the STOPandGO project will be systematized for the benefit of the next use on similar topics, to produce recommendations about strengths and weaknesses of the PPI in the eHealth sector and to suggest the optimal usage of the instrument, as well the risks and the challenges to be faced.

The second perspective focuses on the assessment of the specifications, after reaching the consensus by the Open Market Consultation, with the related toolkit for its application and the educational material. It will consider the actual adaptability and usability of the specifications in the local contexts, together with the strengths and weaknesses resulting from the pilot deployments within the STOPandGO project. In particular, the activities will assess the usability of the guidelines on the metrics to identify profiles of patients who may benefit from the provision of telehealth services (for example: condition, age, severity of the condition, co-morbidity, socio-economic status and any other relevant factors).

The third perspective deals with a comparative evaluation of the local deployments, to validate and strengthen the evidence for implementation of telehealth solutions with chronic disease management, especially on effectiveness, cost-efficiency and transferability of the implementation of the services.

The evaluation activities should build on existing initiatives, using established and scientifically validated methodologies, extending and refining the Model of Assessment of Telemedicine (MAST, a framework developed by previous EU initiatives and already applied in Renewing Health and United for Health) in conjunction with other acknowledged methods. In fact, earlier EU technology projects have sometimes limited their aims to the technology rather than the users of the technology themselves. We therefore aim to include not only the technology aspects by approved evaluation processes such as MAST, but in addition take account of the functional ability of the users using evaluation processes such as the International Functional Independence Measure (FIM). When the WSD evaluation scheme was undertaken some users were very critical of the over burdensome frequency of which they were expected to complete questionnaires. STOPandGO will be mindful of this fact and limit the demand on users and their families when completing the evaluation design.

Earlier work undertaken in the MonAMI. Project, reported in a Final Deliverable, identified cost savings could be made when service providers included the real costs before and after introducing technologies, such as those we will use in STOPandGO. That work showed that frequently the main savings made were in the Health budget rather than that for Social Care, with a reduction in in the number of in-patient hospital bed days. Similar figures have been shown in work undertaken in Scotland and Slovakia where both examples showed such savings. Similar figures will come from the STOPandGO calculations.

Table 4. Benefits and Key Performance Indicators

Benefit	KPIs	Measurement	Target Improvement
Assess potential Market for telehealth/ telecare services for each locality/region	1 Baseline assessment of current usage of telehealth/telecare services	Conduct a survey of the relevant commissioning agencies for clinical and social care services	n/a
	2 Baseline target population by locality [i.e. older persons needing telehealth/telecare services] and identify levels of need	Use risk stratification tools to identify levels of need and stratify target population [e.g. low/medium/high]	n/a
	3 Baseline assessment of public and private sector providers' plans for adoption of telehealth/ telecare services	Negotiate a goal for telehealth/ telecare uptake with the commissioning agencies21	From baseline to goal e.g. x% to y% within z months/years
	4 Assess progress towards agreed goals at regular intervals	Measure the number of service users who will benefit from telehealth/telecare services22	Difference between 3 and 4
Reduction in costs in line with expectations set out in the business case	5 Baseline assessment of the proportion of Accident & Emergency visits, emergency admissions, elective admissions, bed days and levels of mortality attributable to the target population by locality	Obtain data from the relevant medical/social care recording systems covering an agreed period, e.g. 12 months to allow for seasonal variations	n/a
	6 Review of the proportion of Accident & Emergency visits, emergency admissions, elective admissions, bed days and levels of mortality attributable to the target population by locality	Obtain data from the relevant medical/social care recording systems	Reductions in line with or better than WSD headline findings23 and in proportion to people receiving telehealth/ telecare services24
Levels of awareness of telehealth/ telecare services	7 Baseline assessment of commissioning agencies' awareness of telehealth/ telecare services	Use questionnaire to evaluate levels of awareness	n/a
	8 Review of commissioning agencies' awareness of telehealth/telecare services	Use questionnaire to evaluate levels of awareness	Aim for 100% awareness within an agreed timescale

The consortium has experience with the MAST (Model of Assessment of Telemedicine) framework, which is one starting point for an evaluation framework. MAST proposes a model (Figure 6 below) that recognises three main elements (or stages) to be included in an evaluation:

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[21] The Worcestershire pathfinder tender in England is aiming for 15% of an identified cohort of 70,000
[22] As represented in the outcome-based specification used for tender. This is the number of people who will benefit by the project end date
[23] The Whole System Demonstrator study in England resulted in the following outcomes: A&E visits -15%; Emergency admissions -20%; Elective admissions -14%; Bed days -14%; Mortality rates-45%
[24] Telehealth/telcare solutions take time to deploy. This metric represents the number of people to whom relevant services have been deployed

- Preceding considerations
  - o Refer to the aims, patients and context
- Multidisciplinary assessment
  - o Project level outcomes in 7 domains
- Transferability Assessment
  - o Incorporates the key issues of interoperability and increased benefits through economies of scale.

Figure 8. The MAST Framework

Preceding considerations
- **Purpose of the telemedicine application**
- **Relevant alternatives (current practice)**
- **International, national, regional or local level of assessment**
- **Maturity of the application**

Multi-disciplinary assessment (seven domains of data)

1. **Health Problem and characteristic of the application (descriptive)**
2. **Safety (outcome)**
3. **Clinical effectiveness (outcome)**
4. **Patient Perspectives (outcome)**
5. **Economic Aspects (outcome)**
6. **Organisational aspects (outcome)**
7. **Socio-cultural, ethical and legal aspects (descriptive)**

Transferability Assessment

- **Cross-border**
- **Scalability**
- **Generalisability**

Source: Kidholm, K, Ekland, A.G. et al. (2012) A Model for assessment of telemedicine applications: MAST, International Journal of Technology Assessment in Health Care, 28:1 44-51

And see also conference presentation sides at:

http://www.ehtel.eu/references-files/2011-ehtel- symposium-integrated-care/EHT11-RH-MTWS%2014-3%20Anna%20Kotzeva%20MAST%20in%20Practice_final.pdf

MAST offers a framework within which relevant outcome measures can be slotted with varying ease. These include before and after measures of:

- Satisfaction (of patient, carer, family and service)
- Quality of life
- Changed conditions
- Readmissions
- Cost savings

However, as is made clear in the literature, MAST still needs refinement. It is just a framework and it has little to say about how actual assessment is done once the domains are populated with data and or measures. STOPandGO proposes to extend and refine MAST by using it in conjunction with a more people-oriented approach. Detailed consideration will be given to all aspects of the patients/users function, physical, psychological, community, including before and after the intervention. An accepted International system Functional Independence Measure (FIM) will be used.

At each stage of the work, during the procurement and implementation phases all the actors will be expected to undertake relevant aspects of the evaluation. Procurers will be expected to work with arms' length evaluators and to fund their time in order to ensure an acceptable routine and result from the whole scheme and further details are identified.

B3.2b. Work plan

Table 5. Work package list

Work package No.	Work Package Title	Lead Participant No.	Lead Participant Short name	Total person months per WP	Start Month	End Month
WP 1	Project management and coordination	1	SMH	34,5	M1	M36
WP 2	Preparation of the European Specification Template (EST)	2	TSA	24,5	M1	M8
WP 3	General Interoperability Aspects	3	ISCIII	10,0	M1	M36
WP 4	Legal, Ethical and Regulatory aspects	6	LSEE	14,5	M1	M36
WP5	Coordinating the Local Tendering Procedures	12	~~SAS~~	19,0	M6	M20
WP6	Quality Control and Evaluation	6	LSEE	15,5	M1	M36
WP7	Coordinating the exploitation: training programmes and regional procurement plans	7	FSA	12,0	M1	M36
WP8	Dissemination	5	ESP	12,0	M1	M36

Table 6. Deliverables list

ID	Description	Code	Dissemination Level	Delivery Date
D1.1	Periodic reporting of project activities	R	PU	Throughout
D1.2	Quality plan	R	PU	M2
D1.3	Report on the activities of the National Mirror Panels in IT, ES	R	PU	M20,36
D2.1	Reference Business Case	R	PU	M5
D2.2	The European Specification Template (EST) and related materials	R	PU	M8
D3.1	Interoperability requirements: StopAndGo Interoperability Framework	O	CO	M8
D3.2	Evaluation guide for deployments	R	PP	M10,20
D3.3	Analysis of overall performance of the STOPandGO Interoperability Framework (final report)	R	PU	M36
D4.1	Report summarising key legal, ethical and regulatory issues in the four countries	R	PU	M6
D4.2	Preparation of interim guidelines document for procurers on legal, regulatory and ethical issues	R	PU	M8
D4.3	Final version of STOPandGO Legal, Ethical and Regulatory issues handbook for procurement	R	PU	M34
D4.4	Report with lessons learnt on LRE and recommendations for procurement process	R	PU	M34
D5.1	Report on the locality adoption of the project documentation and their intended usage	R	PU	M12
D5.2	Report about the execution of the local tendering procedures	R	PU	M20
D6.1	Evaluation framework for STOPandGO and related handbook for its application	R	PU	M8
D6.2	Evaluation results	R	PU	M36
D6.3	Analysis of results, lessons learnt about the evaluation processes	R	PU	M36
D7.1	Consolidated release of the Reference Business Case	O	PU	M31
D7.2	Consolidated release of the European Specification Template and the related materials	O	PU	M36
D7.3	Report on the comparison among the regional and local exploitation plans that decided to adopt the project's materials	R	PU	M36
D7.4	Report on the lessons learned and recommendations about the appropriate usage of the PPI instrument in the field of eHealth	R	PU	M8,20,36
D8.1	Report on dissemination activities	R	PU	M12,24,36

Table 7. Milestones list

ID	Description	Month
1a	Set up of the Advisory Board	M2
1b	Set up of the mirror panels in IT, ES	M2
2a	Baseline data set for KPIs	M4
2b	Interim draft EST	M5
2c	Publication of PIN (Prior Information Notice) in the OJEU	M5
2d	Consultation on Business Case and EST with the Advisory Board	M5
2e	Consensus meeting with EIP-AHA B3	M7
2f	Formal workshop for the Open Market Consultation	M7
3a	Input to WP2 on conformance to ISO/EN 13940	M4
3b	Agreed input on standards to WP2	M5
3c	Dialogue with CEN and other standardization bodies	M34
4a	LRE helpdesk becomes operative	M3
5a	OJEU Notice published about all the local tenders	M11
5b	All invitations to Tender drawn up and sent to short listed bidders	M19
5c	After the standstill period, all contract signed	M18
6a	All contracts commenced service delivery	M16
7a	Schedule and syllabus for the training programmes	M12
7b	Regional and local exploitation plans by procurers of different localities outside the project, as Early Adopters	M34
7c	Translations of the most significant parts of the STOPandGO consolidated materials into National languages	M34
8a	Launch of project website with associated twitter account and linkedin group	M2
8b	Schedule of dissemination events established (rolling quarterly review)	M4, etc
8c	Dissemination of finalised tender specifications via web and physical events	M9
8d	Announcement of successful tenders, publication of service specifications	M15
8e	Annual public project meetings and press releases with news of results	M8,20,32
8f	Public dissemination materials on PPI instrument	throughout

Work packages Summary

The activities of the project are organized through 8 Work Packages. Due to a limited amount of PMs for the partners, not every partner has PMs in the 8 WPs. However, it is expected that partners – in particular in implementation work – will perform tasks in all WPs. The WP leaders and the non-procuring partners will mainly perform coordination tasks and tasks in developing frameworks and guidelines (e.g., on interoperability, legal and ethical issues), while the procuring partners will implement and use the guidelines and supporting documents in the procurement phases.

- WP1 is about the administration of the project and the general management. It also manages Executive Board and Advisory Board.
- WP2 is designed to produce and validate a version of the Reference Business Case, the European Specification Template and related materials to facilitate its usage, to be used by the localities during the project and organisations outside of the project if the PPI Pilot is deemed to be a success.
- WP3 provides a specific input to WP2 on interoperability.
- WP4 provides a specific input to WP2 on legal and ethical issues.
- WP5 is aimed at delivering the European Specification Template at the level of the localities i.e., to coordinate the local tendering procedures, up to the signature of the contracts.
- WP6 is about evaluation. It coordinates the regular monitoring of the local deployment of the care&cure services; in addition it evaluates the suitability of the tendering procedures according to the European Specification Template and the usability of the PPI instrument.
- WP7 about exploitation regards the **proactive involvement of named procurers**, to plan new tenders according to the STOPandGO European Specification Template. It enacts the spirit of the PPI and **it is the crucial marker of the success of the project**. It facilitates the exploitation of Business Case, European Specification Template and related materials by Early Adopters. It delivers a consolidated version of the STOPandGO material, organizes training programs, and should produce a significant set of realistic Regional Exploitation programs and Local Exploitation plans.
- WP8 copes with the dissemination of the results to the wide public.

