The landscape for bed-based intermediate care in Scotland.

Royal College of Nursing Scotland

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Introduction

Interest is increasing in Scotland in intermediate care as a way to deliver better outcomes for people while reducing pressure on acute hospital beds. Intermediate care services can be used to help people return home without delay or stay at home where hospitalisation is not necessary.[1] There are already a number of different models of intermediate care operating in Scotland.

Regardless of where a person receives care – in an acute hospital, a community care setting, or at home – they should expect that it will be safe, of high quality and enable them to meet the health and wellbeing outcomes that matter to them.

While intermediate care services should be delivered by a multidisciplinary health and social care team, registered nurses have a significant role to play in the delivery of intermediate care services, and their commissioning, procurement and design.

This report focuses specifically on bed-based intermediate care. This model sits at the intersection of a number of the Scottish Government's key strategic areas of work, including health and social care integration, but it has not yet been delivered to the scale to which the strategic vision aspires.

The report aims to set out, from a professional nursing perspective, what RCN Scotland knows about the landscape for bed-based intermediate care in Scotland, and about the evidence that shows what works well for intermediate care.

Alongside this report, RCN Scotland has also developed a tool for nursing leaders who are involved in decision making relating to bed-based intermediate care – whether as part of a commissioning body, in procurement, design and delivery, or in a trade union partnership role. The tool sets out overarching themes on the basis of existing evidence, and within each theme, some questions to consider. The tool is available here.

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Theresa Fyffe
Director, RCN Scotland

Bed-based intermediate care in Scotland

The Scottish Government's vision is for a health and social care system that focuses on prevention, anticipation and supported self-management, and care at home or in a homely environment, to enable people to live longer, healthier lives at home. Equity of access to services and people's individual human rights are also part of the vision for health and social care. The Scottish Government's Integration Planning and Delivery Principles[2] describe an ambition for all people in Scotland to receive high quality care designed around their individual needs and circumstances.

Other key ambitions in the vision are to keep people out of hospital and help them to get home from hospital as soon as possible. Unnecessary admissions or delays in leaving hospital when people are ready to be discharged can lead to poor health and wellbeing. This includes increased risk of an adverse event, such as a fall, and for older people in particular, can lead to a deterioration in their capacity to become active again and return to living at home. For example, older people can lose up to 5% of muscle strength per day of treatment in a hospital bed.[3] Extended hospitalisation also keeps people away from family, friends, and their home environment.

Avoidable or extended hospitalisation is also costly for health services. It was estimated that in 2013/14 the cost to NHS Scotland due to delayed discharges alone was £114 million.[4]

Scotland's integration authorities are establishing programmes of work to enable people to avoid hospital or get out of hospital sooner, a number of which can be defined as intermediate care.

Defining intermediate care

'Intermediate care' covers a range of care options, which allow people to avoid hospital, return home from hospital sooner, recover from illness faster, and plan for their future care. It is a bridge between home and hospital.[5]

Intermediate care is delivered by both health and social care services. The team delivering care often includes allied health professionals (AHPs) – such as occupational therapists and physiotherapists – registered nurses, doctors, social workers and health and social care support workers.

Intermediate care services can support the delivery of the personal outcomes that people want to achieve for their health and wellbeing. They provide assessment and a short-term intervention to help people progress their improvement and rehabilitation more rapidly and allow them to get home as quickly as possible.

Previous work by the Scottish Government's Joint Improvement Team (JIT, which is now disbanded) identified aspects of an effective intermediate care system. These included: a focus on prevention, rehabilitation, reablement and recovery; accessibility; holistic assessment; coordination; and being managed for improvement.[6]

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Intermediate care is often provided in someone's own home, including through specialist hospital at home services, and integrated community support teams. It is also provided, as is the focus of this report, as bed-based intermediate care, which is described in more detail below.

There are no Scottish clinical guidelines for intermediate care. The Department of Health in England has commissioned NICE to develop clinical guidelines for intermediate care and reablement which are due to be published in September 2017.[7]

Bed-based intermediate care

While intermediate care aims to keep people at home, there are times when a person's level of need means they require intermediate care in a setting other than home.

