<table>
<thead>
<tr>
<th>Programme’s name:</th>
<th>National Network for Integrated Continuous Care - Integrating health and social services for prevention and rehabilitation</th>
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<tr>
<td>Original title:</td>
<td>Rede Nacional de Cuidados Continuados Integrados (RNCCI)</td>
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| Organisation/Country: | Central Administration of the Health System (ACSS.IP – Administração Central do Sistema de Saúde)  
Institute for Social Security (ISS – Instituto da Segurança Social) Portugal |
| Website: | More information available [here](#) (in Portuguese) |
| Contact: | Gabriela Maia: [gmaia@acss.min-saude.pt](mailto:gmaia@acss.min-saude.pt)  
Director of the Department of Services for Network Management and Resources in Health, ACSS.IP |
| Summary: | The network was set up in 2006 jointly by the Ministries of Health, Solidarity and Employment and Solidarity and Social Security. |

**Registration & Assessment procedures**
- registration of the patient online through the platform *GestCare CCI*
- assessment of the application by the workers in the primary health care centres (CS) or hospital discharge management team (EGA) to check the availability within the network and development of a personal need
- transfer of the patient’s folder to the Local Coordination Teams (LCT) which then review the patient’s situation and the adequacy of the care suggested by EGA/CS
- admission of the patient into the units of the National Network for Integrated Continuous Care (RNCCI)

The network works at four operational levels and is backed by the online monitoring system for data management, which facilitates online registration of patients, storage of individual care plans, and easy transfer of real-time data between the different units and teams in the network.

The ACSS.IP is the national authority for the coordination and management of the network and is responsible for:
- elaborating guidelines regarding certification criteria, accreditation, quality assessment and global strategies (financial aspects);
- drafting terms of reference for contracting with public or private social care providers within the network;
- analysing data in the online monitoring system.

At the regional level, the five Regional Coordination Teams (ECR) working in regional health administrations and social security districts are in charge of:

- ensuring the equity of access and availability of services,
- reviewing the number of beds available in the units and the effective use of services,
- promoting the conditions developed in partnership with ACSS.IP and the local teams to ensure quality standards in the units,
- managing the communication between the different partners.

Finally, 90 Local Coordination Teams (LCT) work in primary health centres and local councils for:

- assessing individual care plans,
- deciding on the admission of care recipients in the RNCCI,
- ensuring further pooling of resources,
- following up on visits to assess the activity of multidisciplinary teams and the audits of inpatient units every three months.

The network contributes to the sustainable development and modernisation of the national health service and the public social security system. It also promotes different types of health care and social support. The organisations involved in the network are public authorities with administrative and financial autonomy such as hospitals, non-profit organizations as well as private care organisations and health centres providing primary health care.

The network links hospitals and primary health care centres with the social sector and community actors, like patients, families, peer supporters and volunteers. Integrated care services aim at total recovery, provide preventive interventions or offer support in the acute phase of illness. The services include rehabilitation, re-adaptation, social inclusion and the provision and maintenance of well-being and quality of life, even in situations with no possibility of recovery.

The different units and teams account for the different kinds of services.

<table>
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<tr>
<th>Residential units</th>
<th>Integrated long-term care teams</th>
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<tr>
<td>Convalescence care</td>
<td>Home care</td>
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<tr>
<td>Medium term care and rehabilitation</td>
<td>Palliative care</td>
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### Target groups
A range of target groups are the recipients of these services:
- frail older people;
- people in an advanced or terminal stage of a disease;
- people with an acute disability with a serious psychosocial impact;
- people with a temporary functional dependency resulting from recovery or another process;
- people with a long-term functional dependency;

### Issues:
The need for improving the quality of care has been underlined as a major issue in recent years, especially in the fields of residential care and nursing homes. Consequently, national programmes have been implemented to increase the number of places available and to facilitate quality inspections.

### Resources:
The budget is shared between the health and social security sector, with the particular share of cost coverage dependant on the provided type of care. The provided financial support is specific within the budget, with adequate and periodically reviewed prices to ensure the continuity of quality care provision. The payment for medium-term care, rehabilitation programmes, and residential long-term care is shared between the dependent person according to personal or family income. In December 2014, the programme offered 7,160 places and embraced 48,299 users as registered persons.

### Objectives:
- Providing integrated long-term care (both medical and social care) to people who are in a situation of dependency.
- Supporting assisted individual autonomy and consequently the opportunity for older people to stay at home;
- Strengthening informal carers' skills and involvement;
- Improving the quality of residential care (nursing home) by implementing the “Strategy for Quality” and systematise inspections.
- Enhancing the involvement of dependent persons and their family in the provision of care.

### Outcomes:
- Development of a network for long-term and palliative care.

### Evaluation:
An online data management system allows national coordinators to have real time data from the national, regional and local level. This ongoing monitoring allows the implementation of a continuous improvement policy
with training and guidelines. Data on the following aspects can be registered online:
- referrals,
- admissions,
- autonomy/dependence in activities of daily living,
- pain evaluation,
- nutrition status,
- falls, and
- use of pharmaceuticals.

Resources: Find [here](#) the 2014 monitoring report on the RNCCI (in Portuguese)

ESN publication: [Retaining and regaining independence and inclusion in later life: the role of social services](#), October 2012.