Figure 9. The main process in STOPandGO
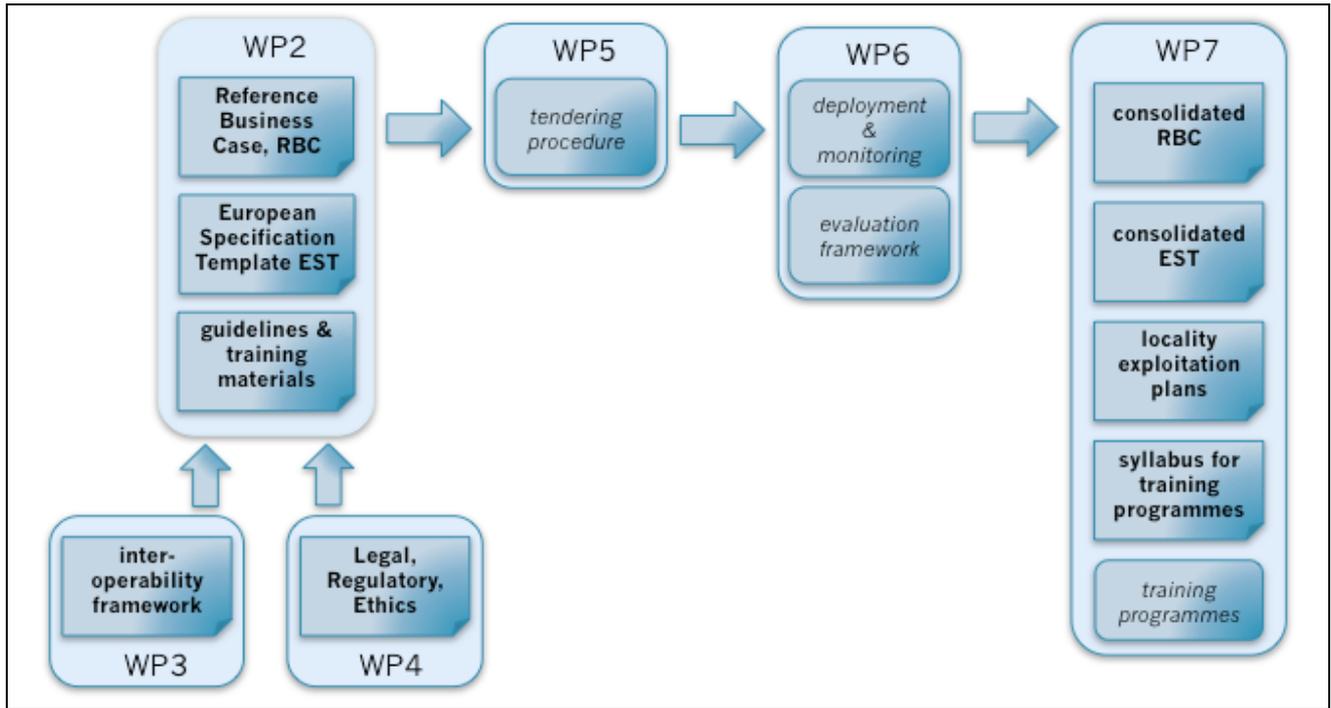
WP1. Project management and coordination

Work Package Number:	1						Start Date: M1 – End Date: M36 (+3)						
Work Package Leader: SMH													
Participant No.	1	2	3	4	5	6	7	8	9	10	11	12	13	
Short name	SMH	TSA	ISCIII	NWC AHSN	ESP	LSEE	FSA	ARSAN*	ASL RMD*	ASP CZ*	EC*	~~SAS~~*	GMH*	total
Person Months	12	2	2	1	2	10	2	0,5	0,5	0,5	0,5	1	0,5	34,5

* = actual procurers

Objectives

This WP supports the administrative issues and the internal organization of the consortium on the following activities:

- To reach the objectives of the project within the agreed budget and time lines

- To orchestrate the work and ensure effective communication between all parties

- To establish a quality policy and ensure the quality of the work and deliverables

- To ensure that decisions are made on the basis of data and factual information

- To solve issues or conflicting situations

- To register all elements of the work appropriately and to time

- To link all the actions of the project to the risk assessment and control patterns

- To ensure that an infrastructure is set up in order to support the above.

In Italy and Spain, a partner will act as National Facilitator and will set up mirror panels to support the activities of the project in the various WPs. The Executive Board (EB) will be supported by the European Learning Network (ELN) and an Advisory Board (AB). The coordinator Smart Homes will work together with LSEE in setting up the ELN and AB, and LSEE will have a major role (as reflected in their PMs for WP1) in managing these bodies and IPR issues. In addition, Smart Homes will be responsible for all financial reports while LSEE is responsible for the scheduling and progressing of deliverables.

Description of tasks

Task 1.1 - Administration

The organization leading this WP is responsible for:

- Organising and running project meetings (SMH)

- Ensuring all elements of the work are registered appropriately and to time (SMH)

- Collecting, submitting and distributing project deliverables (LSEE)

- Compiling and producing project reports, including Annual Reports and six-monthly progress reports (SMH)

- Managing financial reports and payments (SMH)

- Scheduling and progressing deliverables and reporting short-falls to the Executive Board (LSEE)

- Organise regular reporting of work at all levels, links with EU Project Officer (SMH)

- Organise regular reporting and accountability for financial management (SMH)

- All other general project administrative tasks (SMH & LSEE)

Task 1.2 - Internal coordination among the WPs

The EB will perform the following activities:

- to ensure that STOPandGO procurement and technical objectives are met

- to monitor and assess STOPandGO achievements in terms of innovation

- to identify readjustments when needed at an operational level

- to ensure that the same terminology is used and a common understanding is reached

- to create, highlight and possibly identify synergy and dependencies, highlight exchanges and deliveries between WP's

- to highlight STOPandGO objectives and innovation and to assist with the review and adjust internal and official deliverables.

Task 1.3 - Liaison with external bodies and support to Advisory Board and ELN

A liaison will be established with external bodies, as the subgroup on Telemedicine of COCIR and the EIP AHA Action Groups (in particular B3 Integrated Care).

This task will also support the logistics of the Advisory Board (AB) and of the European Learning Network, and will manage the interaction between the project and their members.

Task 1.4 - Support to National activities

Two partners, respectively in IT and ES, will act as National Facilitators and will set up two kinds of Mirror Panels in their own country (one for the procurers, one for the providers). They will convene them periodically to orchestrate input to the project activities, to provide comments on the project outputs and to collaborate with the project as specified in the various WPs. Representatives of these panels will be members of the Advisory Board.

NOTE: Additional Mirror Panels may be established in other countries; their representatives will be included in the Advisory Board, however their activities will not receive a financial support by the project.

Deliverables

ID	Description	Code	Dissemination	Delivery
D1.1	Periodic reporting of project activities	R	PU	Through out
D1.2	Quality plan	R	PU	M2
D1.3	Report on the activities of the National Mirror Panels	R	PU	M20,36

Milestones

ID	Description	Month
1a	Set up of the Advisory Board	M2
1b	Set up of mirror panels in Italy and Spain	M2

WP2. Preparation of the European Specification Template (EST)

Work Package Number:	**2**				Start Date: M1 – End Date: M8									
Work Package Leader: TSA														
Participant No.	1	2	3	4	5	6	7	8	9	10	11	12	13	
Short name	SMH	TSA	ISCIII	NWC AHSN	ESP	LSEE	FSA	ARSAN*	ASL RMD*	ASP CZ*	EC*	~~SAS~~*	GMH*	total
Person Months	2	4	1.5	1	1	4	2	1	1	1	2	2	2	24.5

* = actual procurers

Objectives

The objective of this WP (together with the following WP3 and WP4 on general interoperability aspects and legal/ethical/regulatory issues) is to reach consensus at the European level on the fair and transparent development of an innovative European Specification Template (for the PPI Pilot), which will be delivered and tested through locality tenders (WP5). This activity involves a comprehensive stakeholder engagement and consultation exercise for each locality associated with the PPI Pilot, which will enable the identification and assessment of all stakeholder concerns but especially those regarding issues such as ethical considerations, user safety and confidentiality.

Key objectives for this work package are the production of three products:

- a Reference Business Case (e.g. user requirements, cost data on equipment and services) usable at the European level

- the outcome-based European Specification Template (EST), validated by a formal Open Market Consultation

- additional material to facilitate the application of the Template

The approval of these documents is the main milestone for the preparatory phase and marks the start of the locality procurements as per WP5. A consolidated version of these documents will be produced in WP7, after the evaluation of the Pilot in WP6.

Description of Work

Task 2.1 - Structured collection of information to build the Reference Business Case

The information to be collected could include:

- description of current and planned formal programmes about care&cure provision, with the professional profiles involved

- range of health conditions covered and social care risks addressed, with outcomes data such as mortality rates, emergency admissions, etc.

- number of current telehealth and telecare users in the relevant locality and age range

- levels of usage in terms of the type of service (and associated equipment)

- levels of usage in terms of cost

- qualitative data covering user satisfaction/confidence, if available

- qualitative data covering informal carer perceptions (e.g. how confident do they feel that the service is improving quality of life/reducing risk etc.), if available

The providers will provide input about the currently available solutions, care&cure services augmented by technology, costs and lessons learned by their clients.

It is important to note that since the start of the project informal open market dialogue has been ongoing in each participating country and used to modify the content of this submission.

The request for contributions and the informal dialogue will continue during the first months of the project, involving the potentially interested people through announcements and workshops at major events, as well as through various networks, as the ones of EIP AHA (on the Yammer platform), EHTEL, Momentum, and suitable Linkedin groups.

N.B. It will be important to ensure penetration of, and input derived from other relevant organisations (who may not have seen the PIN e.g. SME's) through use of academic (e.g. Universities), trade association (e.g. TSA), carer/patient/service-user group, Mirror Panel (Spain and Italy) routes across the EU; a catalogue of which to be created during this Task and with feedback from the Advisory Board.

Task 2.2 – Develop a Reference Business Case

The acquired information will be aggregated and harmonised enhancing the most relevant and promising topics, by considering three perspectives:

- the input suggested by analysis of the locality policies on health and social care

- the locality telehealth/telecare initiatives

- the international trends (evidence, best practices and market)

The goal is to build a generalised Reference Business Case, specifying the potential range of components that could be involved in the tenders, in terms of:

- organisational models and locality priority settings

- types of professional profiles and their reciprocal roles, including contact centres

- potential criteria of patients stratification, according to clinical and social features

- types of potential economic and contractual arrangements, including the role of the managers to allocate resources and control the change management processes within the procuring organisations

- types of service delivery solutions (supported by technology), including the connection of telehealth and telecare services with the existing information systems, with the related interoperability issues

Task 2.3 – Produce the European Specification Template (EST) and related materials

The EST will promote an innovative procurement process founded on the service delivery approach and hence will be developed by taking into account inputs from all procurers (both direct and through the PPI Coordinator), WP3, WP4 and the Open Market Consultation (Task 2.4) The European Specification Template will include

- criteria to assess the bids for each component of the tender
- a detailed list of potential indicators that could be later used to evaluate the deployment of the contracts.
- core components that create a single pan- European tender specification, with agreed 'national' provisions to reflect localized service and delivery requirements.

The related activities, coordinated by the PPI Coordinator and approved by the Executive Board, will produce a robust specification capable of being used by any procurer within Europe; based on a consensus-driven, iterative process of intermixed bottom-up and top-down steps.

This activity will begin with a clear definition of terms and metrics so that usage levels can be accurately and consistently measured across all participating localities.

This work will develop high-level scenarios for each selected topic, valid across Europe, giving consideration to the functionalities of the solutions available, or potentially available, now. Additional stakeholders might be engaged in the refinement of the scenarios, to obtain a coherent set of broad European scenarios, together with the high-level specifications of the infrastructures to be offered at the jurisdictional level.

This task will also produce the guidelines of how to apply the European Specification Template at the level of a locality.

The PPI Coordinator will support WP2 in:

- ensuring that the EST's core structure is a single set of components applicable across Europe
- assisting with any issues that arise that may be common across a number of the procurers, or local to just one
- identifying where any localised service and delivery requirements need to be addressed within the EST
- liaising with the Executive Board and Project Coordinator on procurement issues that arise and require resolution.

And for WP 5 supporting the local procurers in developing the final content of their tender specification, and adherence to EU procurement rules and all the aspects of legal and ethical requirements in this project.

Task 2.4 – Open Market Consultation of the European Specification Template

As soon as the preliminary scheme of the EST will be ready, an Open Market Consultation (OMC) will be formally announced via a PIN (Prior Information Notice) published in the OJEU, in order to involve more experts in the development of the EST itself.

The partners will then release the EST and, after a more detailed discussions with the Advisory Board and within the EIP-AHA B3 (namely in the Action Group B3 about "Integrated Care"), it will be published on the web and submitted to a formal OMC, to receive comments and suggestions that will be taken into account in a detailed report (also published on the web). A face-to-face workshop will allow for a public debate, and then the partners will release the version of the EST that will be used to produce the local tenders for the PPI Pilot.

As suggested in the Guidelines for Applicants, the goal of the OMC is to provide additional input on and confirm the following issues:

- models of service provision that provide the most effective benefits

- solutions to assist in achieving identified outcomes on a leasing, payment by results basis

Input from the Advisory Board, the locality procurement teams and the PPI Coordinator will be sought regarding the most comprehensive and efficient manner by which the formal part of the OMC will take place but is likely to minimally involve:

- use of a broad-based on-line questionnaire
- at least one workshop supported by the use of webinars to ensure the involvement of all

N.B. It will be important to ensure penetration of, and input derived from other relevant organisations (who may not have seen the PIN e.g. SME's) through use of academic (e.g. Universities), trade association (e.g. TSA), carer/patient/service-user group, Mirror Panel (Spain and Italy) routes across the EU; a catalogue of which to be created during Task 2.1 and with feedback from the Advisory Board.

The result will be an enhanced and validated version of the European Specification Template, which will then be tested in WP5 by the tenders and evaluated in WP6; a final version of the European Specification Template will be produced in WP7 towards the end of the project.

Deliverables

ID	Description	Code	Dissemination Level	Delivery Date
D2.1	Reference Business Case	R	PU	M3
D2.2	A European Specification Template (EST) and related materials	R	PU	M6

Milestones

ID	Description	Month
2a	Baseline data set for KPIs	M4
2b	Draft EST	M5
2c	Publication of PIN (Prior Information Notice) in the OJEU	M5
2d	Consultation on Business Case and EST with the Advisory Board	M5
2e	Consensus meeting with EIP-AHA B3	M7
2f	Formal workshop for the Open Market Consultation	M7

WP3. General Interoperability Aspects

Work Package Number:		3				Start Date: M1 – End Date: M36							
Work Package Leader: ISCIII													
Participant No.	1	2	3	4	5	6	7	8	9	10	11	12	13	
Short name	SMH	TSA	ISCIII	NWC AHSN	ESP	LSEE	FSA	ARSAN*	ASL RMD*	ASP CZ*	EC*	SAS*	GMH*	total
Person Months	1,5	0	3	0	0	1	0	0,5	0,5	0,5	1	1	1	10

* = actual procurers

Objectives

This Work Package will define the framework of interoperability requirements and mechanisms needed to support the STOPandGO compliant deployments across a constellation of telehealth/telecare services in different national/regional/local environments, enabling synergies with existing legacy systems and allowing for smooth integration of new components.