Bed-based intermediate care is a time-limited episode of care, commissioned and supported by the local integration authority. It is provided as a dedicated service within community hospitals, care homes, standalone intermediate care facilities, or housing with care.[8]

People are referred to bed-based intermediate care either as a 'step up' from home for assessment and rehabilitation – as an alternative to hospital admission – or as a 'step down' from the acute hospital for a period of assessment and/or rehabilitation before they return home. The majority of bed-based intermediate care services provide the latter.[9]

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The effectiveness of intermediate care-bed use appears to be linked to key factors, with local implementation and context playing a large part in its success. In particular, the Nuffield Trust notes that clear referral criteria and good integrated working across health and social care are important.

RCN Scotland has, through engagement with members and stakeholders, identified particular barriers to the appropriate implementation of bed-based intermediate care. These will be explored further in this report.

Evidence for bed-based intermediate care

There is a small but growing evidence base on how bed-based intermediate care supports improved system and individual outcomes.

A Cochrane Review of 10 studies, including 1,800 patients, found that nurse-led intermediate care units (in hospital wards, community hospitals or care homes) delivered a range of better individual outcomes than usual care in a hospital. Benefits included improved functioning and greater wellbeing, more discharges to home, and fewer readmissions to hospital.[10]

Similarly, a study in Norway found that older people who received intermediate care in a community hospital had lower readmission rates. They were also less likely to require further care services in the community than people given traditional care at a general hospital. [11] Another Norwegian study found that, compared to a control group receiving care in hospital, older people who received intermediate care in a care home setting tended to be more independent. They had a higher functional outcome, and were better prepared for discharge.[12] They also had significantly less need for home care or care home services.

"Compared to a control group receiving care in hospital, older people who received intermediate care in a care home setting tended to be more independent. They had a higher functional outcome, and were better prepared for discharge."

One systematic review found that, with regard to musculoskeletal conditions, intermediate care consistently leads to significantly reduced orthopaedic waiting times, as well as high patient satisfaction.[13]

Intermediate care beds are also seen as a mechanism to deliver more cost-effective care. However, a recent paper by Nuffield Trust looking at delayed transfers of care in England noted 'it cannot be assumed that alternatives to hospital will save large amounts of money unless far more radical changes to the system are made'.[14] Looking at intermediate care beds specifically, there is mixed evidence on whether the use of intermediate care beds increases or reduces costs in comparison to hospital care.[15] [16]

National and UK-wide work on bed-based intermediate care

As a policy, intermediate care has been interpreted differently throughout the four countries of the UK.[17] A 2015 review found that in England, provision of intermediate care 'is highly variable, with different referral routes, team structures, skill mix and cost-effectiveness'. [18] The review also noted that in recent years the complexity of service user need has increased. Its authors identified a need for further high quality studies to determine the factors for success at the team level.

One source of evidence on intermediate care, and on what works well, is the National Audit of Intermediate Care (NAIC), which is conducted across England, Northern Ireland and Wales.

The most recent NAIC report (November 2015) detailed some of the successes of intermediate care services over that year. These included: 87% of people using bed-based intermediate care improved their dependency score; over 70% of intermediate care service users returned home on discharge; and goals were met (wholly or partially) for more than 88% of people using health-based intermediate care services.[19]

The audit report also described some challenges for intermediate care services. The challenges included: difficulty in achieving integration of services; concerns from service users around insufficient communication and goal setting; and growing waiting times to access services.

An increasing proportion of the use of bed-based services in particular is by people aged over 90. This age group now makes up a quarter of service users. The higher level of complexity associated with this age group will have an impact on the shape of services in the future.

Overall, the report noted, 'intermediate care services are key to reducing the financial, quality and activity pressures being experienced in secondary care and the care service sector'.

The next NAIC report is due to be published in late 2017. Scotland does not participate in the NAIC. The most recent national report of intermediate care in Scotland was published by JIT in 2014.

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Since that time, there has been some national work undertaken. However, this was delayed by the merger of JIT into Healthcare Improvement Scotland (HIS) in 2015. Following on from JIT's work, the Information Services Division (ISD) of Scottish Government has developed and piloted a core minimum dataset for intermediate care and reablement, although this has not been rolled out nationally.

HIS has been identified as the lead organisation for intermediate care and reablement in Scotland. A workstream has been established as part of Living Well in Communities.[20] However, this

work is in its early stages of development, with its scoping stage underway in 2017. The priorities for health and social care partnerships identified through initial scoping include enhanced opportunities to learn about different models of care, and also for support with evaluation.

These priorities have been echoed by RCN members and partners, who have reported frustration with the lack of national drivers and opportunities to share good practice.

