DELIVERABLE

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This deliverable contains original unpublished work except where clearly indicated otherwise. Acknowledgement of previously published material and of the work of others has been made through appropriate citation, quotation or both.

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Introduction

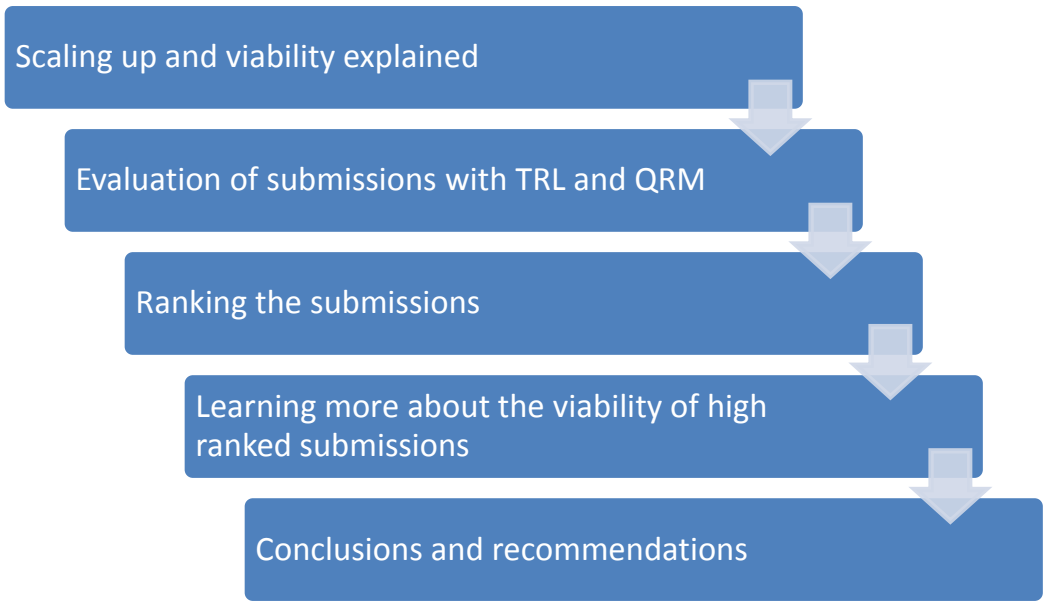
One of the objectives of the AFE-INNOVNET Thematic Network project is to identify innovative pilots[1] with potential for scaling up among notable practices in the on-line repository. Following identification of the initiatives, more detailed analysis was made using the evaluative framework.

This report begins with an introduction to the scaling up strategies developed by the European Commission and ExpandNet/WHO. The findings of the European Commission have been used to develop a questionnaire on viability of initiatives by three European Innovation Partnerships on Active and Healthy Ageing (EIP AHA) working groups in the first months of 2015. This questionnaire will be described and explained. The report then turns to selection of the initiatives. A combination of two different approaches was used and will be presented here. This will be followed by a short description of the pilots that responded to the questionnaire on viability.

The report ends with conclusions and recommendations. The following questions will be answered:

- What do we learn about the two methods used?
- What can we say about the viability/scaling up of the high ranked submissions?
- What recommendations do we have for the repository of AFE-INNOVNET or questionnaire on viability?

More schematic:



[1] In this report we use the terms pilots, initiatives, submissions, notable practices. These all refer to the notable practices in the AFE-INNOVNET repository.

Scaling up and viability

2.1 Scaling up

Throughout Europe numerous examples of age-friendly environments and active and healthy ageing exist that have real impacts on and for their stakeholders. These impacts include better quality of life, impressive savings for public healthcare budgets, economic prosperity and the profitable involvement of SMEs. However, these results often remain confined to pilot-sized initiatives, that is, to initiatives that exist only at the local and/or regional level and within the targeted groups of users rather than at a wider level. Quantitative expanding local or regional initiatives to other localities or regions, or even to other countries and other target groups, often appears to be extremely challenging, if not impossible. The causes of this are manifold: for instance, different local contexts and cultures, lack of funding, negative attitudes to innovations that are developed elsewhere ('not invented here'-syndrome) and lack of political support.

Types of scaling up

Different definitions of scaling up can be identified in the literature. In 1995 Uvin[2] discussed several types of scaling up and finally chose a variety of definitions. He argued that variety is important, because it allows examination of the act and phenomenon of scaling up in a number of different ways, which is essential given its complexity. The fact that a variety of different definitions is required also suggests that there are different kinds of scaling up, which might well be linked but are not identical.

Uvin recognizes the following types of scaling up:

1) Quantitative scaling up: comparable with expansion scaling up. Quantitative scaling up refers to expansion of the programme or organisation size, by increasing membership basis or constituency. Linked to this is concomitant expansion of geographic working area and/or budget.
2) Functional scaling up: refers to expansion of the number and type of activities of a programme or organisation.
3) Political scaling up: refers to expansion of active political involvement and the development of political relations.
4) Organisational scaling up: refers to increase of organisational strength, so as to improve the effectiveness, efficiency and sustainability of activities undertaken.

[2] Peter Uvin, Fighting hunger at the grassroots: paths to scaling up, World Development, Vol. 23, No. 6, pp. 927-939, 1995.

Each type of scaling up can follow several paths to achieve its goals.[3] For example, quantitative scaling up is best suited to spread (increasing the number of people that adhere to the organisation) or replication (aiming for a successful programme to be repeated elsewhere). Functional scaling up aims for horizontal integration (new activities or new programmes by the same organisation) or vertical integration (other activities related to the same chain of activities as the original one are added to an existing programme).

2.2 Viability for scaling up

The European Commission recognises that due to the complex and disruptive nature of health and care interventions it is often difficult to measure their effects in terms of efficacy and efficiency directly[4]. It often takes a long time before the results of large-scale changes can be assessed, and it is hard to date points to the potential of innovative solutions as, at the same time, the results have to be interpreted with caution because in most cases the numbers are small and the methodology debatable.

Therefore the EC proposes assessing the viability for scaling up by using assessment frameworks. Together with members of the Action Groups of EIP AHA viability dimensions have been formulated. These have been formulated with a view to stakeholders potentially interested to work with / to adapt / to take up innovative practices from the EIP AHA repository.[5]

Six dimensions of viability have been identified.

1. Time needed for the practice to be deployed (from the baseline to now). Information about elapsed deployment time is useful to assess whether the implementation of an innovative practice is feasible in the region/organisation that is considering adopting it.
2. Investment per citizen (from the baseline to now). A political decision process is very often based on an available budget, hence it is very important for potential stakeholders to get an understanding of the investment involved for the specific group of citizens that is targeted.
3. Time and kind of impact of the practice (from baseline to now). Impact is a measure of the extent, and way in which, an innovative practice 'makes a difference' to society in general and the stakeholders involved in that practice in particular. Impact has been recognized in two ways: time of the impact of

[3] European Commission, The European Innovation Partnership on Active and Healthy Ageing, European Scaling-Up Strategy in Active & Healthy Ageing, 2015.
[4] European Commission, The European Innovation Partnership on Active and Healthy Ageing, European Scaling-Up Strategy in Active & Healthy Ageing, 2015.
[5] PROEIPAHA Deliverable 3.4: Repository planning, maintenance and enhancement, 2015.

the good practice (during the time of the project and beyond) and the kind of impact that is observed.