This framework will help procurers to take advantage of the benefits provided by adopting appropriate interoperability requirements addressing their specific needs.

To achieve this main objective, the WP will:

- Develop a shared perspective and approach for the practical implementation of sound interoperability solutions for the telehealth/telecare systems to be procured. It will be targeted to achieve a predefined pragmatic level of interoperability (technical, semantic, organisational and legal) as required by the set of services and the different implementation contexts. This interoperability framework will rely on the critical analysis of existing practical experience for telehealth/telecare systems, both internally from STOPandGO partners and externally from other relevant sources. It will exploit the large and deep involvement of STOPandGO partners on standardization bodies (ISO-CEN, HL7, Continua Alliance) and research projects on the matter;
- Identify, analyse and adopt the most suitable standards and guidelines for the interoperability specifications as a critical part of the general specifications;
- Produce criteria for the continuous assessment on interoperability aspects, before, during and after the tendering process, including interoperability testing in the implemented pilots;
- Develop guidelines on interoperability as a companion of the European Specification Template, as part of the materials that will be delivered at the end of the project;
- Contribute with its results to the EIP-AHA effort, regarding interoperability and standards aspects in the deployment at scale of telehealth/telecare systems for integrated care in Europe. Furthermore, it is expected that results will contribute to the construction of the European Interoperability Framework for eHealth and Public Services.

Dependencies: This WP will work closely with the other WPs under the general coordination of the Project. Particularly continuous inter-working will be maintained with WP2 and WP5 on Procurement and Tendering Process. The WP4 on Legal and Ethical aspects will provide basic inputs, particularly to the works on legal interoperability. Furthermore its results will serve as input to the proposed activities of Evaluation and Dissemination WPs.

Description of Tasks

Task 3.1 - Definition of the STOPandGO Interoperability Framework

This task will provide a common reference framework concerning the scope and issues addressed at the WP considering the four levels of Technical, Semantic, Organisational and Legal Interoperability following the recommendations from the European Interoperability Framework (EIF). The task will start with the creation of the STOPandGO Interoperability Working Group (IWG), i.e. a network of interoperability experts associated with contracting authorities through which knowledge, experience, criteria, guidelines and outcomes could be shared along the procurement process and during the implementation and evaluation of the deployments.

The Interoperability framework will be based in pre-existing knowledge and experiences provided by the STOPandGO partners and from other relevant parties through the network of interoperability experts.

Task 3.2 - Definition of Interoperability Requirements for the STOPandGO procurement process

This task will define a set of interoperability requirements which translate the procurers' needs and desires to the market. These requirements will be developed aiming to be clear for vendors knowing what is expected. These specifications will be forwarded and promoted also within the appropriate standard developing organizations.

The interoperability requirements will be established in coherence with the overall specifications in WP2. Finally the Interoperability Procurement Specs will be produced.

Task 3.3 - Conformance of procurement documentation to ISO/EN 13940

This task will focus on the common definition of the concepts managed in the procurement process based on the set of concepts on continuity of care provided by the norm ISO/EN 13940 (ContSys), following the interoperability framework defined. The main objective is to harmonize the concepts across the different STOPandGO sites, setting the bases for the organisational interoperability and facilitating the development of similar specifications for procurements across borders.

Additional sources of conceptualisations relevant to the representation of care&cure services and related technologies will be taken into account. These sources include international standards as ICF and INTERRAI, as well the results of European initiatives, as for example Momentum, K4CARE, ANCIEN, and BRAID.

Task 3.4 – Guidelines on Interoperability Assessment

The complexity of model interoperations between all system types and the impossibility of cataloguing them has precluded the publication of a general method of measuring interoperability. Because of the difficulty in adopting a general interoperability measurement method, this Task will relay upon a problem decomposition approach in order to quantify interoperability in an actionable way. Following that, technical, semantic, organisational and legal dimensions will be addressed in a separate way. The task will produce Interoperability Assessment guidelines for the different stages of the procurement process, from the inception of the system to the evaluation of the implemented pilots after tendering.

Task 3.5 - Evaluation of the interoperability performance in the different localities

This task aims to measure and document the interoperability level of performance achieved by the implemented systems according to the requirements and evaluation methods specified in Task 3.4. It will be devoted to the overall analysis of the information collected about the interoperability approaches, procedures and achievements along all the procurement process (before, during and after) in STOPandGO, making new evidence coming to light from the experience cumulated through the Project practical

implementation. The results of this task will be a very interesting input for the normalization European process, so they will be submitted to the EIP-AHA initiative and to the TC 251 of CEN.

Deliverables

ID	Description	Code	Dissemination Level	Delivery Date
D3.1	Interoperability requirements: STOPandGO Interoperability Framework	SP	CO	M8
D3.2	Evaluation guidelines on interoperability for deployments	R	PP	M10, M20, M34
D3.3	Analysis of overall performance of the STOPandGO Interoperability Framework (final report)	R	PU	M36

Milestones

ID	Description	Month
3a	Input to WP2 on conformance to ISO/EN 13940 and other systematisations	M4
3b	Agreed input on standards to WP2	M4
3c	Dialogue with CEN and other standardization bodies	M34

WP4. Legal, Ethical and Regulatory aspects

Work Package Number:		4				Start Date: M1 – End Date: M36							
Work Package Leader: LSEE													
Participant No.	1	2	3	4	5	6	7	8	9	10	11	12	13	
Short name	SMH	TSA	ISCIII	NWC AHSN	ESP	LSEE	FSA	ARSAN*	ASL RMD*	ASP CZ*	EC*	~~SAS~~*	GMH*	total
Person Months	2	0	1	0	1	4	0,5	1	1	1	1	1	1	14,5

* = actual procurers

Objectives

This Work Package is focused on all legal and ethical issues related to the execution of the project itself as well as all those related to the tendering process and subsequent service provision and evaluation. This involves providing guidance and examples of good practice to help advise on best standards in the management, encryption, storage, transfer and analysis of electronic and physical personal data subject to the provisions of EC Directive 95/46/EC and further national/regional requirements in respect of both electronic and physical data. It will also ensure that any changes in European legal requirements during the lifetime of the project are complied with where necessary. It will also provide guidance and examples of good practice in respect of any ethical and consent issues in respect of data collected from different end users (including service providers, service users and their families) , for instance on their experiences in using / providing the innovative services supplied. In most instances these data will be managed by project partners, but in some instances sub-contractors could potentially be involved (e.g. in respect of local assessment and evaluation).

The principal objectives are therefore:

- To help ensure the use of rigorous standards and protocols to ensure the privacy and security of all collected electronic and physical data
- To assess the need for ethical approval in respect of any data collection and interaction with service providers and service users in each of the four countries and to provide support for any ethical application procedures (or exemptions) that must be obtained at either a central or country specific level.
- To help monitor and provide information and support to help in compliance with ethical requirements throughout the lifetime of the project.
- To develop a guide on managing legal, ethical and regulatory issues across countries asp part of procurement process for the roll out of proven innovative technologies in order to help limit the liability of the supplier and to safeguard the rights of end users.
- To develop a comprehensive map of the legal contexts applicable in innovative procurement in the four countries, including European, national and regional requirements.
- To undertake a limited analysis to identify any further major potential additional issues in respect of procurement that might be seen in some other parts of Europe due to differences in system structures
- To undertake an analysis of results and cross-comparison of experiences to generate "lessons learnt" and recommendations.

Dependencies: it provides input to WP2. It provides helpdesk support to WP5, WP6

Description of Work

Task 4.1 - Analysis of privacy and ethical requirements for the development, implementation and assessment of the procurement process.

This task will involve an analysis of the types of data that need to be collected, scope for anonymising data, and the need to obtain service user experiential assessments. This will involve providing guidance and examples of good practice to help advise on best standards in the management, encryption, storage, transfer and analysis of electronic and physical personal data subject to the provisions of EC Directive 95/46/EC and further national/regional requirements in respect of both electronic and physical data. Special attention will be put cross-border and cross-sector information sharing. Any potential ethical issue will be analysed and a plan developed to comply with any ethical procedures.

Task 4.2 - Analysis of the legal frameworks governing innovative public procurement procedures.

European, national, regional and local standards, regulations and legislation will be analysed to help collate key information to help make the procurement process as clear as possible for procurers.

Task 4.3 - Development of guidelines for procurers and requirements to be included in the tender template to assure the bidders will be compliant with Legal, Regulatory and Ethical issues.

Procurers are very much familiar with data protection, but sub-contracting services is a common risk for lack of compliance. Also STOPandGO consortium is very much aware of the need of imposing a high ethical level requirement in the procurement tender. Regulatory requirements (such as accessibility) and the applicable legal framework for service provision will be included.

Task 4.4 - Legal, ethical and regulatory helpdesk.

Help and support will be provided throughout the project for partners and help in complying, making applications for any ethical approvals that might at all be needed (or required to demonstrate exemptions).

Task 4.5 - Analysis of results and generation of lessons learnt and recommendations

- STOPandGO will include an exit strategy for the patients whenever the project or service provision ends. At that moment, the service providers will provide patients the possibility to continue the services as part of their social and health care.

Deliverables

ID	Description	Code	Dissemination Level	Delivery Date
D4.1	Report summarising key Legal, Ethical and Regulatory issues in the four countries	R	PU	M6
D4.2	Preparation of interim guidelines document for procurers on Legal, Regulatory and Ethical issues	R	PU	M8
D4.3	Final version of STOPandGO Legal, Ethical and Regulatory issues handbook for procurement	R	PU	M34
D4.4	Report with lessons learnt on LRE and recommendations for procurement process	R	PU	M34

Milestones

ID	Description	Month
4a	LRE helpdesk becomes operative	M3

WP5. Coordinating the Local Tendering Procedures

Work Package Number:	5					Start Date: M6 – End Date: M20							
Work Package Leader: ~~SAS~~													
Participant No.	1	2	3	4	5	6	7	8	9	10	11	12	13	
Short name	SMH	TSA	ISCIII	NWC AHSN	ESP	LSEE	FSA	ARSAN*	ASL RMD*	ASP CZ*	EC*	~~SAS~~*	GMH*	total
Person Months	2	1	1	0	0	4	1	1	1	1	2	3	2	19

* = actual procurers

Objectives

This work package is focussing on the locality tendering procedures; it builds on the activities at EU level carried out in WP2, WP3 and WP4. The PPI Coordinator and the Executive Board will assist the WP Leader to coordinate the local activities by the procurers, from the preparation of the tenders up to the signature of the contracts.

Thus the key objectives are:
* to adopt and localize the Reference Business Case and the European Specification Template according to the needs of the locality;
* to award and sign off the contracts.

Additional procurers, in addition to the partners of the project, may wish to manage a tendering process according to the STOPandGO materials; however their deployments will not be evaluated by the project and will not receive a financial support by the project.

Dependencies: receives input from WP2, WP3, WP4; it is a prerequisite for WP6, WP7

Description of Work

Task 5.1 – Adoption of the Business Case and the European Specification Template.

The clinical and operational staff and procurement specialists from the partner organisations will adopt and translate the materials produced by the project (Business case, European Specification Template, etc.) according to their respective contexts, under the supervision of the Executive Board, to obtain a locality version compatible with the European Specification Template developed in WP2.

This material will be suitable for a wider debate beyond the project, for exploitation with early adopters in WP7, and for dissemination purposes in WP8.

Each locality will assess the current and planned organization of its healthcare and social services, and will perform a stocktake for each tender, to determine current telehealth/telecare usage to assist with baselining Key Performance Indicators, so that they will be able to further refine their Business Case:
* Setting out the cost of procuring and delivering the service and how those costs are broken down;
* Specifying the clinical, social, commercial, financial and economic benefits expected from the programme with indications of how and when these will be realised.

Having adopted the European Specification Template, the locality will be able to refine it in accordance to its local needs pending final approval by the Executive Board; the steps involved in producing the service specification for each tender, together with the appropriate assessment criteria, are as follows:
* Define ambition (identify numbers using risk stratification tools). This activity will need to achieve a balance between careful selection of suitable users based on clinical need, user safety and risk assessment and the imperative to scale up service provision in order to reduce costs;

- Define the distinctions and common features of telehealth and telecare. Some users will need care packages composed of elements of both;
- Use available materials and learning from previous projects to identify required outcomes;
- Define what is meant by integrated care and ensure that the specification clearly states how this will contribute to the required outcomes;
- Define the interface between primary care and acute (secondary/hospital) services in both directions, i.e. the criteria for determining when hospital admission (including outpatient services) is appropriate for users and care plans for discharged patients;
- Define service standards for the user.

In the case that peculiar needs will arise during the process of production of the local tenders, earmarked resources are put aside by LSEE to hire specialised consultants.

Task 5.2 - Manage the locality procurement procedure
Each locality, aligned with the other localities within the WP, will issue its invitations to tender and assess the tender responses according to the normal EU/National legislation and current guidance, managing the tendering procedure up to the signature of the contract and the formal OJEU Award Notice. The contract will be awarded to the **M**ost **E**conomically **A**dvantageous **T**ender, rather than merely on price.