What is the Scottish Government's strategic vision for bed-based intermediate care?

The Scottish Government has made clear that bed-based intermediate care is one of the service models which will help deliver on its 2020 Vision. [21 22]

In 2015, Shona Robison MSP, Cabinet Secretary for Health and Sport, spoke about intermediate care beds as "an additional mechanism to help to keep people out of acute beds or get people home when they are clinically ready for discharge from hospital, but need more rehabilitation or aids and adaptations before they can get home". She added: "They are an important part of the system, and we want to see that capacity grow across Scotland." [23]

RCN Scotland agrees that intermediate care beds should be in place across Scotland. These beds should be specifically for people who are ready to leave an acute hospital but have a still high level of health need and require support from a multidisciplinary team. However, bed-based intermediate care is a resource-intensive service with a specific purpose. It is not the right location of care for people who are, for example, waiting on adaptations to their home. A suite of intermediate care and reablement services should be in place to ensure that integration authorities can deliver the right level of health and/or social care to meet different levels of need.

Recent reports suggest that the Scottish Government continues to see an increase in the provision of intermediate care beds across Scotland as key to improving waiting times and reducing delayed discharges.[24 25]

The care home sector has been identified as an even greater provider of these beds in future.[26] Speaking in the Scottish Parliament last year, the Cabinet Secretary for Health and Sport, said: "We will need more intermediate care and we are looking at what the [care home] sector can provide. There are great examples of that. We have hugely expanded the number of intermediate care places, many of which are located in a care home environment. That helps to put the care home sector on a more sustainable footing and provides what is needed. It also provides a service that is a step down and potentially a step up—although that is less developed—between home and hospital. That is a really important development." [27]

However, the actual pace of development of step-up beds is slower than anticipated. The responses of 25 of Scotland's 31 integration authorities were reported in HIS' *Intermediate Care and Reablement Atlas* in April 2017. [28] Of those 25:

- Four integration authorities had no step-up or step-down beds in place or in development
- 14 integration authorities had step-down beds in care homes (an additional three authorities were developing these)
- 10 had step-down beds in community

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hospitals (one more was developing these)
- 10 had step-up beds in care homes (three more were developing these)
- Seven had step-up beds in community hospitals (three more were developing these).

Bed-based intermediate care and reducing delayed discharge

Delayed discharge is a significant problem for Scottish Government, integration authorities, health boards,[29] and for the general public. The Scottish Government has made clear that it sees intermediate care beds as a key part of the solution.

Delayed discharge is often due to a lack of availability of appropriate community packages or care home beds. Intermediate care beds can be an important part of the complementary suite of community-based care models to provide an appropriate stepping stone for people leaving the acute hospital setting.

Delayed discharge from hospital is most commonly experienced by older people, with approximately 70% of people who are delayed aged 75 or over.[30] While all intermediate care services deliver care to a mostly older population, this is particularly true of bed-based services. In Wales, Northern Ireland and England, for example, 51% of all people admitted to intermediate care beds are over 85, and the mean age is 83.[31] In comparison, 39% of people accessing home-based intermediate care and 43% in reablement services, are over 85.

However, it is important that step-down intermediate care beds are used explicitly to provide a period of assessment, reablement and rehabilitation, for people who are clinically ready to leave hospital but not yet ready to return to their own home.

RCN Scotland has heard from members and stakeholders that, in some cases, the establishment or commissioning of new intermediate care beds by highly pressured health and social care partnerships has been informed primarily by a need to address the systemic delays which are leading to people remaining in hospital longer than is appropriate.

"Intermediate care should be focused on delivering the outcomes which meet people's individual needs and preferences and only be used when it is clinically the best setting for the person's care."

While reducing rates of delayed discharge is likely to be an outcome of implementing intermediate care, this should not be its central purpose. Rather, intermediate care should be focused on delivering the outcomes which meet people's individual needs and preferences and only be used when it is clinically the best setting for the person's care. Intermediate care beds should not be used to 'game' the delayed discharge target.

Is the Scottish Government's strategic vision being achieved?

For over a decade the Scottish Government's policy has been to shift the balance of care towards the community. Last year, Audit Scotland stated: 'New integration authorities are still developing and some progress is being made in shifting to new models of care, but it is not happening fast enough to meet the growing need. Effective leadership and a clear plan are required to manage the change.' [32]

"While there are examples of good practice, implementation is piecemeal and sometimes without clear agreement on the scope and purpose of the services."