4. Evidence behind the practice. It is important that decision making is evidence based or at least is built on a thorough base of information, in order to apply investment in the most responsible way.
5. Maturity of the practice. Maturity is a measure of how far an initiative already is along the road from initial idea to standard practice. This dimension is closely related to the TRL.
6. Possible transferability of the practice. It is important in all cases to know in which specific environment a practice has been developed, implemented and eventually tested. Environment should be understood “geographically” (i.e., nationally or regionally) as it can assist the repository users to understand whether the transferability of a practice has been an important issue in the development of the practice or not.

Evaluation and ranking the submissions

The AFE-INNOVNET repository is made up of notable examples of innovative solutions for age-friendly environments in Europe. Its objective is to exchange knowledge, foster synergies and contribute to the scaling up of these initiatives. These were obtained by participants of the thematic network. In total, 68 unique submissions were received electronically between July 2014 and September 8 2015, with data collected in 61 different categories of information.[6]

The interventions in the repository were self-selected, and submitted by individuals involved in some way in implementing or funding them. There was no scope or means of independently assessing the reliability of the submitted interventions. For this reason, we treated all of the submissions as reliable descriptions of the interventions.

We evaluated submissions in September 2015, with the aim of identifying those with the:

- Greatest potential for scaling up;
- Most favourable cost-benefits in terms of overall costs of intervention and beneficiaries reached;
- Greatest likelihood of economic sustainability and contribution to economic growth (as evidenced by research);
- Involvement of organisations from the public *and* private sectors (PPPs).

The submissions that have a high ranking will be invited to fill in the questionnaire on viability.

3.1. Two methods of evaluation

We evaluated submitted interventions using two methods. We then combined the results to arrive at a harmonised list of interventions identified as interesting through both methods. The first method is based on the Technological Readiness Level (TRL) base of initiatives and the second approach is based on a Qualitative Ranking Method (QRM) according to intervention characteristics. The reason for using these

[6] Members of the thematic network were encouraged to submit their notable practices, partly through the stocktaking activities in WP4, but also through sending direct emails to the members. Mid December 2015, the repository contains 84 notable practices.

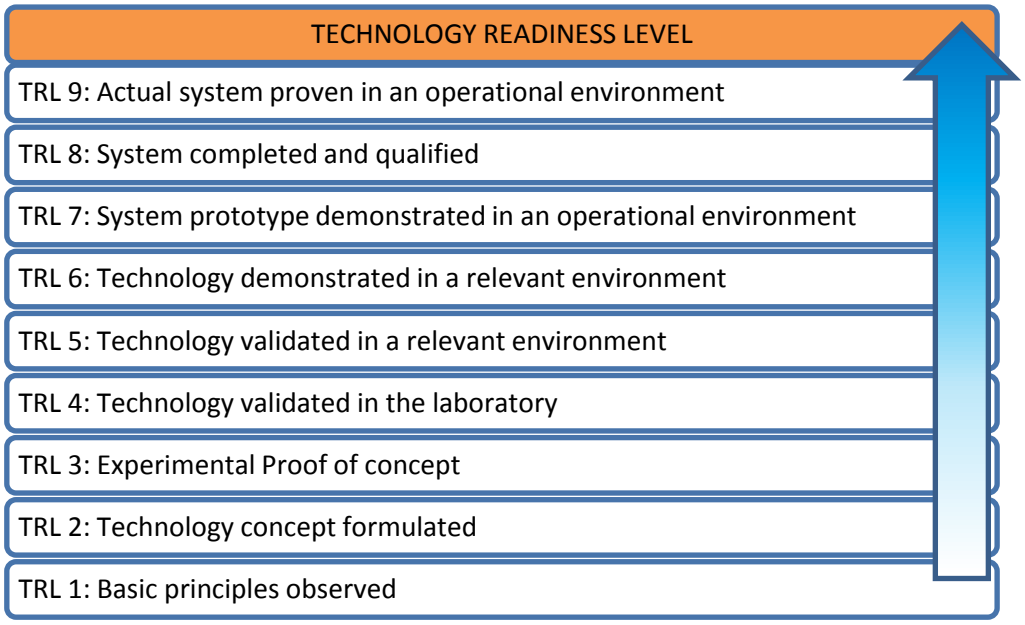
two methods was to compare the results and look what method led to the best results of identifying innovative viable pilots.

1. TRL approach

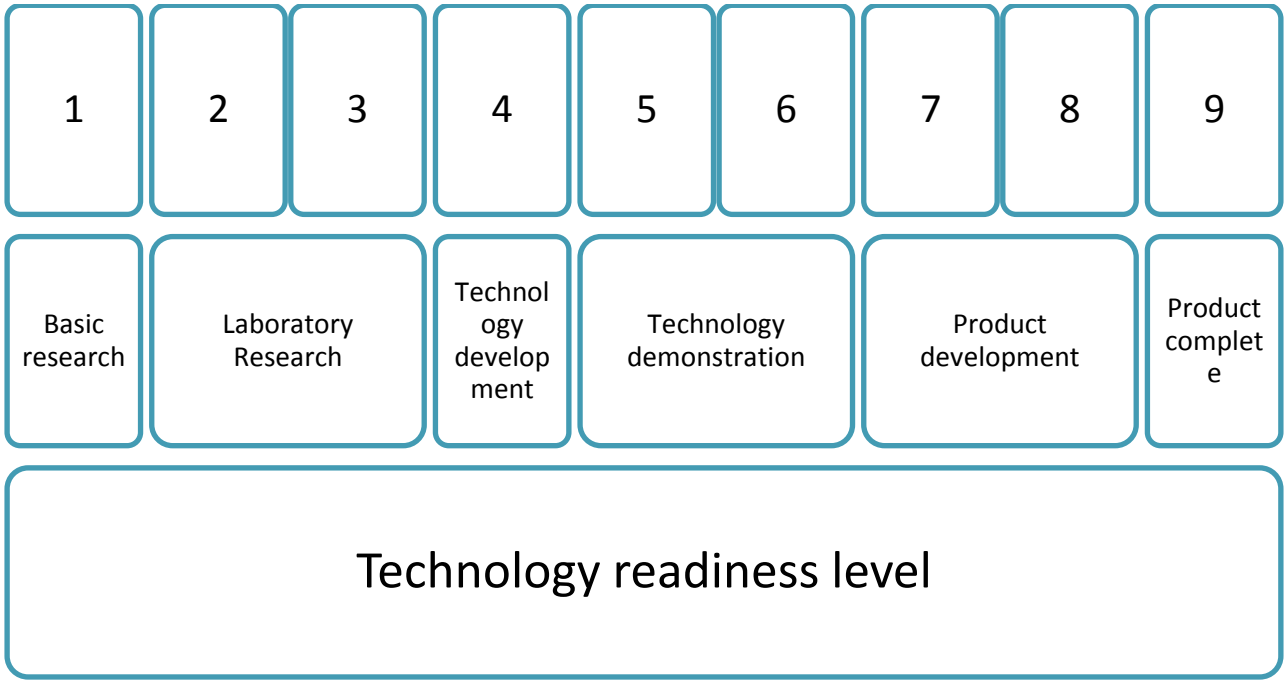
The TRL is a scale from 1 to 9 which expresses the level of science or commercial state of play of technologies[7]. Technologies and ICT solutions that have been demonstrated and proven to work in operational environments are most likely to be implemented and found fit to be scaled up. We choose all the initiatives that scored 7-9 on TRL.