Deliverables

ID	Description	Code	Dissemination Level	Delivery Date
D5.1	Report on the locality adoption of the project documentation and their intended usage	R	PU	M12
D5.2	Report about the execution of the local tendering procedures	R	PU	M20

Milestones

ID	Description	Month
5a	All the OJEU Notices and local tenders have been published	M11
5b	All local Tender procedures completed and OJEU Award Notice published	M16
5c	After standstill periods, all contracts have been signed	M18

WP6. Quality control and evaluation

Work Package Number:	6						Start Date: M1 – End Date: M36						
Work Package Leader: LSEE													
Participant No.	1	2	3	4	5	6	7	8	9	10	11	12	13	
Short name	SMH	TSA	ISCIII	NWC AHSN	ESP	LSEE	FSA	ARSAN*	ASL RMD*	ASP CZ*	EC*	~~SAS~~*	GMH*	total
Person Months	1	0	1,5	0	0	3	1	1	1	1	2	2	2	15,5

* = actual procurers

Objectives

This WP is focused on the evaluation and quality assessment of the project development and project outcomes. The main objectives are:

- Evaluation of the achievement of **project objectives (public procurement procedure, quality of services provided, experience in local implementation, quality of feedback from service users and service providers …)**.
- Evaluation of agreed key indicators on the **quality and impact of the project sites** in terms of including quality of service provided, impact on health status of target population and informal carers, budgetary impacts and return on investment
- Evaluation of the contribution of the project to the achievement of the **EIP-AHA objectives**.
- Contribution to the European Knowledge Base by extracting **lessons learnt** from the comparative analysis.

To develop this work it will be necessary first to define the evaluation methodology and secondly to apply it.

The results of this work package should be useful for adoption and refinement of innovative procurement procedure, decisions making on extension or adoption of services and cross-learning.

Dependencies: It starts in M1 to monitor the activities on the indicators in WP2. The main operational phase follows the signature of contracts in WP5. It influences the exploitation in WP7 and the dissemination in WP8.

Description of Work

Task 6.1 - Development of an evaluation framework for STOPandGO.

During this task the specific elements to be evaluated will be identified as the time that the scope of the tendering process is being determined in earlier work packages. This will help determine a range of generic outcome measures for all countries, as well as potentially some country specific outcomes depending on how the scope of tenders may differ.. These outcomes will both inform the ongoing implementation of innovation but also can be used in terms of judging the performance of service providers in line with any stipulations set out in contracts for service provision. This information can also be used by service providers to improve the quality of services providers, e.g. drawing on feedback and experience from end users.

When possible, existing methodologies already in use in Europe will be adopted (as MAST or FIM, for example). The contribution to the EIP-AHA will be evaluated using the framework currently under development by IPTS, if available at the proper moment.

Complete plan of evaluation including indicators, evaluation procedure and adequate timescale for collection of data will be developed.

The collection of necessary data from pilot sites will be included as part of tender requirements and

subsequent contracts with procurers.

Task 6.2 - Actual services deployment and continuous evaluation.

The providers will deploy their services and each local procurer will monitor the steps in the advancement of the contract in its locality, reporting continuously to the Executive Board about quality control and evaluation of the service provision.

Evaluation will be performed by collecting data and applying the adopted methodology to get the full set of indicators, described in previous task.

Task 6.3 - Analysis of results.

The obtained results will be analysed, when necessary further inquiries will be made to identify the reasons behind unexpected results.

Comparative analysis will be performed and lesson learnt will be developed.

Deliverables

ID	Description	Code	Dissemination Level	Delivery Date
D6.1	Evaluation framework for STOPandGO and related handbook for its application	R	PU	M8
D6.2	Analytics on performance measurement	R	PU	M36
D6.3	Lessons learned about the evaluation processes	R	PU	M36

Milestones

ID	Description	Month
6a	All contracts have started to deliver services	M19

WP7. Coordinating the exploitation: training programmes and regional procurement plans

Work Package Number:	7						Start Date: M1 – End Date: M36 (+2)						
Work Package Leader: FSA													
Participant No.	1	2	3	4	5	6	7	8	9	10	11	12	13	
Short name	SMH	TSA	ISCIII	NWC AHSN	ESP	LSEE	FSA	ARSAN*	ASL RMD*	ASP CZ*	EC*	SAS*	GMH*	total
Person Months	1	1	1	1	1	1	3	0,5	0,5	0,5	0,5	0,5	0,5	12

* = actual procurers

Objectives

The ultimate goal of the PPI instrument is to stimulate a progressive process of adoption of innovative solutions; the project will develop a handbook with a Business Plan to advise future "Early Adopters" of such schemes.

Therefore the project will revise the tendering materials (Business Case, European Specification Template, educational materials, etc.), using the accumulated advancing insight, knowledge and experience acquired through the project and in particular within the initial deployments.

To take advantage of the lessons learned and of the structured know how, during and after the project end, STOPandGO will promote training programmes and the propagation of the procurement activities to new named localities.

Dependencies: it is related with the main WPs on procurement and deployment (WP2, WP5, WP6). It provides input to the dissemination activities in WP8.

Description of Work

Task 7.1 – Training programme on the STOPandGO methodology

A training programme will be developed to support businesses and government agencies, as well new potential procurers, on the procurement processes according to the material produced by the project. The first version of the programme will be based on the version of the project's materials produced within WP2.

The programme will be first applied in UK and Italy, as part of the identified WPs in STOPandGO; it will continue up to the end of the project and beyond:

- UK - Development of Continuing Professional Development (CPD) for vendor and purchaser actors based on extension of existing TSA Codes of Practice and emerging CCG procurement guidance;

- IT – FSA, through its ongoing collaboration with the National High School of Administration - SSPA of the Council of Ministers, will introduce the topics of the project within suitable courses for public healthcare managers. In addition it will organize training programmes among its members, also through its CPD programme "SALUSNET" for Continuing Education in Medicine (ECM).

Further organisations may be willing to organise training programmes in additional localities, adopting the STOPandGO materials; however these activities will not be considered as a contractual obligation for the other project's partners.

Task 7.2 – Consolidated release of the Reference Business Case, the European Specification Template and the related materials.

The task focuses on the assessment of the EST and of the related materials for its application. It will consider the actual adaptability and usability of the specification in the local contexts, to perform a

revision of the Reference Business Case and the European Specification Template, together with the materials to facilitate the exploitation of the Template by the Early Adopters in their particular context. The training programme of Task 7.1 will be revised accordingly.

An earmarked discussion will be carried on within the EIP-AHA Action Group B3 "Integrated Care" to reach consensus on the consolidated release of these materials, which could be then endorsed by the Action Group.

The most significant parts of the STOPandGO consolidated materials will be translated into the languages of the involved countries.

Task 7.3 – Lessons learned about the PPI instrument and exploitation plans based the project materials

The lessons learned by the STOPandGO project will be systematized for the benefit of the next use in similar topics, to produce recommendations about strengths and weaknesses of the PPI instrument and to suggest its optimal usage, as well the risks and the challenges to be faced. For this purpose, this WP will monitor the advancement of the PPI pilot since the beginning.

The process of change management demonstrated with the PPI deployments should continue with a set of explicit Programmes in various jurisdictions. They will propagate the experience of the procurers within the project (i.e. the pathfinders, acting as Innovators) to fast followers localities (Early Adopters) and eventually to entire Regions (Early Majority), after an assessment of the benefits and obstacles related to the tender(s), a re-assessment of priorities and needs across the jurisdiction, and an extension in various zones and/or for different target populations.

The lessons learned and the comparison among the locality exploitation activities will provide useful suggestions to further refine the project's materials.

Deliverables

ID	Description	Code	Dissemination Level	Delivery Date
D7.1	Consolidated release of the Reference Business Case	O	PU	M31
D7.2	Consolidated release of the European Specification Template and the related materials	O	PU	M36
D7.3	Report on the comparison among the exploitation plans in the localities that decided to adopt the project's materials	R	PU	M36
D7.4	Report on the lessons learned and recommendations about the appropriate usage of the PPI instrument in the field of eHealth	R	PU	M8, M20, M36

Milestones

ID	Description	Month
7a	Schedule and syllabus for the training programmes	M12
7b	Regional and local exploitation plans by procurers of different localities outside the project, as Early Adopters	M34
7c	Translations of the most significant parts of the STOPandGO consolidated materials into National languages	M34

WP8. Dissemination

Work Package Number:	8					Start Date: M1 – End Date: M36(+2)							
Work Package Leader: ESP													
Participant No.	1	2	3	4	5	6	7	8	9	10	11	12	13	
Short name	SMH	TSA	ISCIII	NWC AHSN	ESP	LSEE	FSA	ARSAN*	ASL RMD*	ASP CZ*	EC*	SAS*	GMH*	total
Person Months	2	1	1,5	1	3	2	1,5	0	0	0	0	0	0	12

* = actual procurers

Objectives

The principal purpose of the WP is to spread best practice as it emerges over a wide variety of media. There are three innovations being prototyped:

1. An outcomes based service specification that does not prescribe the technological means to deliver services (it is technology/supplier agnostic);
2. Best value Most Economically Advantageous Tender (MEAT) assessment of tenders and selection based on KPIs that demonstrate improved life outcomes (added Healthy Life Years - HLY), and an element of payment by results (PBR);
3. The ongoing management and evaluation of services based on output and outcome KPIs.

A further objective is to share learning with other PPI projects, primarily from the SILVER and HAPPI programmes. This shared experience shared across networks and be fed back to the EC and at relevant public H2020 information/briefing events. STOPandGO is a pathfinder project. There is scope for rapid and significant improvement in the effectiveness and economy of services that support Independent Healthy Living through widespread adoption of the STOPandGO materials.

In this WP we will raise awareness of the project and promulgate know-how, including of measures that will establish better procurement of more relevant services, in locations outside of the project in a timely manner.

The PPI instrument is of itself innovative, with a clear purpose to promote coherent, innovative procurements that result in the evolution of the market. EIP-AHA is the privileged environment for dissemination. Hundreds of organizations manifested their commitments towards the goals of Horizon 2020 and in particular on Active and Healthy Ageing actual programs.

Press releases: Press releases will be launched and sent for publication in different media and the different publications of the different partners.

A press release will be issued on the occasion of or soon following Grant Signature, within 2 months after GA signature. The press release will be about the real benefits of the project for citizens, businesses, administrations, and their component on European cooperation. The EC Project Officer (PO) will receive a copy of the press release.

Website: A website will be created for STOP and GO and will be launched within 2 months after GA signature.

Dependencies: It receives input by all the previous WPs.

Description of tasks

Task 8.1 Dissemination through EIP AHA and H2020 information days.

The lessons learned by the project, and in particular the STOPandGO materials (EST + Guidelines on Interoperability, LRE issues, evaluation and education), will be systematically disseminated in public related events, e.g. on EIP-AHA and at the H2020 Information days.

Task 8.2 European Learning Network (ELN).

The ELN, working closely with the European Knowledge Tree Group, will be developed as a relevant dissemination channel. As a network of networks it will disseminate high-level news and updates on progress of STOPandGO. Membership will be such that it links through:

- Across Europe - European Knowledge Tree Group activity across this domain, AAL Forum, Care Assistance Search Agency (CASA) project, EIP AHA and PPI programmes/projects (e.g. SILVER; HAPPI)
- UK - ESP and HealthTech and Medicines Knowledge Transfer Networks, TSA, 3millionlives
- The Netherlands – Slimmer Leven 2020 ('Smarter Living 2020') innovation network, Brainport, the province of Noord-Brabant and Stichting Smart Homes partner communities
- Italy – FSA, the Italian Federation of Healthcare Trusts and Municipalities, which will involve the network of its members.

Task 8.3 Web and media based dissemination.

- UK – ESP will actively host the project portal carrying news items, public deliverables, articles and collateral from events, blogs (including that of project leaders); a dedicated twitter account; a TSA online presence; linkage to the Telecare Learning and Innovation Network; journalistic description of the project.
- The Netherlands – Smart Homes web portal, LinkedIn groups on domotics and smart living, web portal of the province Noord Brabant.
- IT – FSA will disseminate the know how through its initiative, named "*CATALIS*", which involves a community about care&cure services augmented by technology, providing a portal, a newsletter, a documentation centre, a discussion forum, face-to-face workshops involving also industry and top management of the local trusts and municipalities
- All Partners will support dissemination through their own websites, and similar connectors to promulgate material developed throughout the project.
- Extensions of education and training material generated in other WPs will also be disseminated in this manner.

Task 8.4 Programme of dedicated events

Presentations at relevant events, such as: the European Knowledge Tree Group, the AAL Forum 2014, Domotics and Smart Living Fair 2014, Health & ICT fair 2014, EKTG 2014. Events to be determined in quarterly rolling review.

Deliverables

ID	Description	Code	Dissemination	Delivery
D8.1	Report on dissemination activities	R	PU	M12,24,36

Milestones

8a	Launch of project website with associated twitter account and linkedin group	M2
8b	Schedule of dissemination events established (*rolling quarterly review*)	M4, etc
8c	Dissemination of finalised EST via web and face-to-face events	M9
8d	Announcement of successful tenders, publication of service specifications	M15
8e	Annual public project meetings and press releases with news of results	M9,21,35
8f	Public dissemination materials on PPI instrument	throughout

Summary of effort

In the table below, the number of person months in STOPandGO over the whole duration of the planned work and for each work package by each participant is presented. The details of the budget covers the expenditure but not all the tasks may be included in the Work Packages, but mismatches can be explained.

The high level of person months allocated to Participant 1 reflect the unusual nature of the whole project and the heavy load associated with the Coordination role alongside the work of the European Learning Network, The Advisory Board, the more usual academic roles of regulation, evaluation, and frequent recording and reporting. The calculations for the Procurers are based on the planned numbers of patients during the Procurement phase. The details of this will develop through the various Work Packages of STOPandGO. Our listed Procurers have all emphasised their enthusiasm to engage their patient group in this work alongside their local service delivery team and organisations. The main outcomes from STOPandGO are designed to ultimately be promulgated and extended across Europe and the European Learning Network, The Advisory Board are already to extend this work to a worldwide audience.