Over a year into the formal integration of health and social care, and more than five years after JIT published best practice guidance, there has been increased development of bed-based intermediate care services. However, these remain localised, on a small scale, and provided unevenly both within and between health and social care partnership areas.

RCN members and stakeholders have reported their concerns to RCN Scotland about the implementation of bed-based intermediate care. While there are examples of good practice, implementation is piecemeal and sometimes without clear agreement on the scope and purpose of the services.

RCN Scotland has heard of instances in which people have been discharged to commissioned intermediate care units who have complex care needs outwith the scope of expertise of the staff working in the unit. In many cases, people are being discharged to units with short notice and without suitable planning.

Integration authorities are facing a number of thorny issues which affect their ability to implement and develop their own bed-based intermediate care services. These include: limited finances in a time of austerity; lack of clarity on what is expected of care home providers; and the challenges relating to developing an innovative model within an existing system and with existing infrastructure. Nationally, these and other issues have meant that the Scottish Government's strategic vision has not yet translated to the large-scale delivery of intermediate care in bed-based settings.

Financial limitations

In a recent RCN Scotland report, nurses and other health professionals, who worked through the transition in mental health services from acute to community settings, expressed their concerns.[33] They felt that 'delivering on the vision of integration will take more funding than has been made available so far'. The report continued: 'As the transformation of mental health progressed, there was investment in the process of change. In many areas, the deinstitutionalisation of mental health services was underpinned by additional pump-priming investment which allowed new models to be up and running before the institutions were closed.'

Sufficient pump-priming funding is not available to health and social care services today to make the enormous step change required. While funding has been allocated to a number of programmes such as the Primary Care Transformation Fund, many of these funding streams support local pilots rather than systematic change programmes.

More broadly, integration in Scotland has, in principle, seen an end to separate funding streams for health and social care. However, at a local level, staff report continuing challenges in integrating the funding and delivery of community health and social care. Finance across both health and social care is under pressure and coming to an agreement on integrated budgets is proving challenging in some areas.[34]

In relation to the NHS, Audit Scotland describes the savings expected by NHS boards in the 2016/17 financial year as 'unprecedented'. These will be on top of savings measures in the previous financial year, which many boards struggled to meet.[35] Of particular relevance for the development of fit-for-purpose, intermediate care facilities, Audit Scotland notes that 2015/16 saw a 20.3% decrease in NHS boards' capital budgets.

"Bed-based intermediate care services are the most expensive model of intermediate care to deliver … This makes bed-based models a difficult investment for commissioners to make while working with reduced funding."

Alongside this, Scotland's local authorities intended to save £54 million from social work budgets over 2016/17. This was to be achieved mainly through changing and reducing service provision, and making efficiency savings.[36]

Bed-based intermediate care services are the most expensive model of intermediate care to deliver. In other UK countries they cost an approximate average of £5,500 per service user for an average stay of 26.8 days. By comparison, home-based models of intermediate care cost £1,205 per service user for an average stay of 29.3 days.[37] This makes bed-based models a difficult investment for commissioners to make while working with reduced funding, even where it would be the most appropriate provision for people.

As noted by the Nuffield Trust in reference to shifting the balance of care in England: 'The wider problem remains: more patient-centred, efficient and appropriate models of care require more investment than is likely to be possible given the current funding envelope.' [38]

Lack of clarity on what is required from the care home sector

Another key influence on the slow development of bed-based intermediate care services is the hesitancy from many care home providers to develop new models of care. While providers have expressed interest in providing innovative models, many have described their current approach as cautious, for a number of reasons, including:

- Concerns about their ability to continue meeting current levels of provision in the current funding environment
- Increasing workforce costs and recruitment issues
- Lack of confidence in the ongoing commitment from commissioners to fund innovative services
- A regulatory environment which is not conducive to innovation
- Reluctance from other partners in health and social care to regard the care home sector as equals.[39]

The National Care Home Contract in particular has been described by providers as a restraint on what models of care can be offered at present. Innovation, including intermediate care, is under consideration in the current care home contract reform process.

This is not just a concern for providers. RCN Scotland has found a strong sense among stakeholders that the current National Care Home Contract does not support innovation within the care home sector. However, following a tense negotiation of the 2017 National Care Home Contract, the future of Scotland's national approach to contracting care homes is precarious. If Scotland moves to a more fragmented local model of care home procurement, this will add pressure on providers and potentially affect their appetite to take the business risks inherent in developing new models of care.