Together with TRL 7-9, we identified those initiatives that seriously answered the questions about possibilities to scale up, economic sustainability and key success factors and main barriers. In this way we found 12 initiatives that were suitable for further examination and analysis.

Figure 1: TRL scale



[7] Annex G (TRL) of the General Annexes of Horizon 2020.



Technology readiness level and the state of product.

2. QRM

We focused on the 10 fields that appeared to be most directly related to the aims of the exercise: identifying interventions with promise in terms of scaling up. For each of these 10 fields, we conducted one or more of the following criteria (see table 1 below):

- Inclusion/Exclusion: Application of inclusion/exclusion criteria according to submission category.
- Category assessment: Application of fixed scores defined by category response.
- Likert-scale assessment: Subject text descriptions to clarifying questions and allocation of Likert-scale score;
- Cost-benefit ranking: Division of mid-points of "Cost" and "Number of beneficiaries reached"; when figures missing in either field a score of 0 were applied. Calculated divisions were sorted from high to low and scores assigned as follows – 5=first ten 'best-values', 4=Next 10, 3=Next 10, 2=Next 10, 1=Next 10.

Table 1: 9 fields used in the QRM

Name	Assessment type	Assessment options	Notes/Clarifying questions
Status	Inclusion/Exclusion	Exclude: Planned Include: On-going, Completed	
TRL	Inclusion/Exclusion	Exclude: Proof of concept (1-3), Validation (4-6). Include: Not applicable, Blank, Prototype (7-9)	Submissions that did not include a TRL level were not excluded to avoid discriminating against non-technological initiatives.
Budget & beneficiaries reached	Cost-benefit ranking	1-5, based on cost-benefit ranking	Interventions with the lowest costs were treated most favourably. Not answering this question was treated as unfavourable to the evaluation exercise.
Type of initiative	Category assessment	PPPs=5 Public, Private=3 Blank=1	We favoured PPPs, and disfavoured those that did not answer this question.
How could the initiative be	Likert-scale assessment	No=1 > to Very much so=5	*Is there potential to scale up?*

scaled up?		No response=1	*Are there clear ideas?*
Can the initiative be transferred to other regions?	Likert-scale assessment	No=1 > to Very much so=5 No response=1	*What is the potential to transfer?* *Are there clear ideas concerning transfer?*
Is it economically sustainable and does it contribute to economic growth?	Likert-scale assessment	No=1 > to Very much so=5 No response=1	*Does it really seem to be sustainable?* *Does it really seem to contribute to economic growth?*
If yes, how do you collect data?	Category assessment	Two or more methods = 5 One method = 3 No methods stated = 1	We favoured more than one methodology because we assume that multi-methods are needed to make a fuller and more comprehensive assessment. No methods was treated unfavourably.
Main barriers	Category assessment	Barrier does not appear to represent a serious threat to scaling up = 3 Barrier appears to represent a serious threat to scaling up = 1 No answer = 0	*Do the barriers represent a threat to successful scaling up?* We treated submissions that described barriers more favourably than those that did not. We also favoured those submissions where the threat did not appear to represent a serious threat to scaling up.

For those interventions that were not excluded, a calculation was made of the sum of the scores received across the different evaluation criteria. By necessity, submissions with the most detailed descriptions were favoured, and those that provided fewer details disfavoured. Interventions were sorted, ranging from highest to lowest scores. Those with the highest scores, i.e. over 20 were considered most interesting.

3.2 Combined results: ranking the submissions

After identifying the potential initiatives we combined both lists. Eight out of the 12 initiatives with TRL 7-9 also scored over 20 points in the QRM. The last 4 initiatives scored from 16-19 in the ranking system. This suggests both methods were capturing

a strongly overlapping selection of the interventions, though both focused on slightly different elements of the most interesting features of the potentials of scaling up.

Table 2: Combination of two ranking methods

Order with the second method	TRL 7-9	Name of initiative	Acronym	Country	Score	Viability Q. received from the promoter?
1	✓	Aiding SuStainable Independent Senior TrAvellers to Navigate in Towns	ASSISTANT	UK	27	No
2		Durango, ciudad amigable con las personas 13ayors / Durango, Age-Friendy City	N/A	Spain	25	No
3	✓	Dementia Ambient Care: Multi-Sensing Monitoring for Intelligent Remote Management and Decision Support	Dem@Care	Greece	24	No
4		Ageing Well in Wales		UK	23	No
5	✓	Smart House Living Lab	SHLL	Spain	23	Yes
6		Life Long Living – maintaining independent living as long as possible	LMIEL (Længst Muligt I Eget Liv)	Denmark	22	No
7		Cities in Balance	CIB	UK	22	Yes
8		Senior Citizen's Board- The board acts in an advisory capacity to help the city council to deal with the issues related to improvement of the quality of life for senior citizens.	N/A	Latvia	22	No
9		Series of lectures and seminars for elderly people about the importance of promoting psycho-emotional health and opportunities for different age groups and family members of different generations, health day for senior citizens	N/A	Latvia	22	No
10	✓	Textiles for an Ageing Society	TAGS project	Austria (multi country)	22	Yes
11	✓	VITLAB – eHealth and eInclusion Innovation Ecosystem	VITLAB	Spain	22	Yes
12		My Home Fits / The Home Test	Mijn Huis Op Maat / Huistest	Netherlands	21	Yes
13		Campania Small Municipalities Collaborative Network	CosMiC-NET	Italy	21	No
14	✓	Salute & Risparmio	SARI	Italy	21	Yes
15		Promoting Physical Activity and Health in Ageing	PAHA	Belgium	20	Yes
16		REHACOP & REHACOG brain training for prevention of disability	REHACOP	Spain	20	Yes
17	✓	Mobilt dokumentationssystem inom hemtjänsten/Tidsregistrerings- och dokumentationssystemet, ParaGå	ParaGå	Sweden	20	No
18	✓	Mapping age friendly environments for the elderly and for people with physical disabilities	Map-AFE	Spain	20	Yes
19	✓	KINEAGE: Adapted Kinect game for exercise and fun	KINAGE	Spain	19	Yes
20	✓	Card Junta 65 - transport discounts and others benefits		Spain	18	No
21	✓	eZaintza	eZaintza	Spain		Yes
22	✓	Multidimensional integrated services to support independent living at home for people with chronic conditions	Autonom@Dom	France		Yes

The last TRL pilots have a lower than 20 score.

3.3 Summaries of the projects, including answers to questionnaire

Source: Summaries uploaded in the AFE-INNOVNET repository

1. ASSISTANT contributes to maintaining the mobility of older people in Europe, in order to safeguard their social and economic participation in an increasingly ageing society. It does this by helping them to travel safely and independently by public transport, enabling them to relax and enjoy the journey whilst doing so. ASSISTANT includes: • an on-line means of planning a trip • guidance on making multi-step journeys • an alert which tells the user when it is time to leave the vehicle. The project offers seamless support for the entire length of a journey, across different means of public transport, and in both rural and urban environments. The target group for ASSISTANT is essentially mobile older people, but the system is designed so it is accessible for all potential users.