Table 8. Distribution of Person Months by Work Package

No.	Participant		WP1	WP2	WP3	WP4	WP5	WP6	WP7	WP8	Total PM
1	Stichting Smart Homes	SMH	12	2	1,5	2	2	1	1	2	**23,5**
2	Telecare Services Association	TSA	2	4	0	0	1	0	1	1	**9**
3	Instituto de Salud Carlos III	ISCIII	2	1,5	3	1	1	1,5	1	1,5	**12,5**
4	North West Coast Academic Health Science Network	NWC	1	1	0	0	0	0	1	1	**4**
5	ESP Central Ltd	ESP	2	1	0	1	0	0	1	3	**8**
6	LSE Enterprise Ltd	LSEE	10	4	1	4	4	3	1	2	**29**
7	Federsanita Servizi	FSA	2	2	0	0,5	1	1	3	1,5	**11**
8	Agenzia Regionale Sanitaria della Regione Campania	ARSAN*	0,5	1	0,5	1	1	1	0,5	0	**5,5**
9	Azienda Unità Sanitaria Locale of Roma D	RMD*	0,5	1	0,5	1	1	1	0,5	0	**5,5**
10	Azienda Sanitaria Provinciale of Catanzaro	CZ*	0,5	1	0,5	1	1	1	0,5	0	**5,5**
11	Eastern Cheshire Clinical Commissioning Group	EC*	0,5	2	1	1	2	2	0,5	0	**9**
12	Junta de Andalucia	SAS*	1	2	1	1	3	2	0,5	0	**10,5**
13	Gemeente Helmond	GMH*	0,5	2	1	1	2	2	0,5	0	**9**
	Total		**34,5**	**24,5**	**10,0**	**14,5**	**19,0**	**15,5**	**12,0**	**12,0**	**142**

* = actual procurers

Table 9. Possible risks and remedial actions

Description of possible risk	Impact	Probability of occurrence	Remedial Actions
Inadequate resourcing of project management leading to weak coordination.	High	Low	Significant proportion of project resource directed at core coordination functions.
Inability to agree on common specifications/reference business case.	High	Medium	Local variations will preclude overly detailed specifications. Focus will be on high level outcomes based specifications. Executive Board to manage dispute resolution if required.
Lack of clinical engagement.	High	Low	Partners bring clinician communities with them, involvement of clinicians in the procurement process.
Lack of wider stakeholder engagement.	Medium	Medium	Development of stakeholder engagement strategy, inclusion through consultation, outreach activity demonstrating benefits.
Failure to recognise legal and ethical issues.	High	Medium	Definition of clear standards referencing relevant art and best practice.
Market distortion from procurement specification.	Medium	Medium	Meticulous OJEU process for open market consultation and technology agnostic specifications.
Inability to achieve interoperability between solutions.	Medium	High	Use of CEN EN 13606 archetypes, HL7-ANSI CDA and CCD document and coding schema. Tie to current standards development activity.
Breach of Data Privacy rules	Low	Medium	Identification of case specific applicable norms, best practice, operative guidelines and monitoring.
Challenge to procurement process	High	Low	Ensure compliance with European Public Procurement Rules.
Inability to evaluate results meaningfully.	Medium	High	Inclusion of previously agreed outcomes based KPIs in procurement specification.
No persistence of knowledge beyond the lifetime of the project.	Medium	Medium	Development of CPD materials. Community development and management (through existing fora and ELN).

B3.2c Project management

The STOPandGO consortium will develop a procurement strategy and specification – following EU regulations - for new interoperable services and outcomes that support active and healthy ageing across member states. We have been working with our European Learning Network (ELN) to establish user, management and political views on requirements for urgent solutions to what is needed. The impact of the PPI Pilot will be evaluated in economic, medical, social and individual utility terms. From this analysis, best practice recommendations will be developed and disseminated for a broader and sustainable application across the EU. The consortium will build on and extend the existing evidence base and leverage the experience of its members in the procurement and provision of care, technological developments in the health sector and the needs of the elderly in society.

Objectives

The coordination and management of the project has the following objectives:
- To ensure that the project is conducted in accordance with EC procurement rules and regulations
- To reach the objectives of the project within the agreed budget and time lines
- To ensure the position of users/patients is respected at all times
- To coordinate the work and ensure effective communication between all parties
- To ensure the quality of the work and deliverables
- To maximise the potential for exploiting results
- To ensure that decisions are made on the basis of data and factual information
- To solve issues or conflicting situations
- To establish a quality policy, including quality objectives for the project
- To link all the actions of the project to the risk assessment and control patterns
- To ensure that an infrastructure is set up in order to support the above.

STOPandGO is organised around the following management entities:
- Executive Board
- EU Learning Network
- Advisory Board
- Project Coordinator
- PPI Coordinator
- Administrative Coordinator
- Work Packages (WP)

The overall organisation of the project was already shown in Figure 4.

The following description of the project management structure defines the relationships between the Executive Board, Advisory Board and ELN; respective roles, responsibilities, processes and governance will be codified in the Consortium Agreement.

The Executive Board will be supported by a European Learning Network and an Advisory Board. Members of the ELN, and prospective members of the Advisory Board, have contributed to the preparation of this bid. Through this activity, we have already established our outline plan of how to design, tender and implement the scheme from STOPandGO.

Executive Board (EB)

The Executive Board (EB) is made up of the representatives of the partner organisations; its meetings can also be managed at distance, by electronic means.

EB has the overall responsibility for the governance of the technical, financial, administrative and exploitation aspects of the project according to the contract and the advice of the AB and ELN in particular, but not restricted to, the following issues:
- Coordinating, monitoring and controlling progress of the work at the intra Project/SP level and overall management of the planned interdependencies

- Monitoring the budget in accordance with the EU Contract (including consumption monitoring/warning)
- Determining minor changes to the Description of Work
- Seeking approval of the Project Officer about any proposals for major changes
- Ensuring adequate user/patient respect, involvement and reporting back systems
- Proposing the addition/changes/removal of partners
- Launching the procurement process
- Managing IPR issues
- Legal and ethical issues
- Developing and updating dissemination and exploitation plans
- Linking with European Learning Network
- Appointing Advisory Board members
- Controlling knowledge management
- Proposing budgets and execution plans
- Proposing actions against defaulting partners

In terms of membership, EB will consist of
- The Project Coordinator, acting as Chair
- The Administrative Coordinator
- The PPI Coordinator
- Work Package leaders and at least one person from each partner.

Executive Board Main Management Processes

The following describes briefly how some main management and governance processes will be handled in STOPandGO. These processes will also be included and further specified in the Project Consortium Agreement and the Project Handbook.

1. **Contractual changes**

   Adding a new partner
   - Any partner can initiate the process of adding a new partner by contacting the Executive Board, providing justification for the addition
   - The Executive Board will assess the candidates and present a proposal, based on the competence, previous record and potential of the candidates
   - Following the EB's decision, the Project Coordinator will request to the Commission to add the new partner.

   Removal of a partner
   - Every effort should be made to avoid the forced removal of a partner
   - If all other means have failed, the Executive Board will make a decision with justification, after hearing the partner concerned
   - Following the EB's decision, the Project Coordinator will request to the Commission to terminate the participation of the contractor concerned, in accordance with Article II.15 of the contract.

   Other major changes to the contract
   - The Executive Board will make a change proposal, in coordination with the partners concerned
   - The Project Coordinator will submit a request for amendment to the contract to the Commission.
     Major changes include, but are not limited to:
     - Duration of the project
     - Community contribution
     - Reporting periods
     - Frequency of submission of the audit certificates
     - Complementary pre-financing
     - Intermediate pre-financing percentage

- Addition or removal of one or more special clauses
- Change of banking details
- Transfer of rights and obligations

Minor changes to the contract
- The Project Coordinator will make a proposal, in coordination with the partners concerned
- The Executive Board will decide
- The Project Coordinator will notify the Commission
  Minor changes include, but are not limited to:
  - Change of address, telephone number, etc of contractor
  - Change of personnel at contractor
  - Change of legal name of contractor

2. Approval of deliverables and financial statements

The Project Handbook will include requirements and guidelines for deliverables. Each deliverable will be checked by the respective WP leader, Administrative Coordinator, PPI Coordinator and Project Coordinator. Financial statements will be checked by the Project Coordinator and the EB.

Conflict resolution

At all times and at all levels, consensus will be sought. If not possible, the matter will be brought up to a Work Package Leader, Project Coordinator, and Executive Board, where, if necessary, a vote may be taken, each partner having one vote. In case of a tie, the vote of the Project Coordinator decides.

Advisory Board (AB)

An Advisory Board will provide input from major stakeholders at European level. It is comprised of representatives of industry, public bodies, service providers and users. The Project Coordinator is de jure member of the AB. The project partners may suggest to the Executive Board the inclusion of new members. The Advisory Board will meet with the Executive Board at least once a year and also have at least six-monthly input into the project working.

The members will nominate two co-chairs and the Project Coordinator will act as Secretary. The main tasks of the Advisory Board will be to:

- Continue to have active and regular input to project work, as has already been the case with this submission.
- Review the plans and the achievements of the project
- Provide input and advise from the respective stakeholders' perspectives
- Assist with links to policy makers and organisations to ensure maximum exploitation of STOPandGO
- Advise on legal implications
- Help disseminate information about the project and project results

Members of the Advisory Board

Stephen Johnson has been Head of Long Term Conditions at the Department of Health. He has been dealing with the UK Scheme for Telehealth and Telecare called Whole Systems Demonstrator where early WSD results demonstrate telehealth can deliver reduction in AE visits, emergency admissions, elective admissions, bed days and tariff costs. Currently Stephen is leading the 3MillionLives scheme. He strongly believes that when implemented effectively as part of a whole system redesign of care, telehealth and telecare can alleviate pressure on long term NHS costs and improve people's quality of life. Stephen has held a number of policy roles in the Department of Health including system reform, establishing PCTs, commissioning, workforce planning, and NHS pay reform and since the summer of 2008 head of Long Term Conditions. Prior to joining the Department ten years ago, Stephen worked in the NHS in both provider and commissioner roles. This includes experience in primary care, general surgery, orthopaedic surgery, A&E, theatres, learning disabilities, performance management and joint working with local authorities. Stephen is now also leading the new actions on Commissioning Services in the revised structure for health in England.

Icíar Abad Acebedo (iabad@externos.msssi.es), holder of a medical degree (Complutense University, Madrid) and Specialist in Family and Community medicine (General Practitioner). Since 2008 working at the Ministry of Health, Social Services and Equality within the team for the Spanish National Project of "Electronic Health Records within the National Health System", mainly as technical support for the national pilot within the different regions, at the definition and dissemination of the semantic strategy (terminologies and datamodels) and at the international scope (international related projects): 1) epSOS: National epSOS Pilot Coordinator (NEPC), functional definition leader the second phase of epSOS1, participation in different groups; 2) eSENS: eHealth coordinator for the pilot and the semantic groups; 3) Participation in other projects: eHealth Governance Initiative, Trillium Bridge, working group with Minas Gerais (Brasil) to share 13606 implementation experiences.

Francesca Avolio is a Manager of the Quality Accreditation Research Area at the Regional Healthcare Agency of the Apulia (Puglia) Region, in Bari, Italy. She is deeply involved in the European Innovation Partnership onActive and Healthy Ageing, and in particular she is a member of the coordination committee of the Action Group B3 on 'Replicating and tutoring integrated care for chronic diseases, including remote monitoring at regional levels'. She is also appointed as reference persons for the Apulia Region within the project "Mattone Internazionale" of the Italian Ministry of Health for the coordination of the European activities of the Italian Regions.

David Collins is the senior Quality Assurance Officer at the European Space Research Agency, based in the Netherlands. His responsibilities involve reviewing and ensuring quality of products within outsourced and allocated projects in European Contracts.

Roberto Dandi, PhD, is Assistant Professor of Management of the University Luiss Guido Carli in Rome (Luiss Business School - Public Administration, Healthcare & Non-profit Unit) focusing on methodologies and technologies for the efficiency and effectiveness of health administration. He is involved in national projects on quality indicators for healthcare education and on the innovation processes in the medical device industry. He obtained a PhD in Organisational Behaviour in 2004 with a dissertation on Computer-Mediated Communication. From 2001 to 2003 he was a researcher in a FP5 project team (Commorg) on email use in the workplace. In 2005 he was a post-doctoral researcher at the National Center for Supercomputing Applications (USA) studying online social networks and virtual collaboration. He was the principal investigator of the Luiss team in the ANCIEN project (2009-2012), "Assessing Needs of Care in European Nations" (within the EU program "HEALTH-2007-3.2-2: Health systems and long term care of the elderly").

Edwin Mermans is a senior policy officer at the Department of Social and Cultural Development fromthe Province Noord-Brabant in the Netherlands. He is among others involved in the Health & Care Economy Programme that aims to promote E-health, LifeSciences & HomeCare in Noord-Brabant with the focus on social innovation. Edwin Mermans is responsible for international affairs within the Department of Social and Cultural Development. He is co-iniator of the Community of Regions for Assisted Living, (CORAL) which is a European network about regional policy for Active and Healthy Ageing. Apart from that Edwin Mermans is the regional coordinator of the Interreg IVC project CASA in which thirteen European regions exchange knowledge about the use of innovative tools and services for independent living. He is involved with the CIP ICT PSP Thematic Network ENGAGED.

Dr. Elizabeth Mestheneos, a UK trained sociologist, has worked in Greece as an independent researcher since 1988 (see www.sextant.gr) mainly in EU funded research projects e.g. family care, older workers, elder abuse, home care services, older women, and long term care systems; she has published widely on these subjects. She is a founder member of the Greek NGO "50+ Hellas" that aims to promote the well-being of all older people through information, advocacy and research. She served as the elected President of AGE-Platform Europe 2008-2011 of 160 member organisations and 28 million members, speaking on a wide range of subjects. She was elected in 2008 as a Director of IFA (International Federation of Ageing) and in May 2012 at Vice President for Europe. She has spoken on new technologies and been in a number of juries to evaluate the value of ICT projects for older people.