"There is still formally a lack of clarity on what kinds of care can be provided in care homes, and for what purpose."

Similarly, the Public Services Reform (Scotland) Act 2010 – which is the regulatory framework against which the Care Inspectorate regulates and scrutinises services – is silent on specialist models of care including intermediate care. The Care Inspectorate has developed a self-assessment process for care homes to complete when they intend to deliver intermediate care.

However, there is still formally a lack of clarity on what kinds of care can be provided in care homes, and for what purpose. For example, many care homes have been commissioned by health

and social care partnerships to provide 'interim' care home places. This is a different model of care, which is made available for people who are leaving hospital and waiting for a long-stay place in a care home, but do not require clinical intervention. Interim care beds are generally made available for up to six weeks. Other care homes have been delivering a similar model under the label 'flexi beds'.

Neither interim care nor flexi beds are formally defined. It is also questionable whether it is appropriate to move people into another setting other than home to avoid delayed discharge, without clear individual benefits of doing so.

Without clarity on the regulatory and funding arrangements around intermediate care beds and other innovative models of care, many providers will continue to be apprehensive. They will hesitate to take on the risk of developing new models with higher service user dependency and acuity levels and higher staffing costs.

Building on historical arrangements

In some cases, intermediate care services have been developed by health and social care partnerships as part of a spectrum of services and pathways with a focus on enabling people to be at home or in a homely environment.

In many cases partnerships are developing intermediate care services on the back of historical arrangements, which can lead to variability in care.

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There is extensive variability in the geographical availability of existing facilities for intermediate care use. Some integration authorities have a large number of community hospital facilities, while others have few or none.

RCN Scotland has heard concerns from stakeholders that some NHS facilities are not appropriate for intermediate care. As noted in the most recent *Annual State of NHS Scotland Assets and Facilities* report, many NHS assets require updating, with 44% of total maintenance backlog expenditure requirement being recorded as 'significant and high risk'.[40] Community hospital facilities in particular are often outdated and not suitable for the kinds of care that they are expected to deliver – for example, many have multiple-bedded wards.[41]

It is not clear how many community hospitals there are in Scotland, with different figures provided by ISD, the Scottish Association of Community Hospitals and RCN Scotland's web research. Community hospitals also look different depending on contractual arrangements and availability of GPs, location, and what other infrastructure is available. At a 2016 conference of GPs working in community hospitals, attendees noted that community hospitals vary considerably, with wide diversity across Scotland.[42] They also noted that this diversity would need to be taken into account as future models of care are developed by integration authorities.

Different integration authorities also have varied care home infrastructure. Some areas are mostly serviced by small independent providers. These small providers are, because of size and lack of resources, far less likely to have the capacity to recruit or develop the skilled registered nurses required to deliver intermediate care in a care home setting.

Variability in arrangements can also be shaped by politics. For example, in some areas a community hospital with outdated infrastructure might be the location of intermediate care. This can be a result of a lack of alternative facilities and a reluctance from politicians at all

levels and health and social care officials to oversee the closure of a much-loved community asset.

However, the biggest issue is restriction on health and social partnerships' capacity to develop fit-for-purpose bed-based intermediate care services due to limited health and social care budgets.

Medical cover for intermediate care beds

Other problems faced by Scotland's integration authorities are establishing appropriate medical cover for their bed-based intermediate care services, and being clear on the responsible medical officer for each service user.

Arrangements for medical cover are often historical. It is not uncommon that in one locality, there may be cover for different intermediate care beds by a number of general practices, and also by a consultant geriatrician. These arrangements could have an impact on continuity and consistency of care.

Several stakeholders have reported to RCN Scotland concern about the acute sector's reliance on community hospital beds for step down. In some cases, this has led to reduced access for GPs to use them as step-up beds for their own patients whose condition is deteriorating.

Most concerning, pressures on general practice have resulted in a number of health and social care partnerships having difficulty in arranging medical cover for services.

In the future, advanced nurse practitioners (ANPs) may play a significant role as the senior clinical decision makers supporting bed-based intermediate care units. This shift must be fully planned if people using bed-based intermediate care are to have access to appropriate clinical decision makers.