2. Durango, Ciudad amigable: they may engage in participatory processes that examine how friendly their municipality is towards seniors in terms of housing, transportation, outdoor spaces and buildings, community support and health services, communication and information, civic participation and employment, respect and social inclusion, and social participation. The project has accomplished a thorough and participatory diagnostic study of the factors that enable and contribute towards active and healthy ageing processes, and has identify areas that need improvement. These areas have been included in an action plan that will be carried out in the next three years. The University is interested in finding out to what extent the participants in this process benefit form takin part in it in terms of wellbeing, and a sense of community. The municipality of Durango has recently joined the World Health Organization's Global Network of Age Friendly Cities and Communities.

3. Dem@Care aspires to contribute to the timely diagnosis, assessment, maintenance and promotion of self-independence of people with dementia, by deepening the understanding of how the disease affects their everyday life and behaviour It implements a multi-parametric closed-loop remote management solution that affords adaptive feedback to the person with dementia, while at the same time including clinicians into the remote follow-up, enabling them to maintain a comprehensive view of the health status and progress of the affected person. The system includes: a loop for people with dementia and their informal caregivers to monitor and assess their cognitive and behavioural status by integrating a multiplicity of wearable and in-situ sensors, enable time evolving context-sensitive profiling to support reactive and proactive care, and afford personalised and adaptive feedback. a loop for dementia clinicians to provide objective observations regarding the health progression of the person with dementia and medication effectiveness, warn about trends closely related to dementia (e.g. apathy), and support preventive care decision making and adjustment of treatment recommendations.

4. Ageing Well in Wales is a national Programme hosted by the Older People's Commissioner for Wales. It brings together individuals and communities with public, private and voluntary sectors to develop and promote practical and innovative ways to make Wales a good place to grow older for everyone. The Ageing Well Programme is actively supported by Welsh Government and key national organisations. It has a rapidly growing network of members encompassing diverse organisations and interests across Wales. Strong links are also maintained with partners across Europe, reflecting Wales being awarded the highest three star Reference Site status as part of the EIP AHA. The programme has five objectives: - to make Wales a nation of age-friendly communities. - to make Wales a nation of dementia-supportive communities. - to reduce the number of falls. - to reduce loneliness and unwanted isolation. - to increase learning and employment opportunities. For more information, email ageingwell@olderpeoplewales.com or refer to our website, www.ageingwellinwales.com.

5. The *Smart House Living Lab* objective is to research and develop in the Ambient Intelligence and Ambient (Active) Assisted Living context of technology and services to prevent, care and promote the health and welfare of people, support social inclusion and independent living of fragile and dependent groups, in all stages of the value chain: training, experimental research, technological development and technology transfer. The Smart House Living Lab is the main infrastructure for ICT R&D&I experiments and demonstrations. Since 2008 (3rd wave) SHLL is part of the European Network of Living Labs (ENoLL). Since 2014 SHLL is also part of the Laboratories and Infrastructures network of Madrid Region that aims at improving and facilitating the services provision offered by the research infrastructure and laboratories of the Madrid region.

Viability Questions Smart House Living Lab	
Time	More than three years
Investment per citizen	1000-5000 euro
Time of impact	Long-term and sustainable
Kind of impact	Better quality of life
Evidence	Documented
Maturity	Proof of concept
Transferability	Has been transferred

6. "*Life Long Living*" is a new model of interaction between the municipality and the elderly citizen who request practical or personal care and assistance. The intension of the initiative is to change the conditions of future care by focusing on the resources of each individual, and support empowerment instead of delivering traditional, compensatory and pacifying care. The focus in the welfare services is extended from providing care and practical assistance, to an overall focus on regaining physical, social and cognitive abilities. The objective is to postpone age-related weakening and dependence, and maintain independent living as long as possible.

7. Cities in Balance explored: empowering seniors to participate fully in community life; information and communication provision; securing social, financial and digital inclusion; business and employment opportunities. CIB grew two pilots that had run previously in Stockport called Manage your Money and Silver Entrepreneurs. In Cities in Balance we could run these across the whole city and extend our reach to Seniors. The Manage your Money pilot was a financial exclusion project targeting older people. The Silver Entrepreneurs Project was an employment project targeting older people to set up their own business.

Viability Questions Cities in Balance	
Time	Less than a year
Investment per citizen	100-1000 euro
Time of impact	Long-term and sustainable
Kind of impact	Better health Better quality of life Fewer isolated persons Creation of jobs or SMEs
Evidence	Documented
Maturity	Economically viable
Transferability	Ready for transfer

8. Senior Citizen's Board: the board cooperates with the city council and expresses the concerns of senior citizens regarding social care, social security, active ageing, cooperation between generations and other issues.

9. Lectures and seminars: celebrating the International Day of Senior Citizens on October 1, Kuldīga District Museum welcomes all seniors to visit the museum free of charge. Kuldīga Town Council organizes a health day for senior citizens offering different activities and visits to different specialists.

10. The *TAGS (Textiles)* project has four topics of research: Bedding Textiles Clothing Hygiene and Personal Care Textiles Therapeutic and Recreational Textiles For each topic we look into and asses the types of textiles currently in used by caregivers and/or the elderly. Through means of questionnaire analysis we also look into desired functions or features which would benefit both caregiver and elderly in terms of textile functionality. The idea is to collect new ideas/initiatives to generate new projects in which innovative textiles solutions are implemented into the manufacturing chain.

Viability Questions TAGS	
Time	Between one year and three years
Investment per citizen	No available calculation
Time of impact	Medium and long-term and sustainable
Kind of impact	Better quality of life Better care integration Creation of jobs or SMEs
Evidence	Documented

Maturity	On the market
Transferability	Has been transferred

11. VITLAB is an open innovation platform to promote an ecosystem to favor collaborative innovation processes in the field of e-Health and e-Inclusion. These processes are based on the capabilities of different agents involved in the creation of methodologies, tools and structures oriented to the development and the improvement of solutions for the main challenges in this field of SUDOE countries. VITLAB is a tool for supporting and exchanging of knowledge in order to encourage the development of social and healthcare innovation, mainly in rural areas.

Viability Questions Vitlab	
Time	Between one year and three years
Investment per citizen	No calculation available
Time of impact	Long-term and sustainable
Kind of impact	Better care integration
Evidence	Agreed
Maturity	Economically viable
Transferability	Has been transferred

12. Practical tool *My Home Fits* for awareness and information for older people on what improvements are possible in their own homes in order to leave independently for as long as they want. The tool is used by over 50 local authorities in the Netherlands and is meant to support local policy for independent living.

Viability Questions My home fits	
Time	Less than a year
Investment per citizen	Less than 100 euro
Time of impact	
Kind of impact	Better quality of life Shorter stays in hospital Creation of jobs or SMEs
Evidence	
Maturity	On the market
Transferability	Has been transferred

13. CosMic Net: the current economic crisis has been determining a general reduction of the services provided to European citizen, due to spending reviews applied to the Health Care system, to the Social Services, to Schools. This has determined a further reduction of funding allocated to city environments and spaces, that are currently unfit to the challenge of an aging population. Most small municipalities do not possess alternative funding, and cannot sustain the initial investment required by the internationalization effort. Aim of this project is to create a network of small Municipalities in Campania Region, to build up their capacity to join European initiatives.