Mike Pluke, Mike is a Vice Chairman of the HF committee in Brussels, and who has worked on a team writing a standard for eHealth. He has been involved in the work of the EU standards body ETSI for many years. He is also currently involved in the re-drafting of the ETSI eAccessibility Documents.

Peter Saraga CBE, obtained an MA degree in Natural Sciences (Physics) at Cambridge University and an MPhil in Electrical Engineering at Imperial College. From 1964 to 1992 he worked for Philips Research in the fields of optical character recognition, machine vision for industrial robots, high definition television. liquid crystal display systems, and artificial intelligence. From 1992 to 2002, he was Director of Philips Research Laboratories UK responsible for major research programmes in displays, wireless communications, and interactive digital television. He was also a member of the international management team of Philips Research He had particular responsibility for worldwide research on displays, including building relationships with Japanese and Korean joint venture partners. He was President of the Institute of Physics from 2006 to 2008, and was a Vice President and Honorary International Secretary of the Royal Academy of Engineering from 2003 to 2009. He was a member of the Board of the Higher Education Funding Council for England from 2002 to 2008, and chaired the Business and Community Strategic Committee. He was a visiting professor at Imperial College London for many years and is currently Vice Chair of Sussex University Council. He also chairs advisory boards at the University of Surrey, where he was awarded an Honorary Doctorate in 2002. He chairs the Advisory Board of the European Ambient Assisted Living programme and has acted as an advisor, and served on a number of committees for the UK Government relating to technology, and the UK Research Councils. He was awarded an OBE in 2002 and a CBE in 2009. Peter is a founder member of the European Knowledge Tree Group.

Karen Taylor Research Director at Deloitte UK qualified as a Member of the Chartered Institute of Public Finance and Accountancy (CIPFA) in March 1982. Since then specialised in value for money and performance audit of central government and associated arms-length bodies with a proven track record of delivering hard hitting national reports that have led to significant and sustainable improvements in service delivery. In 2001 awarded Public Finance: Public Servant of the Year Award - Central Government category; for work on the management and control of hospital acquired infection. Awarded Order of the British Empire in the 2001 New Year's Honours List for work on health value for money audit.

Professor Martin Knapp, Director and Professor of Social Policy; Director, NIHR School for Social Care Research LSE health, social care policy and practice and Professor of Health Economics, King's College. Research specialises in mental health economics and policy (financing, patterns of social exclusion, cost-effectiveness, evaluations and international comparisons). Work evaluating the WSD project has brought close contact with telehealth and telecare systems.

Martin Knapp has appointments at two universities: the LSE and KCL. At LSE, he has been Professor of Social Policy and Director of the Personal Social Services Research Unit since 1996. He has also been Co-Director of LSE Health and Social Care since this over-arching centre was set up in 2000. At King's, he is Professor of Health Economics, based in the Centre for the Economics of Mental and Physical Health, which he established in 1993. In 2009, Martin was invited by the National Institute of Health Research (NIHR, part of the Department of Health) in England to set up and direct the School for Social Care Research. In recent years research has mainly been in the areas of mental health, dementia, autism and long-term care. Most of this work has had a particular focus on economic issues.

European Learning Network

"The EU Learning Network" is an international body comprising people from relevant groups across Member States intending to implement STOPandGO; and wider user, professional industry representatives and User Groups from across Europe.

Throughout the course of the project the ELN will contribute to, comment on, and support the project by ensuring continued relevance as STOPandGO services are deployed. Some ELN members will be actively involved in aspects of STOPandGO, including the programme for implementation, evaluation, reporting, and change. At minimum the whole ELN will meet once a year with the Consortium to advise on process and actions.

European Learning Network (ELN) provides a connection between the project and the wider stakeholder communities. The core of the ELN is formed from nominated key leaders in government, industry, user representatives, trade bodies and other professional organisations. It is responsible for, but not restricted to, the following issues:

- Assisting with implementing the planned scheme, users, professional, and industry from across Europe.
- Communicating the positive impacts of STOPandGO deployments when evaluated in economic, medical, social and individual utility terms.
- Ensuring adequate user/patient respect, governance, involvement and   reporting back systems
- Ethical issues
- Supporting the development and execution of dissemination and exploitation plans
- Oversight of knowledge management

In terms of membership, EU Learning Network consists of

- An independent Chair
- Nominated individuals from Governmental bodies
- Industry
- Older persons and their carers representatives
- Trade bodies
- Professional organisations
- Standards Development Organisations
- Service delivery organisations.

Work package leaders or other project participants may be asked by the EU Learning Network to attend its meetings as required.

Members of the EU Learning Network

D. Luis Morell Baladrón, Head of Information Technologies department The National Institute for Healthcare Management (INGESA), depending on the Ministry of Healthcare, Social Services and Equality, is responsible for the management of the healthcare provision in the territories of the Cities of Ceuta and Melilla. They have one hospital in each of the cities, seven healthcare centres, and their corresponding services of emergencies attention, from which healthcare services are provided to the hundred and forty thousand inhabitants. The small size of the population makes the services list and the healthcare technology to have an obligatory offer with some limitations, something that frequently causes patient referral to other reference centres for diagnosis and treatment. This organizational peculiarity, along with its special location in the northern African continent, generates a context susceptible of benefits from the use of services provided by different Telemedicine modalities.

Johan G. Beun is a co-founder (1988) and former chairman of the NVACP (Dutch Addison and Cushing Patients). Together with others he founded (Oct. 99) EHTEL (= European Health Telematics Association) till 2003 he was a board member. He is a former board member (1998/1999/2000) of MPZ (= Dutch Millennium Committee for Care) and a co-founder (2001) and former board member of NICTIZ (= Dutch Nat. ICT Institute for Healthcare). He is the founder (2000), chairman of a charity foundation to initiate and support more research for the members of the NVACP. Anno 2010/2011 Johan is ICT coordinator/advisor for miscellaneous healthcare provider organizations and a permanent advisor to some of their boards in the fields of good innovative healthcare administration, information policies and strategic issues. He was an advisor towards the Wales NHS. Johan is an international advisor of the EPR (=electronic patient record), one of the excellent instruments for better patient safety.

Dr. Jose Maria de La Higuera. Secretary of the Committee for Evaluation of ICT and Public Procurement initiatives Regional Ministry of Health and Welfare of Andalucia. MD (1979). Specialist in Family and Community Medicine (1982). MSc Health Economics and Health Services Administration (2001). After a period of clinical practice, he started to work in health services management in 1985, first in Primary Health Care and Community services, at different levels: local, provincial, regional (1985-1998), very active in

leading PHC radical reform in Andalucian Region and the development and implementation of the first great scale EHCR in a PHC regional service (1.500 PHC centres of the Andalucian Health Service). From 2001 to 2010, in charge of the strategy and innovation directorate in University Hospital Virgen del Rocío in Seville the main hospital in Andalusia Region and one of the biggest in Spain, main projects: clinical governance organisational transformation project, Institute of Biomedicine, Innovation Support Unit, EHCR – later reference model for the whole regional system- strategic plan. Since 2011 he has been involved in evaluating and developing new approaches of the Health Research+Development+Innovation plan and strategy for the regional Ministry of Health and Welfare of Andalucia, as senior adviser on innovation. He is currently secretary of the committee for evaluation of ICT and Public Procurement initiatives within the regional public health and social services system.

Galo Peralta represents the Consejería de Sanidad y Servicios Sociales de Cantabria, which is the Regional Ministry of Health and Social Affairs of Cantabria. It is the Authority to decide on health and social care initiatives and strategy, and provide with health and social services to the population of Cantabria, 600.000 inhabitants. It has recently developed and launched a Strategy to provide with integrated care to chronic patients involving primary, hospital and social care. The Regional Ministry of Health includes in its organisational chart, the Servicio Cántabro de Salud (SCS), provider of health services and manager of hospitals and primary care centres of Cantabria; and the Instituto Cántabro de Servicios Sociales (ICASS), provider of the social care services. Marqués de Valdecilla University Hospital is a high specialization hospital, and is a national referent in some health specialities, such as neurodegenerative diseases and transplant. IFIMAV is the Biomedical Research Centre related to Marqués de Valdecilla University Hospital, with the aim of managing and promoting research and innovation in healthcare in the Region of Cantabria. All these institutions are integrated in improving knowledge, innovating and providing care to chronic patients.

Juan Lucas Retamar Gentil is Subdirector de Tecnologías de la Información y Comunicaciones Dirección Estratégica de TIC del Sistema Sociosanitario Público de Andalucía Consejería de Salud y Bienestar Social Avda. SAS (Andalusian Health Service) and the ASSDA (Agency of Social Services and Dependency of Andalusia) are dependent bodies of the Consejería de Salud y Binestar Social (Regional Ministry of Health and Social Welfare (RMHSW) for the provision of health and social care services to 100% of the population in the region (8.449.985 inhabitants; 4.169.634 men; 4.254.468 women). Around 1.3 million are 65 or more years old.). The RMHSW public body of the Regional Government of Andalusia which is the responsible of the health and social policies in the region, currently manages the greater volume (44%) of budgetary resources of the regional government up to 10,086 million € (2013). Health Care network of 47 public hospitals and more than 1,500 primary healthcare centres. Care for persons with chronic multimorbidities and associated aging needs is one of the main strategies of services development and innovation. Andalucia has been very active in the development of new models of services for those patients based on ICT and EHCR. Several pilots are currently being developed in order to identify critical issues of effectiveness, cost and efficiency that can aloud massive extension of new services. Public procurement is part of the components tools considered for fostering technologically based services innovation, and some SAS Hospitals experiences are considered reference good practices at national level.

Anu Soderstrom, lately President, COTEC, the European Committee for Occupational Therapists where she coordinates and lead the activities of OT's in Europe. She has a bachelor's degree in OT, she has worked as a clinical OT with eleven years experience of clinical OT with children and adult neurological patients. For the last twelve years she has worked in COTEC encouraging better understanding and status for OT in Europe.

Mariëlle Swinkels is a strategic advisor and developer of the province of Noord-Brabant in the Netherlands. She has been working for years with the concept of social innovation inseveral regional programs such as the Smart Care program to improve the implementation of technological innovations. Important topics in which she is specialized are community building of new stakeholder cooperation (quadruple helix) and demand driven and bottom up approaches and methods. Mariëlle is a team member of the regional program *Health and Social Care Economy* of the province of Noord-Brabant. The goal of this program is

to achieve a triple win: to develop a future proof health and social care system, to improve the quality of life of citizens in Brabant and to strengthen the opportunities for innovative business's in Noord-Brabant. The province of Noord-Brabant is one of the initiators of the Community of Regions for Assisted Living (CORAL). In this growing community 25 regions across Europe actively work together on regional policy development for Active & Healthy Ageing. On behalf of CORAL Mariëlle Swinkels participates in European projects such as the Interreg IVC project CASA, the CIP thematic network project ENGAGED and in the action group *Deployment of Interoperable independent living solutions* of the European Innovation Partnership of Active and Healthy Ageing.

Project Coordinator

In addition to those resulting from the EC contract, he will have the following responsibilities:
- All STOPandGO-related contacts with the Commission working alongside
  - The Administrative Coordinator (AC)
  - The PPI Coordinator (PC)
  - Other work package leaders
- Representing STOPandGO in other external contacts
- Chair of the EB
- Administration, preparation of minutes of the AB and the EB and internal project documents such as handbooks
- Operational follow-up of decisions
- Transmission of any documents and information connected with the project between the partners
- Coordinate the functions of the Project Office

Administrative Coordinator

In addition to those resulting from the EC contract, he will have the following responsibilities:
- Preparing and use of administrative systems forms and time sheets
- Preparing minutes with the PC and circulation
- Preparing reports and records as agreed for the project
- Will function with the Project Office at Smart Homes

PPI Coordinator

The PPI Coordinator will be appointed and employed by LSEE. The Executive Board will be able to review the proposed candidates for the appointment and submit comments to LSEE. The candidate will not gain any financial benefit from the creation and outcomes of the proposed European Tender Specification and once appointed will become a member of the Executive Board. They will assist the WP2 Leader and WP5 Leader to plan the tender process and also to oversee the work of the procurement teams within the localities forming the PPI Pilot to ensure adherence to EU Procurement Policies and Procedures.

Project Office

A Project Office comprising a staff familiar with administrative, legal, financial, communication and IPR issues will support the Project Coordinator in all the above responsibilities. The Project Office will get advice from financial, legal, IPR, etc specialists whenever required. Specifically, the Project Office
- manages the delivery and the flow of administrative and financial documents,
- manages the delivery of deliverables and reports to the Commission
- is a permanent contact point for the Project Coordinator and all the Partners regarding their participation in the project, responding to any relevant requests and maintaining a high level of communication within the Consortium,
- prepares the project meetings in cooperation with Technical Coordinator and hosting partner.

Management of Project Information, Knowledge and IPR

Management of Project Information, Knowledge and IPR extends over the whole project duration with the following main objectives:

- Inventory and respect of the background brought by the STOPandGO partners
- Continuous monitoring of innovation throughout the project
- Identifying where potential intellectual property is generated (as a foreground item) and encourage partners or groups of partners to take appropriate measures (patent filing etc.)
- Liaison with the standardisation bodies to orient main knowledge advances towards the standardisation bodies once the IPR protection is completed.
- Following good practice guidelines on IPR, FRAND, as advised by the EU IPR Help Desk.
- Agreeing within the Partnership via the EB how intra project IPR is handled and the implications for external project IPR issues are promulgated.

Meetings and Travel Management

Project Meetings are organised in order to minimise time and expense; the Project Coordinator ensures that all relevant stakeholders are invited and meeting venues are shared. Travel is organised to create and maintain the cooperation momentum. Video and teleconference meetings will be held when possible.

