

---

## CONFERENCE ABSTRACT

# Understanding intermediate care development, supporting implementation and scaling up of intermediate care in Europe

16<sup>th</sup> International Conference on Integrated Care, Barcelona 23-25 May 2016

Verdiana Morando<sup>1</sup>, Claire Holditch<sup>2</sup>, Marco Inzitari<sup>3</sup>, Valeria Tozzi<sup>4</sup>, Anne Hendry<sup>5</sup>

1: SDA Bocconi, school of management, Italy;

2: NHS Benchmarking Network, United Kingdom;

3: Parc Sanitari Pere Virgili, Barcelona, Spain;

4: SDA Bocconi, school of management, Italy;

5: National Clinical Lead for Integrated Care Joint Improvement Team, Scottish Government, Scotland.

---

Intermediate care (IC) provides an integrated approach for service users at key points of transition in the system, stepping up or down from hospital. The issues intermediate care seeks to address are common across Europe but there is wide variation in the solutions being implemented. For instance, there are significant variations with the definition of IC, a clear understanding of the scopes, organisational patterns and professionals involved and the types of services users. Even within countries, service models and capacity between regions display great heterogeneities.

The paper aims to understand the development of IC in Europe, providing a synthesis of the current development of IC in Europe and using benchmarking studies undertaken in the England, Catalonia Region (Spain) and Scotland to spread learning and good practice in this important area.

In the UK, the provision of IC services became a national policy in 2001, whereas the first National Audit of Intermediate Care (NAIC) was conducted in 2012 to understand how IC had developed in terms of scale, scope and quality. The study was extended in 2013 to cover crisis response and social care re-ablement services, in addition to bed based and home/community based IC, and to incorporate clinical outcome and patient experience measures. The audit is now in its fourth iteration (NAIC 2015) and the results suggest IC is now well developed in the UK, although the scale and nature of provision varies considerably. The findings from NAIC 2015 deliver a range of performance indicators including, outcome measure scores over users' functional outcome from their episode of intermediate care; the access to IC services measured by the proxy of the average waiting times; the level of care integration and the development of tools to foster these processes; and, finally, the workforce employed in IC, focusing on the ratio of registered nursing compared to unregistered health staff. Further, in considering the overall need for IC, it was calculated in NAIC 2012 that intermediate care capacity in England needs to approximately double to meet potential demand. However, as in NAIC 2013 and NAIC 2014, there is no evidence in NAIC 2015 of a material increase in capacity

Morando; Understanding intermediate care development, supporting implementation and scaling up of intermediate care in Europe.

nationally which may be due to the fragmented nature of health and social care funding arrangements in the UK. Scotland has also introduced a national policy on IC with a national framework and underpinning principles that can be tailored to local context. A community of practice and web portal to share learning and good practice case study examples support IC development. Benchmarking data is being progressed through a national health and social care data project that will link client or patient level data to allow IC activity and resources to be viewed within the whole system pathway of care.

In Catalonia, IC has been homogeneously implemented, with a population-based distribution, since 1986. IC services are bed-based (convalescence and rehabilitation, palliative care, long term care), ambulatory (day hospital, outpatients) and home-based. Quality indicators for each type of service are homogeneously set, and accomplishment is associated to a % of reimbursement. Recently, in 2014, shared indicators between institutions operating across different levels of care of a same area have been introduced, to promote integrated care and common goals. Other sources of data include patient level activity data (admissions, discharges etc) and data of patients' Minimum Data Set (a simple comprehensive geriatric assessment), also matched with acute hospital data and users' satisfaction, all centrally collected and virtually available for 100% of institutions. These data are the basis for the benchmarking initiative, publicly available since 2014, which includes areas of case-mix, functional improvement, discharge destination, length of stay, satisfaction, and costs, among others.

The paper intends therefore to discuss the dissemination of health policies to encourage the development of IC in Europe, providing a first rapid evidence synthesis on the current situation and a comparative analysis using benchmark and outcome data available in this field. Whereas this major strand represent a common denominator between European and Western Countries to achieve integrated care delivery system, there is a lack of consensus on the definition and purpose of IC. Where IC have been recently introduced, in fact, they result more akin to organisational adjustments and temporary solutions replacing the cuts from other services in the supply chain (hospital beds or personnel in long term care settings), but they struggle to achieve autonomous organisation in the health service delivery system. This variation in progress with IC highlights the value of comparing different experiences across Europe and sharing learning from countries with experiences in areas such as the development of performance indicators and benchmarking evaluative processes.

---

**Keywords:** intermediate care; post-acute care; comparative policy analysis; benchmarking

---