14. The goal of *SARI 2000* is an insurance service and wants to take care of everyone's health. We would like to allow anyone to benefit from high quality, timely and cost-effective diagnostic health services. We would like to develop and improve the prevention phase, extremely too expensive, both for the Sate and the traditional Insurances.

Viability Questions SARI 2000	
Time	More than three years
Investment per citizen	No calculation available
Time of impact	Longterm and sustainable
Kind of impact	Better care integration
Evidence	Documented
Maturity	Economically viable
Transferability	Not been considered

15. The *Promoting Physical Activity and Health in Ageing (PAHA)* project is a tailored intervention for older adults with different functional capacities. Through a supervised and structured exercise programme for senior citizens (55-65 years old), PAHA intends to convert currently inactive people into regular exercisers at a level that is beneficial to their health, supporting the EU Guidelines on Physical Activity and the European Week of Sport. In each one of the 8 project partner countries – Denmark, Finland, Germany, Greece, Hungary, Ireland, Portugal and the United Kingdom – 3 fitness centres will run 3 trial sessions of supervised exercise of 6 weeks duration, for 15 participants at each session. For that purpose, the fitness coaches, instructors and other community workers involved in the project will receive specific training on both motivational skills and in active ageing promotion. The participation in the trial periods will be free and the older adults who take part in the project will be offered preferential arrangements for them to continue exercising for a minimum of a further 6 months period as well as some non-monetary incentives. Last but not least, proper measurement and assessment will be crucial. Through a comprehensive evaluation system, the PAHA Project will develop transversal standards that will be made available for education structures of sports organisations across Europe. The aim is to create a methodology that can easily be adapted and replicated in different settings, allowing more citizens to take up regular exercise and health-enhancing physical activities.

Viability Questions PAHA	
Time	Between one year and three years
Investment per citizen	100-1000 euro
Time of impact	Longterm and sustainable
Kind of impact	Better health Better quality of life Fewer isolated persons Creation of jobs or SMEs
Evidence	Agreed
Maturity	Idea

Transferability	Ready for transfer

16. REHACOP brain training has just recently been completed and local institutions through the Regional Government (Diputación Foral de Bizkaia), are looking forward to extending the experience to further similar environments for the maximum population benefit. This initiative was presented initially in the participants' environment to know the process and encourage them to participate. They also provided feedback to the agents about their thoughts, worries and recommendations of improvements. This feedback, when possible, was implemented into the activity.

Viability Questions REHACOP	
Time	Between one year and three years
Investment per citizen	100-1000 euro
Time of impact	Longterm and sustainable
Kind of impact	Better health Better quality of life Fewer isolated persons Better care integration Fewer hospital re-admissions Shorter stays in hospital Creation of jobs or SMEs
Evidence	Agreed, including peer reviewed articles
Maturity	On the market
Transferability	Has been transferred

17. The time registration system *ParaGå* enables better monitoring, improved quality and more efficient administration. With ParaGå, the municipality can monitor the amount of time care providers spend in/attend the elderlys home in a completely different way, so that the elderly people get the time and services they are paying for and the city re-imburses. Before, this was manually handled. Today, about 6 000 people regularly use ParaGå to register visits and other kind of services provided. Each month a total of one million visits to nearly 20 000 people with home care services, is registered. MORE TIME FOR THE ELDERLY PERSON For the home care providers, the new system stimulates more time spent at the elderly person's home. It is now also possible for the municipality assessors to follow up the services provided. At the same time this also saves Money both for the municipality and for the (private) home care providers. All staff within home care service has been equipped with smart phones and through the application ParaGå Android - which is connected to the City's IT-system, they register the time spent with the elderly and are also able to make journal entries/notes.

18. Map-AFE: "Friendly Cities for All" is a citizen science project in which Secondary Education (ESO) students get involved in the reporting of urban accessibility of their environment. To this end, a space for collaboration between ESO students, professional users and elderly people associations, teachers, researchers and

representatives of the municipal administration will be generated; where the scientific role will rely on ESO teachers while the other agents act as chaperones in the process of the scientific action The ultimate goal is that ESO students complete all the phases of a scientific project which promotes civic awareness on urban accessibility: with the formulation of hypotheses; data collection, interpretation and analysis and presentation of findings to stakeholders. For this it is indispensable to form students "technologically" (open data sources, tools for visualization and analysis of geospatial data, etc.) and "socially" (concepts of accessibility). Thus, from different areas, knowledge and community experts, they learn how to do science while making a real contribution to their environment (Service-Learning methodology) with specific products (such as making accessibility reports or friendly routing). In fact, the foundation of the project from the perspective of the functional diversity, allows a broader conception of disability and / or aging; not only in terms of age groups and barriers, but from a global perception of the rights, opportunities / bias settings, surpassing the model that highlights the difficulties in and from the people. Interdisciplinary and cooperative learning are essential in this proposal. Thus, the relationship between the scientific process, technological development and civic engagement of students in dialogue with society is consolidated.

Viability Questions Map-AFE	
Time	Less than a year
Investment per citizen	100-1000 euro
Time of impact	Demonstrated: low impact Supposed: Long-term and sustainable
Kind of impact	Fewer isolated persons
Evidence	Agreed
Maturity	Economically viable
Transferability	Ready for transfer

19. Kineage system is divided into two sections, devoted to physical and cognitive rehabilitation respectively: Physical Rehabilitation: This part of the game consist of three different levels in which the user should collect various objects appearing on the screen by moving the arms, in order not to let the objects fall, promoting this way both the mobility of the user during the training (game play) and the cognitive process. Firstly, and in order to do the game more generalized, the game allows to specify the typology of the user, i.e., with or without any movement in their legs (use of the wheelchair), and giving the player the option to play standing or sitting. Additionally, users may present limit mobility in either arm (even absence of absolute movement in either of the two members), thus being the game configured in such a way that the user can choose if it wished to play with the left arm, right arm or both. The game displays three different levels of three minutes each to avoid fatigue in training. In the first level, the objects (cupcakes and bottles of wine) shall follow a vertical path. In the second level the number of these objects increases and in the level three the objects follow a horizontal path. At the end of each one of the levels

the user shall reach a piece of cake, until achieving as a final reward a whole cake after finishing the three levels. Cognitive Rehabilitation: The main purpose of this part is to improve the memory and psychomotor activity by performing activities, as well as encouraging them to do physical exercise. A range of exercises, in which the user must perform various physical motions in order to solve them, have been developed following the clinicians' recommendations. In these activities the user has to memorize images or relate numbers to their corresponding de nition (1-one), amongst others. The objective is to choose the correct answers (images) by moving the correct arm and thus improving the psychomotor activity of the patient. Even by having a total lack of knowledge of new technologies, the users are able to play the game, learn about its use and apply this knowledge in other technological fields, addressing the problem of the digital divide.