Project Timetable

The main flow of the project is as follows:

- from M1 to M8 (presumably October 2014) we will work out the European Specification Template (EST). WP2 is more related to the care&cure content of the tender, while WP3 deals with interoperability and WP4 copes with the Legal, Ethical and Regulatory issues.

  As early as possible, we will promote our activities within the Integrated Care milieu and the eHealth community, in order to register the interest in the EST; as soon as the main building blocks of the EST are available, we will circulate them among the registered parties, collecting their informal contributions.

  When the EST will be ready for the formal consultation, we will publish it for a period of comments and we will organize a workshop to discuss our replies on the comments. This process ends with the production of a release of the EST to be used for the tenders in the rest of PPI Pilot.

- from M9 to M18 (i.e. presumably from November 2014 to October 2015) the local procurers will manage their tendering procedures as activities within WP5, under the supervision by the Executive Board and of the PPI Coordinator. All the local contract should be signed at the latest by M18 (end of August 2015).

- According to the local processes, the actual deployments will start between M17 and M19. There will be a continuous monitoring of the advancement of the contracts, with a main check point in M25 (March 2016).

  During this period a particular attention will be devoted to activate realistic Exploitation Plans based on the EST, for Regional and Local Authorities inside and outside the project. Towards the end of the project, a deep evaluation of the impact of the deployments, as well as a new release of the main deliverables will be published, to be used in the follow-up exploitation of the EST.

For the whole duration of the project, WP1 will provide the context for administrative and organizational activities, while WP8 will deal with the activities of dissemination.

The project is currently organized to close at M36 (February 2016); however it could perhaps be necessary to ask for an extension of the project, to perform the evaluation for further 6-8 months, if the complexity of the change management process, involved by the novelty of the holistic organizational models put in place, will suggest that the expected impact cannot be reached by M36.
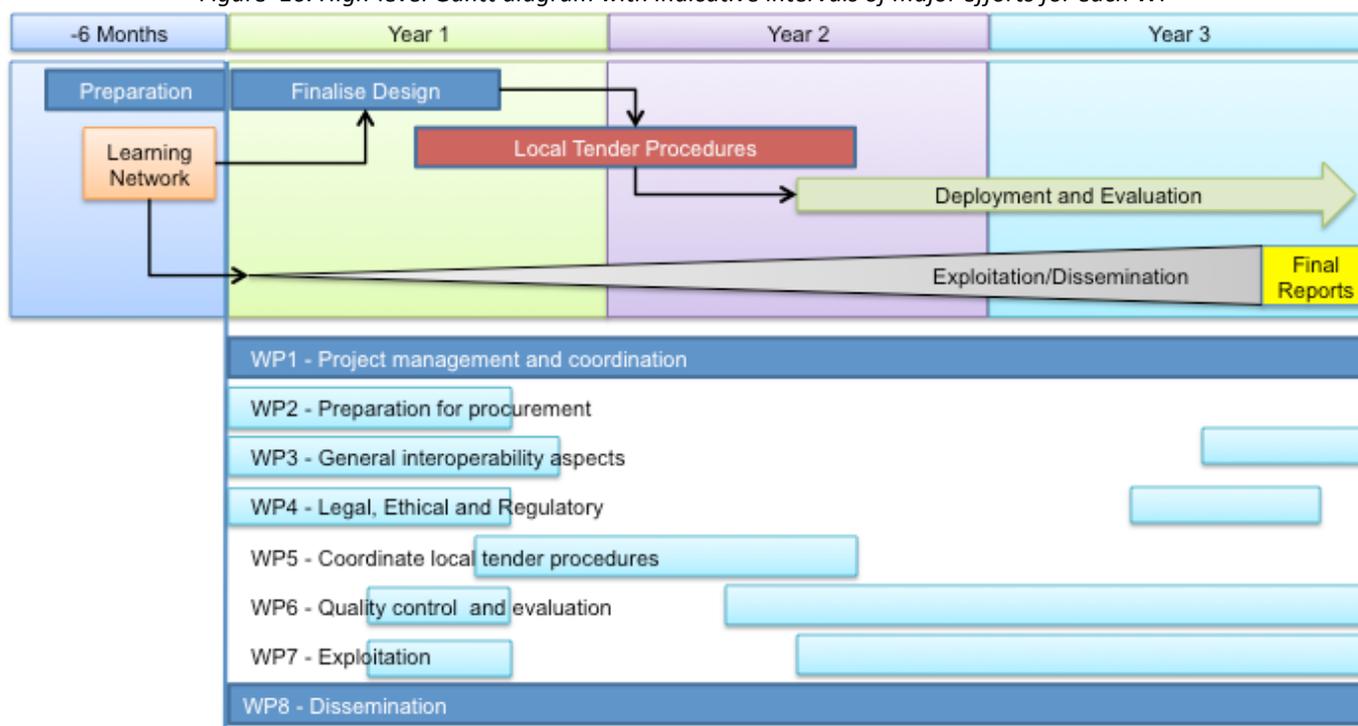
In fact, the full application of the EST will require to activate new professional profiles, to train the existing professionals to new roles, to educate the patients and their informal caregivers.

In addition, the size of the pilot, involving more than 5000 users, will require an adequate time to enroll the full cohort and to reach an adequate observation interval for each user to measure the effects on their health and welfare.

High-level Gantt diagram

The diagram below illustrates the interdependencies of the various sections of the project and their relationship to the Work Packages. Exploitation and dissemination of all learning commence at the start of the project to enhance the return on investment generated not only within this project but for others too. Evaluation is also a whole project endeavour to ensure delivery of the identified KPIs.

Figure 10. High-level Gantt diagram with indicative intervals of major efforts for each WP

Detailed Gantt diagram

Figure 11. The detailed Gantt diagram (darker colours suggest a more intense effort)

B3.3. Resources to be committed

Coordination costs across the 13 partners total € 996.569, comprising direct costs of € 839.908 for personnel and € 102.000 for other costs (60.000 + 42.000), indirect costs calculated at a flat 7% of € 58.981 and other coordination costs of €60,000.

Direct costs primarily represent the time inputs of partners' staff to the various work package tasks detailed above. All partners have an allocation under WP1 project management to allow for attendance at project meetings. The allocation of € 263.583 for LSEE is due to its hosting the Project Office, providing secretariat functions for the Executive and Advisory Boards, and the European Learning Network. Alongside these responsibilities for organisation and control of funding to all partners, including those in the procurement and implementation phases, and the production of hard output deliverables. These administratively heavy tasks are key to the successful progression, execution and completion of STOPandGO.

Allocations across partners within other work packages are flatter and appear modest. It is important to note that STOPandGO is congruent to the partners' ordinary courses of business. We are not planning to recruit many new staff; rather existing staff will dedicate a proportion of their time collaboration within the project. This keeps project costs manageable and gears in value by ensuring that STOPandGO is grounded in existing structures. This close association increases the relevance of common STOPandGO specifications and likelihood of rapid adoption throughout the life of the project.

STOPandGO coordination/preparation will represent around 5% - 10% of partners working time over the course of the project.

Procurement costs of € 18.230.703 are shown. This is based on procurements that are foreseen in the UK, Italy, Spain and the Netherlands. The reimbursement requested is € 3.446.703 being 20% of the total procurement costs.

B3.4. Indicators to evaluate the STOPandGO project

The following table provides a set of classes of indicators to evaluate the activities and the outcomes of the STOPandGO project. Most indicators will be repeated for each "locality" a Tender Specification as required. Key: EB = Executive Board, PC = Project Coordinator, PPIC=PPI Coordinator

Table 10. Indicators to evaluate the STOPandGO project

Project Objective	Indicator Class	Indicator	Method of Measurement	Measured By	Expected Progress – Years		
					1	2	3
Guide for Applicants requirement	1	Open Market Dialogue	Delivery of EU-wide open meeting. Measures will be: - Date of Meeting - Number of attendees - Number of countries represented	EB	Q1 /2		
To accelerate the availability and large scale deployment by stimulating procurements in the field of health and social care, of new ICT based products and services which have demonstrated in a smaller scale settings significant improvement of independence, functionality and well-being of older persons	2	Creation of Business Case	One Business Case per locality	PPIC	Q3		
	3	Issuing of Tender Specification	The creation and issuing of one tender specification per locality	PPIC	Q4		
	4	Awarding of Contract	OJEU Contract Award Notice	EB		Q2 /3	
	5	Evaluation Delta's	Difference between Contract numbers and Actual numbers (delta): - Number of users - Cost per user Any other qualitative measure included within the awarded contract i.e. relevant KPI's	PC/ EB		Q4	Q1 /4
Standards for consumers (public, private or voluntary) that require high quality, guaranteed, challenging and audited KPI's for the delivery of telecare and telehealth services	6	Adherence to Standards	Utilisation of the TSA Integrated Telecare and Telehealth Code of Practice wherever possible or KPIs built upon the specifications of this Code to ensure commonality of expectations (KPIs) across all localities	PPIC / EB		Q1 /4	Q1 /4

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Appendix 1. Glossary of terms and acronyms

The following explanations are provided for clarity and easy-reference. They have no legal authority, and do not replace any official definitions set out in the relevant legal acts.

3MillionLives
A UK Government initiative to extend telehealth and telecare to an additional 3 million users over a 5 year period.

Ambient Assisted Living (AAL EU)
Intelligent systems of assistance for a better, healthier and safer life in the preferred living environment and covers concepts, products and services that interlink and improve new technologies and the social environment

Administration Coordinator
In addition to those resulting from the EC contract, he will have the following responsibilities:
Preparing and use of administrative systems forms and time sheets
Preparing minutes with the PC and circulation
Preparing reports and records as agreed for the project
Will act as a virtual project office

Advisory Board
The Advisory Board will provide input from major stakeholders at European level. It is comprised of representatives of industry, public bodies, service providers and users.

Balanced Scorecard (BSC)
A strategy performance management tool (a semi-standard structured report) supported by design methods and automation tools that can be used by managers to keep track of the execution of activities by the staff within their control and to monitor the consequences arising from these actions.

Comitè Europeen de Normalisation (CEN EU)

CENELEC (EU)

Chronic Obstructive Pulmonary Disease (COPD)

Clinical Commissioning Group (CCG UK)

Competitiveness and Innovation Framework Programme (CIP EU)
With small and medium-sized enterprises (SMEs) as its main target, the Competitiveness and Innovation Framework Programme (CIP) supports innovation activities (including eco-innovation), provides better access to finance and delivers business support services in the regions. It encourages a better take-up and use of information and communication technologies (ICT) and helps to develop the information society.

Continuing Professional Development (CPD UK)

Data Protection Policy
The personal data collected in the context of the call for proposals will be processed in accordance

with the 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 L8,12.01.2001, p.1).

Deliverable
Represents a verifiable output of the project. Normally, each work package will produce one or more deliverables during its lifetime. Deliverables are often written reports but can also take another form, for example the completion of a prototype etc.

Direct Costs
Direct costs are all eligible costs which can be attributed directly to the project and are identified by the participant as such, in accordance with its accounting principles and its usual internal rules.

eHealth
Healthcare practice supported by electronic processes and communication, mainly the Internet.

Electronic Health Records (EHR)
Enabling the communication of patient data between different healthcare professionals (GPs, specialists etc.)

Eligibility Criteria
The minimum conditions which a proposal must fulfil if it is to be evaluated. Some of the eligibility criteria are applicable for all proposals throughout ICT PSP (e.g. relating to submission before the deadline, completeness of the proposal), and some criteria are different for the different instruments (in particular the minimum participation requirements).

Eligible Costs
These are costs accepted by the Commission as being reimbursable (up to the limits established in the grant agreement).

European Innovation Partnership on Active and Healthy Ageing (EIP AHA)

European Interoperability Framework (EIF EU)

European Learning Network (ELN)
A connection between the project and the wider stakeholder communities. The core of the ELN is formed from nominated key leaders in government, industry, user representatives, trade bodies and other professional organisations.

European Norm (EN EU)

ETSI
European Telecommunications Standards Institute (ETSI) produces globally-applicable standards for Information and Communications Technologies (ICT), including fixed, mobile, radio, converged, broadcast and internet technologies.

Evaluation
The process by which proposals are, or are not, retained with a view to selection as projects. Evaluation is conducted through the application of eligibility, award and selection criteria identified in a work programme. The evaluation is conducted by the local Commissions assisted by independent experts.

Evaluation Criteria
The eligibility, award and selection criteria against which proposals are assessed.

Evaluation Summary Report (ESR)
The assessment of a particular proposal following the evaluation. It normally contains both comments and scores for each evaluation criterion.

Executive Board
Consists of partners. It has overall responsibility for governance of the technical, financial, administrative and exploitation aspects of the project according to the contract and the advice of the Advisory Board and European Learning Network.

Functional Independence Measure (FIM)
The Functional Independence Measure (FIM) is an international 18-item, 7-level scale developed to uniformly assess severity of patient disability and medical rehabilitation functional outcome.

International Monetary Fund (IMF)
An organisation of 188 countries, working to foster global monetary cooperation, secure financial stability, facilitate international trade, promote high employment and sustainable economic growth, and reduce poverty around the world.

ICT PSP
The "Information and Communication Technologies Policy Support Programme" (ICT PSP) is one of the three specific programmes of the "Competitiveness and Innovation Framework Programme" (CIP).

ICT PSP Associated Countries
Non-EU countries which have agreed, negotiated and paid to participate in the ICT Policy Support Programme as part of the Competitiveness and Innovation Framework Programme. In the context of proposal consortia, organisations from these countries are treated on the same footing as those in the EU.

Indirect Costs
Indirect costs, (sometimes called overheads), are all those eligible costs which cannot be identified by the participant as being directly attributed to the project, but which can be identified and justified by its accounting system as being incurred in direct relationship with the eligible direct costs attributed to the project.

Individual Assessment
The stage in the evaluation process when experts assess the merits of a particular proposal before discussion with their peers.