Variable contractual processes

When a person requires an intermediate care bed, rather than care in the home environment, it is likely that they have a high level of clinical need and dependency, and are older. The majority of people accessing bed-based intermediate care are likely to also have, in addition to a rehabilitation need, a cognitive impairment and/or challenging behavioural disturbance.[43]

There is no national data available on the health and dependency profile of intermediate care service users in Scotland. The development of a nationally standardised tool by ISD means this could be a possibility in the future (although funding for this work is not confirmed).

However, some nursing staff have shared with RCN Scotland their concern that people admitted to intermediate care beds from an acute hospital often have complex needs requiring the support of staff with specialist skills. In many cases, these needs are beyond the knowledge and training of existing care home staff.

This situation is difficult for staff. It can also put at risk the safety of the individual, and impact on other long-term residents and their right to a homely environment.

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The RCN has heard that contracts for bed-based intermediate care are often limited in information about expected staffing models. There is also frequently a lack of strict admission and discharge criteria.

Some integration authorities have identified training of intermediate care staff as a priority. A number are implementing programmes of training for staff in care homes commissioned to deliver intermediate care. While a welcome start, this training is often post hoc and can be on the basis of the needs of an individual admission.

What needs to be in place to deliver intermediate care beds in an integrated and planned way?

A large amount of work has been undertaken in Scotland (particularly through JIT when it existed) to set out a framework for the delivery of high quality intermediate care. However, as described in this report, this has not yet translated into wide scale innovation and implementation on the ground. Many integration authorities are still developing and testing discrete approaches to bed-based intermediate care.

There is a need to share good practice and the contributing factors that underlie effective and person-centred intermediate care delivery in bed-based settings.

Nursing staff have a significant role to play in commissioning, planning and delivery of bed-based intermediate care services. To support senior nurses to make these decisions, RCN Scotland has developed a decision making tool (available here) to help them think through what needs to be considered and put in place. This tool will, RCN Scotland hopes, go some way to addressing some of the concerns raised in this report, but this is just one action and not sufficient on its own.

Ensuring quality and consistency of delivery will require action at all levels.

It is impossible to ignore the fact that lack of funding is a significant pressure on developing this model of care as the Scottish Government intends. A frank, open discussion on the cost of bed-based intermediate care – and indeed, the cost of not providing it – is required nationally if local commissioners are to be supported to invest as the Scottish Government clearly wants.

In conversation with key partners and stakeholders, RCN has identified a number of policy levers for change. These include: the National Review of Targets and Indicators; the Safe and Effective Staffing Bill; a new National Health and Social Care Workforce Plan; new National Care Home Contract and GMS contracts in 2018; and the emerging regionalisation agenda.

"There is a need to share good practice and the contributing factors which underlie effective and person-centred intermediate care delivery in bed-based settings."

All of these must adequately reflect the need for appropriately funded, safe, quality bed-based intermediate care for those who genuinely require it. For example, the ongoing negotiations on the future of the National Care Home Contract must deliver models for care within care homes, which reflect the acuity and dependencies of those using these services, including in intermediate care beds. This includes funding the right levels of nursing provision and expertise for these beds.

Linked to this, plans to increase the number of ANPs in Scotland must take into account the need for the right clinical decision-making expertise for people receiving bed-based intermediate care.

Importantly, the implementation of Scotland's first National Health and Social Care Standards will be an opportunity to improve consistency of approaches to similar forms of care across different settings. However, there is a need to consider whether we have the

right regulatory frameworks to support positive innovation, while ensuring the development of safe and effective models of bed-based intermediate care.

It would also be helpful for HIS, in its new national leadership role for intermediate care, to consider how admission criteria for bed-based intermediate care could be better defined by both commissioners and providers.

"A frank, open discussion on the costs of intermediate care – and indeed the cost of not providing it – is required nationally if local commissioners are to be supported to invest as the Scottish Government clearly wants."

There is a specific need for a national steer and direction of travel for intermediate care services. This should build on the 2012 intermediate care framework *Maximising Recovery, Promoting Independence*[44] and JIT and HIS work to embed this in practice. A national direction could be supported by the collection and publication of national data on intermediate care. Scotland is currently the only UK nation not to do this.

As some of these changes to health and social care come together, there is an opportunity to think carefully about what is required from intermediate care services. RCN Scotland will continue to champion the need for quality and safety in bed-based intermediate care services. RCN Scotland will also work with partners to support new approaches that ensure all people needing a period of intermediate care can receive care which enables them to meet the health and wellbeing outcomes which matter to them.

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