Viability Questions Kineage	
Time	Between one year and three years
Investment per citizen	100-1000 euro
Time of impact	Long-term and sustainable
Kind of impact	Better quality of life Fewer isolated persons Better care integration
Evidence	Documented
Maturity	Proof of concept
Transferability	Not been considered

20. The *Junta 65 Card* is a free document that is at the disposal of people over 65 years old provided by the Regional Ministry of Equality and Social Policies of the Government of Andalusia, through the Agency of Social Services and Dependency of Andalusia. It is an ITC tool, provided with chip and magnetic stripe, about the services for elderly people, with no more formality. It was created in 2001 and it's used for a period of 5 years. Its renovation is also free. With this card elderly people can enjoy of services and benefits in a very quickly and easy way: discounts, grants, access to programmes, etc. Between these services the cardholders have a discount of a 50% in the public interurban transports of general and permanent use, with origin and destination inside the Andalusia Region, that are provided by the companies that have signed an agreement with the Agency of Social Services and Dependency of Andalusia. Other services provided by the Junta 65 Card are in relation with the Tele-assistance Service in Andalusia, discounts in optical goods and hearing aids, legal advice service, dinning service, etc.

21. eZaintza is a system that provides care for people with problems of temporal and spatial orientation, and support for their carers. Its aim is to improve self-esteem, confidence, wellbeing and, at the end of the day, the autonomy of people, in addition to improving social and medical intervention in prevention and care. It can be used in a family environment, or can be a work tool for professional carers, and can even be connected with telecare services.

Viability Questions eZaintza	
Time	Between one year and three years
Investment per citizen	100-1000 Euro
Time of impact	Medium
Kind of impact	Better quality of life Fewer isolated persons Better care integration
Evidence	Documented
Maturity	Economically viable
Transferability	Not been considered

22. Autonom@Dom® aims to combine a broad range of personal and technology services and assistance for people in need of care who want to stay at home. It covers telecare, telehealth and telemedicine, personal and household services and medical assistance available 24/7 through a telephone helpline. Autonom@dom is based on a call-center and an open software platform for service integration, acting as a one-stop shop for demands and needs for health care and social care from different stakeholders (professionals, older people, families, social workers, carers). It is based on the cooperation between health and social care professionals, the private and the public sector and enabled by ICT and data sharing and analysis. Besides the professional coordination centred on the individual need of the person, services will be proposed to different cohorts of users: - Retired people: Support for personal management and empowerment, based on physical activity, cognitive stimulation, nutritional education and social activities. - Seniors at risk of losing their independence: A prevention program plus a fall prevention program and remote surveillance and monitoring of motor and cognitive activity - Patients suffering from chronic diseases (diabetes, heart disease, Alzheimer's disease, epilepsy): The same package for the group above plus integrated care and remote surveillance and monitoring - Patients suffering from cancer: Coordination of health care and social care, scalability of home services, secondary prevention and remote surveillance -A one-stop front office for anyone facing health or social difficulties, or looking for a home service.

Viability Questions Autonom@Dom	
Time	More than three years
Investment per citizen	Not available
Time of impact	Long-term and sustainable
Kind of impact	Better health Better quality of life Fewer isolated persons Better care integration Fewer hospital re-admissions Shorter stays in hospital Creation of jobs or SMEs
Evidence	None
Maturity	Proof of concept

Transferability	Ready for transfer

3.3 Evaluation of the responses on viability

The above 22 identified initiatives were invited on 5 October 2015 to answer questions about viability (for procedure see Annex). We received 12 filled-in questionnaires (54%).

Breakdown of the 12 viability reports received.

Country breakdown

Country	Count
Spain	6
UK	2
France	1
Netherlands	1
Italy	1
1 Multi-country	EU funded: Denmark, Finland, Germany, Greece, Hungary, Ireland, Portugal and the United Kingdom

Spain is very well represented (50% of the answers received). This suggests that Spanish organisations have been effectively mobilised to participate in EIP AHA and EU processes and/or that Spain has many examples of innovative, transferable and scalable projects.

Western or 'old member state' EU countries dominate this list. While this could well suggest that these countries have scalable and transferable projects than other parts of Europe, more likely it also suggests that they are better connected to EIP AHA processes. Surprisingly, given resource availability, no countries from Scandinavia are represented.

The one multi-country example suggests that the EU can (and should) play an important role in trying to encourage development of scalable and transferable practices that have a multi-country and cross-border character. Such multi-country examples could aim to involve countries that are currently not well connected.

Time needed from baseline to deployment

Time in years	Count
< 1	3
1 to 3	6
3+	3

Most of the initiatives are developed in the medium and long term that suggests that successful initiatives for AFE need from 1 to 3 years to deliver quantifiable results.

Investment per citizen

Investment per citizen in euro	Count
< 100	1
100-1000	6
1000-5000	1
Not calculated	4

The investment per citizen calculation could be considered part of a cost-benefit calculation. Evidence suggests that cost-benefit calculations are increasingly important in advocacy efforts (of which advocating for the scaling up of an intervention is arguably a part)[8]. As such, however crude they are, cost-benefit calculations are important in evaluating how likely an intervention is to be scaled up. It is therefore surprising that a large number of interventions did not provide a calculation.

It is important to note that cost categories in this exercise are very 'wide'. For example, 1000 euro is ten times more than 100, and 100 euro is 100 times more than 1 euro.

Of course, investment per citizen can only really be assessed alongside the kinds of impact it has on a citizen; this could cut across domains (independent living, mental health, social inclusion, health) and time (short-term only, medium to long-term effects, etc.). If an intervention has very little impact then less than 100 euro per citizen could still be considered good value for money. However, if the intervention has very little impact and costs in excess of 1000 euro per citizen then it is probably much less likely to be considered interesting.

Time of impact

Time of impact	Count
Medium-term impact	1
Medium-term & long-term impact	1
Short-term & long-term impact	1

[8] See for instance: 1) FARRER, L., MARINETTI, C., CAVACO, Y. K. and COSTONGS, C. (2015), Advocacy for Health Equity: A Synthesis Review. Milbank Quarterly, 93: 392–437. doi: 10.1111/1468-0009.12112. Available at : http://onlinelibrary.wiley.com/doi/10.1111/1468-0009.12112/abstract. 2) DRIVERS Advocacy Toolkit - HOW TO MAKE USE OF ECONOMIC ARGUMENTS IN POLICY MAKING AND ADVOCACY? Available at: http://health-gradient.eu/wp-content/uploads/2015/02/Economic-arguments-4-advocacy.pdf.

Long-term impact	7
No response/No evidence	2

It is clear that projects see their potential impacts as taking place in different timescales – e.g. short and long-term impacts. This seems realistic, but of course needs to be backed by evidence. It would be interesting to see where the impacts are made during the beneficiary lifecycle of an intervention, though this of course depends on intervention type.

Evidence behind innovative practice

Type of evidence	**Count**
Agreed evidence	4
Documented evidence	6
No response/Too soon to say	2

It is often difficult to say whether evidence is ‘agreed’ in the academic world, rather than simply documented in some way. The large number of ‘agreed evidence’ interventions suggests that interventions consider ‘agreed’ by a different yardstick.