Institute of Health Carlos III (ISCIII): the main Public Research Entity funding, managing and carrying out biomedical research in Spain

International Standard Organisation (ISO)

Invitation to Tender (ITT)

Interoperability Working Group (S+G) (IWG)

ISO EN 13606: International standard (adaptation of the European namesake, developed by the TC 215 of CEN) for the interchange of electronic health records; it is based in a double model strategy

(information and knowledge) that provides semantic interoperability and protection against changes in the knowledge domain.

Key Performance Indicators (KPI)
A performance indicator or key performance indicator (KPI) is a type of performance measurement. An organisation may use KPIs to evaluate its success, or to evaluate the success of a particular activity in which it is engaged. Sometimes success is defined in terms of making progress toward strategic goals but often success is simply the repeated, periodic achievement of some level of operational goal (e.g. zero defects, 10/10 customer satisfaction, etc.).
Legal, Regulatory and Ethical issues (LRE) Locality
At its highest level of definition this could be a country and its lowest a small group of consumers.

London School of Economics (LSE)

London School of Economics Enterprise (LSEE)

Ministry of Health, Social Services and Equality (MSSSI), Spain

Model of Assessment of Telemedicine (MAST)

Most Economically Advantageous Tender (MEAT)

Medicines and Healthcare Products Regulatory Agency (MRHA UK)

NHS Eastern Cheshire Clinical Commissioning Group (ECCCG), UK

Official Journal of EU (OJEU)

Participants
The members of a consortium in a proposal or project.

Participant Identification Code (PIC)
Organisations participating in FP7/ICT-PSP will be assigned Participant Identification Codes (PIC). Possession of a PIC will enable organisations to take advantage of the Unique Registration Facility and to identify themselves in all transactions related to FP7/ICT-PSP proposals and grants.

Payment By Results (PBR UK)

Personal Emergency Response Systems (PERS)
An alarm system designed to signal the presence of a hazard requiring urgent attention and to summon emergency medical personnel.

Person Month (PM)

Pre-Qualifying Questionnaire (PQQ)

Prior Information Notice (PIN)

PPI Coordinator
The PPI Coordinator will be appointed and employed by LSEE. The Executive Board will be able to review the proposed candidates for the appointment and submit comments to LSEE. The candidate will not gain any financial benefit from the creation and outcomes of the proposed European Tender Specification and once appointed will become a member of the Executive Board.   They will assist the WP2 Leader and WP5

Leader to plan the tender process and also to oversee the work of the procurement teams within the localities forming the PPI Pilot to ensure adherence to EU Procurement Policies and Procedures.

Project Consortium Agreement
As defined in the project Handbook for the working of STOPandGO

Project Coordinator
In addition to those resulting from the EC contract, this person will have the following responsibilities:
- All STOPandGO-related contacts with the Commission working alongside
  - The Administrative Coordinator
  - The PPI Coordinator
  - Other work package leaders
- Representing STOPandGO in other external contacts
- Chair of the Executive Board
- Administration, preparation of minutes of the Advisory Board and the Executive Board and internal project documents such as handbooks
- Operational follow-up of decisions
- Transmission of any documents and information connected with the project between the partners
- Monitoring of Key Performance Indicators

Project Handbook
The definition of the project, methods and practices which will be followed throughout STOPandGO

Proposal
A description of the planned activities, information on who will carry them out, how much they will cost, and how much funding is requested.

Public Procurement of Innovative Solutions (PPI) Pilot
ICT PSP instrument supporting the use of public procurement for early adoption / deployment of innovative goods or services, which are not yet available on a large-scale commercial basis.

Smart Homes
A home that is highly automated. It is entirely networked not only for computers, A/V entertainment and security, but also for healthcare, energy management, heating, air-conditioning and lighting control.

STOPandGO
Sustainable Technology for Older People – Get Organised Our submission for the FP7 ICT-CSP 3.2b for 2013

Randomised Control Trial (RCT)
A specific type of scientific experiment, and the gold standard for a clinical trial. RCT are often used to test the efficacy and/or effectiveness of various types of medical intervention within a patient population. RCT may also provide an opportunity to gather useful information about adverse effects, such as drug reactions.

Technical Committee 251 of CEN (Health Informatics) (TC251)

Telecare
The provision of care services at a distance using a range of analogue, digital and mobile technologies. These range from simple personal alarms, devices and sensors in the home, through to more complex technologies such as those which monitor daily activity patterns, home care activity, enable "safer walking" in the community for people with cognitive impairments/physical frailties, detect falls and epilepsy seizures, facilitate medication prompting, and provide enhance environmental safety i.e. the continuous, automatic and remote monitoring of real-time emergencies and lifestyle changes over time in order to manage the risks associated with independent living

Telecare Services Association (TSA)
A UK membership based, not for profit organisation, formed in 1995 whose members (360+ organisations) provide telecare and telehealth to over 1.7 million service users within the UK (far more when the overseas membership is considered).

Telehealth
The provision of health services at a distance using a range of digital and mobile technologies. This includes the capture and relay of physiological measurements from the home/community for clinical review and early intervention, often in support of self-management; and "teleconsultations" where technology such as email, telephone, telemetry, video conferencing, digital imaging, web and digital television are used to support consultations between professional to professional, clinicians and patients, or between groups of clinicians.

Telehealthcare
An overarching term to describe both telehealth and telecare together

Telemedicine
The use of telecommunication and information technologies in order to provide clinical health care at a distance. It helps eliminate distance barriers and can improve access to medical services that would often not be consistently available in distant rural communities. It is also used to save lives in critical care and emergency situations.

Whole System Demonstrator (WSD)
The largest randomised control trial of telehealth and telecare in the world. It involved 6191 patients, 238 GP practices across three sites, Newham, Kent and Cornwall. WSD was set up to look at cost effectiveness, clinical effectiveness, organisational issues, effect on carers and workforce issues. It focused on three conditions, diabetes, COPD and coronary heart disease.

Workpackage (WP)
A work package is a major sub-division of the proposed project with a verifiable end-point - normally a deliverable or a milestone in the overall project.

Work Programme
A formal document of the Commission that sets out the objectives and topics to be addressed. It also contains information that is set out further in this guide, including the schedule and details of the calls for proposals, indicative budgets, and the evaluation procedure.

Appendix 2: EU Guidelines about Informed Consent

EU GUIDANCE FOR APPLICANTS INFORMED CONSENT Directive 2001/20/EC relating to the implementation of good clinical practice in the conduct of clinical trials on medicinal products for humans.

Although STOPandGo is not a research project, because we are working with the cooperation of health and welfare organisations we must meet any ethical aspects as they are identified. Again, we will review this EU Guidance and include any aspect we believe to be essential.

For the purposes of the Ethics Review process, the definition of Informed Consent given in the Directive 2001/20/EC relating to the implementation of good clinical practice in the conduct of clinical trials on medicinal products for human use is adopted. The principle of "informed and free decision" remains valid for any other kind of research.

"Informed Consent is the decision, which must be written, dated and signed, taken freely after being duly informed of its nature, significance, implications and risks and appropriately documented, by any person capable of giving consent or, where the person is not capable of giving consent, by his or her legal representative; if the person concerned is unable to write, oral consent in the presence of at least one witness may be given in exceptional cases, as provided for in national legislation."

The Informed consent form must contain adequate information to meet the necessary requirements. In most cases, an information sheet should be attached. It is recommended that drafts of the consent form and the information sheet are submitted to the Commission with the application. In almost all cases the above drafts have to be available when applying for local ethics committee opinion and approval from national competent authorities, prior to the start of the proposed research.

What type of information should be provided to the research subject:
General information:

A statement that the study involves research subjects and an explanation of the purposes of the research.
The expected duration of the subject's participation.
A description of the procedures to be followed/ of the medicine that is going to be tested, and an identification of any procedures which are experimental.
A statement that participation is voluntary.
Information about who is organising and funding the research.
A description of any reasonably foreseeable risk, discomfort or disadvantages.
A description of any benefits to the subject or to others, which may reasonably be expected from the research avoiding inappropriate expectations.
A disclosure of appropriate alternative procedures for treatment/diagnosis if any, that might be advantageous to the subject.

A statement describing the procedures adopted for ensuring data protection/confidentiality/privacy including duration of storage of personal data.
A description of how incidental findings are handled.
A description of any planned genetic tests.
For research involving more than minimal risk, an explanation as to whether there are any treatments or compensation if injury occurs and, if so, what they consist of, or where further information may be obtained. Insurance coverage should be mentioned.

A reference to whom to contact for answers to pertinent questions about the research and research subjects' rights, and whom to contact in the event of a research-related injury to the subject.
A statement offering the subject the opportunity to ask questions and to withdraw at any time from the research without consequences.
An explanation of what will happen with the data or samples at the end of the research period and if the data/ samples are retained or sent/sold to a third party for further research.
Information about what will happen to the results of the research.

WHO SHOULD GIVE THE INFORMATION? / HOW TO INFORM?

The information must be given by a physician or by other individuals with appropriate scientific training and qualifications. This point is also remarked in the Declaration of Helsinki (paragraph 14): "After ensuring that the potential subject has understood the information, the physician or another appropriately qualified individual must then seek the potential subject's freely-given informed consent."

Information must be given in lay terms and under no circumstances pressure of any kind should be exercised on the individual participant nor her/his family/legal custodian. The communication/information dissemination means used should be adjusted to the particularities of situation/research subject at hand.

Consent should be a continuing process, especially in long-term trials or projects, researchers should foster a continuous dialogue with participants and inform them of anything new related to the trial.

Appendix 3. Supporting letters

Supporting letters have already been submitted from UK Minister of State for Care and Support, Norman Lamb MP and Minister for Culture, Communications and Creative Industries, the Hon. Ed Vaizey MP and the letter from Mrs. Drs. Jansen.

Department for Culture Media & Sport

Senior ePolicy Advisor for the Minister
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Your Ref: CIP ICT Objective 3.2b
Our Ref: CIP ICT/Approval
       9th May 2013

Dear

As a Minister with responsibility for eAccessibility in the Department of Culture, Media and Sport in the UK Government, I was delighted to hear about the plans for a bid from the group based at London School of economics (LSE), who have been working with Stephen Johnson, Head of Long Term Conditions at the Department of Health and other senior officials in NHS England, in the preparation for CIP ICT Objective 3.2b.

We understand they want to accelerate the availability and large scale deployment, through stimulating procurements in the field of health and social care, of new ICT based products and services which have demonstrated in smaller scale settings significant improvement of independence, functionality and well-being of older persons. The outcome of this work is very important for us, especially in understanding how to build success at scale.

I would like to express my support for the submission of the "STOPandGO" project under the Proposals of the Competitiveness and Innovation Framework Programme (Policy Support Programme).

The UK Government has already identified that the time is right to establish increasing telehealth services and integrated care systems as set out in the priorities of the European Innovation Partnership on Active and Healthy Ageing. This important process will build upon the body of evidence from the UK 3millionlives and Whole System Demonstrator projects. The STOPandGO project will provide real evidence and enable users, industry and policy makers to move quickly forward with other European experts.

In the UK, responsibilities for these technologies cross many boundaries. My own Department wants to work with the STOPandGO group through our eAccessibility Forum, and at least two members of the consortium are involved with the Forum (Maggie Ellis and Richard Foggie). This will facilitate easy exchange of information and maximise the potential of the project outcomes.

I strongly urge the Commission to give the STOPandGO project proposal a favourable consideration and look forward to following the developments closely.

Ed Vaizey MP

Adrian Goodall
Senior ePolicy advisor for The Minister for Culture, Communications and Creative Industries

E: minister-culture@culture.gsi.gov.uk

Stichting Smart Homes
Nationaal Kenniscentrum Domotica & Slim Wonen
Duizelseweg 4a
5521 AC EERSEL

Onderwerp
STOPandGO

To whom it may concern,

As acting director Social & Cultural Development of the Province of Noord-Brabant I would hereby like to express my support to the submission of the "STOPandGO" project under the CIP ICT PSP work programme 2013, objective 3.2 - Supporting public procurement for innovative solutions (PPI) in eHealth, active and healthy ageing and assisted living.

This project will develop a procurement strategy and specification for new interoperable services and outcomes that support active and healthy ageing across member states. STOPandGO will put out the tenders and with the support of the Province of Noord-Brabant carry out the full procurement process. I therefore strongly urge the Commission to give the STOPandGO project proposal a favourable consideration, take part of the project's EU Learning Network, and look forward to following the developments closely.

Thank you for your attention

Kind regards,

Mrs. drs. C.M.L. Jansen,
acting director Social & Cultural Development

Datum
14 mei 2013
Ons kenmerk

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Het provinciehuis is vanaf het centraal station bereikbaar met stadsbus, lijn 61 en 64, halte Provinciehuis, met de treintaxi en met de OV-fiets.

NHS

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SK10 3BL

Tel: 01625 663477
www.easterncheshireccg.nhs.uk

9th September 2013

To whom it may concern

Sustainable Technology for Older People – Get Organised

I am writing to confirm that Eastern Cheshire Clinical Commisioning Group is pleased to participate as a procurer in the above project to develop an innovative procurement process focussing on clinical and social outcomes.

We feel the approach being taken to this project fits with our local focus on developing integrated health and social care services supported by a range of technologies. We have, in fact, already been engaged in similar strategies with our Social Care Partners for the last two years. We intend to work with our partners to allocate funding of up to €4,375,000 (£3,675,000) to the project, anticipating a return of €875,000 (£735,000) based on services being provided to 1250 people during the 3 years of the project. This commitment is made with the proviso that the figures may need to be revised if there are statutory changes to the NHS in England during the life of the project.

We look forward to working with the range of organisations in the project to secure the European Union Commissions support and then to deliver the project and its outcomes.

Yours faithfully

Jerry Hawker
Chief Officer

Inspiring Better Health and Wellbeing

Dr Paul Bowen BMBS MRCGP Clinical Chair
Jerry Hawker Chief Officer