Evidence behind interventions should come from suitable methodologies, which may not always align with the scientific ‘hierarchy of evidence’, which puts RCTs at the top and qualitative interviews towards the bottom. Some kinds of evidence will be harder to ‘agree’ than others – but that does not mean that efforts should not be made to document them. For instance, assessing the qualitative impacts of interventions on mental well-being may be challenging, rather than collecting quantitative data about ‘visits to GPs’, but could be indispensable for demonstrating whether an intervention does what it intends to or not.

In addition, research needs to focus on transfer of evidence; it is well-known that transferred interventions often lose effectiveness (compared to where they were first implemented).

Level of Maturity

Level of maturity	**Count**
Economically viable	3
Economically viable & on the market	3
On the market	2
Pre-proof of concept	1
Proof of concept	3

It is very encouraging to see the interventions considered here as being predominantly on the market or economically viable.

However, whether or not an intervention is 'economically viable' will depend on externalities – costs or additional revenue added or subtracted from other actors in the economy. For instance, an intervention may be economically viable to the organisations implementing or funding them, but they could impose additional costs elsewhere (e.g. redundancies, reduced demand in the economy for certain services or products, downwards pressures on skills of jobs).

Transferability	Count
Has been transferred	5
Not considered	3
Ready for transfer	4

It is encouraging that 5 of the interventions we identified had already been transferred, and that another 4 were ready. However, and given how important transfer is as part of innovation, it is concerning that 3 of the interventions had not considered it – though it is understandable that one pilot (SARI 2000) wanted to keep their product (insurance service) only for themselves. For the other there are almost certainly understandable reasons for this, such as lack of capacity, the interventions still being implemented or developed in the pilot region, etc.

Transferred pilots

Above exercise shows a lot of diversity in answers. To learn if we can draw any conclusions from the pilots that have been transferred to other levels, regions or countries we have a closer look at them:

Table 3: Initiatives with transferred pilots

Name	Time	Investment	Evidence	Maturity
Smart House Living Lab	3+ years	1000-5000	Documented	Proof of concept
TAGS	1-3 years	NA	Documented	On the market
Vitlab	1-3 years	NA	Agreed	Economically viable
My home fits	<1 year	< 100	NA	On the market
REHACOP	1-3 years	100-1000	Agreed	On the market

From above table we learn that most common is:

- A preparation time from 1 year to 3 years (60%).
- The product/service/innovation is already on the market (60%).

Conclusions and recommendations

- **What do we learn when we use the method by looking at the TRL or the QRM?**

The two methods used differed substantially, but led to similar (though not identical results). Both methods can be adapted, combined or used as they are – meaning they are quite flexible. In principle, they should both achieve the same goal: identifying the most promising practices for scaling up. They both suffer the same weakness: they rely on information submitted by third parties.

The following table summarises some of the main characteristics and differences between the two approaches:

TRL	QRM
Quick, requires little effort	Thorough, requires more effort
Relies on informants knowledge of TRL	Does not rely on informants knowledge of TRL
Excludes initiatives that have not entered a TRL, or have entered one that is below TRL 7-9	Does not exclude initiatives that have not entered a TRL, but does exclude those that entered a TRL under levels 7-9
Appears to favour initiatives that are more IT based	Does not appear to favour initiatives that are IT base
Leads to a pool of initiatives with no ranking or differentiation	Leads to a ranked pool of initiatives with scores for certain criteria
No qualitative assessment and use of text responses	Qualitative assessment undertaken, disfavours those responses without free-text responses
Requires less time from submitters (though suggests questionnaire collected superfluous information)	Requires more time from submitters

- **What can we say about the viability/scaling up of the high ranked submissions?**

It is difficult to assess differences between high ranked initiatives and those with a lower ranking. This is because: 1) we did not receive responses to the viability questionnaire for initiatives with the highest scores (27-24), and only received viability questionnaires for those scored (23-19) which seems to narrow a band to comment.

- **What recommendations do we have for the repository or questionnaire?**

In theory, a minimum number of question fields should be included in the questionnaire to encourage people to enter data, and to enter data fully.

The type of questionnaire employed will depend on the type of analysis conducted. For this reason, use of the TRL assessment suggests that far too many fields of information were requested. However, the QRM made more thorough use of the data supplied. In both cases, however, there were fields that were not essential to the exercise, and which represent a loss of effort.

A more streamlined questionnaire would allow the viability questions to be incorporated. This would reduce the 'time lag' between filling the questionnaire and receiving the viability report – which could be several months. In time-limited initiatives, in those where funding could come to an end without further market interest, or where there is staff turnover, this lag in time reduces response rate to the viability questionnaire.

Open text responses were important for the QRM, but not for TRL. Open text responses require thought and effort on the part of respondents, and should be limited. Where they are used (which should be dependent on the type of evaluation), explanation should be given of precise information requested (that relevant to the evaluation question and scoring), and limits on length imposed.

Relating both to TRL levels and the open text responses, we saw considerable differences in understanding of key concepts. Short explanations of what TRL levels, data, different terms, should be provided to improve accuracy and cross-comparability of responses.

Some of the categories, particularly relating to cost per beneficiary and budget, were particularly large. This begs the question of how useful these large categories are to evaluation.

Finally, there was a surprising lack of cross-member state co-operation on submitted initiatives. The pool of respondents is likely to include some of the most attuned stakeholders to European funding and policy developments, yet few initiatives were worked on by multi-member state teams. This suggests a need for European funding to encourage such initiatives – as these are likely to tackle the specificities of culture, economy, language, etc., from the outset and perhaps be much more viable in terms of scaling up than initiatives developed (in isolation) in certain localities or regions without cross-cultural and cross-member state exchange and feedback.

It would be a great shame if no further use was made of the information collected in the repository. At the very least, the contacts and organisations included are a useful pool of supportive contacts and experts for creating and sharing ideas and tackling the challenge of demographic ageing.

Annex: Assessment of viability

Invitation email

In the AFE-INNOVNET project we assemble notable practices of age-friendly environments across Europe. Your initiative is one of them. Part of the AFE-INNOVNET project is also to make an analysis of 5-10 innovative initiatives with potential for scaling up. We identified your initiative as one of them. We intend to make a report of these initiatives with a short description of each initiative and an analysis of the main success factors and barriers.

We kindly invite you to answer 6 questions in attached questionnaire about viability and return the questionnaire to me before October 21th. It is no problem if you could only tick your information in the 6 multiple choice questions, but we would very welcome if you could provide us also with the requested additional information.

The questionnaire has been developed in the EIP AHA action groups together with the European Commission. It is part of the Scaling-Up strategy the EC launched last year.

If you have any further questions or comments, please don't hesitate to contact me.

1. Time needed for the practice to be deployed (from the baseline to now) [9]

In the following, please estimate how much time you have spent in your region / organisation from deciding to work with the specific challenge that you faced at the point of the baseline until deployment of the practice.

Time needed from baseline to deployment	**Please indicate**
No evidence or no record kept of prior preparation	
Less than a year	
Between one year and three years	
More than three years	

[9] This dimension is about the time needed to undertake the initiative, how to prepare for the introduction of the initiative at the right time, or how to make time available to attract the critical people involved, e.g., by establishing priorities, setting deadlines, and applying appropriate phasing and staging. It is important to be aware of the length of time that has to be used to prepare the implementation of the innovative practice. The time involved in deploying the practice may have been substantial. In some cases, you may have kept no record of the length of time it took (since you did the work so long ago).

Please explain what you did to prepare the implementation of the innovative practice (max 2,000 characters). Insert relevant web-based links if possible

2. Investment per citizen / service user / patient (from the baseline to now)[10]

The cost of investment is a calculation of costs (from the baseline until deployment of the practice). It can include e.g. expenditures related to such examples as feasibility studies, development of (technological) solutions, acquisition of material, and training of staff.

Investment per citizen / service user / patient (from baseline to now)	Please indicate
No available calculation	
Between 100 – 1.000 EUR per targeted citizen / patient	
Between 1.000 – 5.000 EUR per targeted citizen / patient	
More than 5.000 EUR per targeted citizen / patient	

Please explain your calculation of cost and total budget of the initiative (max 2.000 characters). Insert relevant web-based links if possible

3. Time of impact of the practice (from baseline to now)

Impact is a measure of the extent, and way in which, an innovative practice "makes a difference" to society in general and the stakeholders involved in that practice in particular. Hence, Impact is the determining outcome factor. There are many

[10] A political decision process is very often based on an available budget, hence it is very important for potential stakeholders to get an understanding of the investment involved for the specific group of citizens, service users, or patients that is targeted.
The actual calculation of the cost of investment may differ substantially among practices depending whether your practice involves e.g., volunteers, is a public health information programme or the acquisition of expensive technologies.

methods and approaches to assess impact on the market. What they have in common is that impact is generally assessed against a baseline scenario of the consequences of continuing a current practice (this is known as the “cost of doing nothing”)

This dimension focuses on the time of impact. What are the main aspects of the time of impact that the practice addresses?

In the following, please indicate at which period of time impact began to emerge.

Time of impact of the good practice	**Please indicate**
No evidence or no demonstrated impact	
Low impact – e.g. impact has been seen only while a pilot project was running	
Medium impact – e.g. shortly beyond the pilot project period	
Longterm and sustainable impact – e.g. a long time after the pilot project ended and routine day-to-day operation began	

Please explain the aspects of the time of impact that you have identified and how you have identified it (max 2,000 characters). Insert relevant web-based links if possible

What kind of impact did you observe	**Please indicate**
Better health (societal)	
Better quality of life (societal)	
Fewer isolated persons (societal)	

Better care integration (economic and societal)	
Fewer hospital re-admissions (economic)	
Shorter stays in hospital (economic)	
Creation of jobs or SMEs, or a growth in local companies	

4. Evidence behind the practice

In order to give the users of the repository an overall understanding of the level of evidence available in relation to your practice, please indicate on which level your practice can show evidence. The figure below shows you graphically four levels of evidence. After looking at it, please then complete the table below.

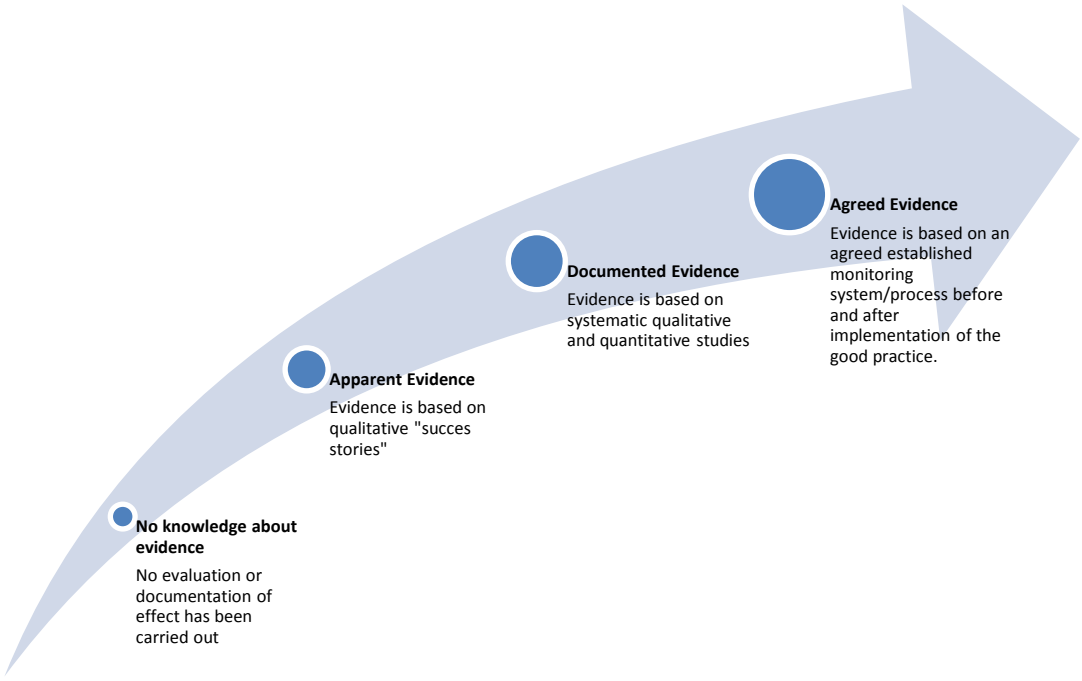


Figure 1: Four levels of evidence

Evidence behind the innovative practice	Please indicate
No knowledge about evidence	
Apparent evidence	

Documented evidence	
Agreed evidence	

Please explain what you did to create the evidence for your practice (max 2,000 characters) **Insert relevant web-based links if possible**

5. Maturity[11] of the practice

Maturity of the practice	**Please indicate**
The idea has been formulated and/or research and experiments are underway to test a 'proof of concept'.	
Proof of concept is available: it works in a test setting and the potential end-users are positive about the concept.	
There is evidence that the practice is economically viable and brings benefits to the target group. Further research and development is needed in order to achieve market impact and for the practice to become routine use	
The practice is "on the market" and integrated in routine use. There is proven market impact, in terms of job creation, spin-off creation or other company growth.	

[11] Maturity is a measure of how far an initiative already is along the road from initial idea to standard practice. Information on the maturity of a practice is important from a viability viewpoint so as to match innovative practices to the needs, capabilities and expectations of those interested in adopting them.
If people are looking for practices that have proven themselves in everyday routine and, instead, they get something that is still in early pilot stage, that is not going to work. Conversely, someone looking for cutting-edge innovation that pushes the envelope is going to be disappointed by a finished initiative because they "already know that".

Please explain the maturity level of the practice (max 2,000 characters) **Insert relevant web-based links if possible**

6. Possible transferability of the practice

This dimension is based on four levels which can be described in the following way:

1) The innovative practice has been developed on a local/regional/national level and transferability has **not been considered** in a systematic way
2) The innovative practice has been developed on local/regional/national level and transferability has been considered and structural, political and systematic recommendations have been presented. However, the innovative practice has **not been transferred yet.**
3) The innovative practice has been **transferred** to other locations or regions or national scale **in the same country**
4) The innovative practice has been **transferred** to either at local, regional or national level **in at least one other country**.

Level of transferability	**Please indicate**
Transferability has not been considered	
Ready for transfer but the innovative practice has not been transferred yet	
The innovative practice has been transferred within the same country	
The innovative practice has been transferred to at least one other country at some level	

Please explain the transferability that you have identified and how you have identified it (max 2,000 Characters) **Insert relevant web-based links if possible**