Tool to support nursing leaders making decisions about bed-based intermediate care.

Royal College of Nursing Scotland

Introduction

Intermediate care is a broad term covering 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.

This model of care, where available to health and social care commissioners, can enable more seamless care pathways and support people to rehabilitate and avoid unnecessary hospitalisation or delays.

Bed-based intermediate care is one of a number of models of intermediate care that may be made available by an integration authority. It is delivered in NHS facilities, local authority care homes, and in independent and third sector care homes.

As explored in the RCN Scotland report *The Landscape for Bed-based Intermediate Care* in Scotland [available here], RCN Scotland has undertaken work to understand the landscape for bed-based intermediate care in Scotland. Through this work, RCN Scotland has identified gaps and barriers to appropriate implementation of the model of care. RCN members and partners report that while there are examples of good practice across Scotland, implementation of bed-based intermediate care is often piecemeal and sometimes undertaken without clear agreement on the scope and purpose of the services.

RCN Scotland wants to support improved decision making about these services, to help deliver a more cohesive approach to delivering safe, effective, quality bed-based intermediate care across Scotland.

Theresa Fyffe
Director, RCN Scotland

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Who is this tool for?

The aim of this tool is to support nursing leaders 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.

It has been developed through a process of engagement with registered nurses in senior decision-making roles and other key stakeholders working in health and social care, as well as with reference to existing resources and guidance.

The tool is designed to be used by those nursing staff to think through what needs to be considered to ensure intermediate care beds are delivered in a planned and integrated way to provide safe and effective care.

While this tool takes a nursing perspective, a multidisciplinary team approach is essential for effective bed-based intermediate care. Allied health professionals, medical staff, social workers and social care staff are key to its success. While RCN Scotland has designed this to be specific to registered nurses in senior decision-making roles, we recognise that it may be useful to other professions, as well as service planners.

Acknowledgements

The RCN would like to thank the members and other partners from across health and social care who were involved in shaping and developing this tool.

How to use this tool

Below are a series of questions relating to eight interrelated themes, and space for you to complete your own assessment of the bed-based intermediate care service under consideration. A resources list is made available for each theme.

Answering the questions will help you to identify whether the essential elements are in place within a service to deliver safe and high-quality intermediate care. The ultimate goal of this tool is to ensure better bed-based intermediate care for people accessing these services.

This toolkit covers the core issues that the RCN believes it is important to consider in delivering intermediate care. However, not all questions may be relevant to you in your particular circumstances; for example, some questions are specific to commissioners of services. Complete all the questions you are able to in your particular circumstances; but pay particular attention to those you feel you cannot answer and consider whether there is further action you should take to fill those gaps.

When completing this tool, consider how the intermediate care service under consideration will ensure registered nurses can meet the professional requirements of the NMC code (**www.nmc.org.uk/standards/code/**).

Themes

The tool sets out eight overarching themes (Figure 1) that together represent what needs to be in place for high quality, bed-based intermediate care.

The first theme is overarching and the most significant for the successful implementation of a bed-based intermediate care service: 'The bed-based intermediate care service has a defined scope and purpose'.

Without defining the scope and purpose of a service, it will be challenging to deliver on the vision for quality care set out in detail across the other seven themes. It should also be clear who is responsible for setting this overarching scope and purpose.

A defined scope should not, however, mean lack of flexibility. Any intermediate care service will need to flex and adapt on the basis of changing service user and community needs, as long as both the quality and safety of care are maintained or improved.

Figure 1 Eight themes for high quality, bed-based intermediate care

Tool to support nursing leaders making decisions about bed-based intermediate care

1. The bed-based intermediate care service has a defined scope and purpose

All intermediate care services should be focused on prevention, rehabilitation, reablement and recovery, to prevent unnecessary admission or avoid admission. Being clear on the expectation of what the bed-based intermediate care service will provide will ensure that care is delivered safely and the right staff are available to deliver the expected outcomes. This scope and purpose will be defined by the health and social care partnership within the context of its other services, approach to commissioning, agreed outcomes, and approach to measuring success.

Background and resources

- A partnership-wide intermediate care strategy or plan should set out the outcomes to be met and how it is expected that different forms of intermediate care will contribute to meeting those outcomes. The strategy should be informed by the integration authority's strategic plan. http://ihub.scot/a-z-programmes/ijb-strategic-plans/
- Resources on outcomes-based commissioning include the Healthcare Improvement Scotland (HIS) document Taking a personal outcomes approach. http://ihub.scot/a-z-programmes/personal-outcomes/ and Department of Health England's Configuring Joint Preventive Services: A Structured Approach to Service Transformation and Delivering Better Outcomes for Older People. https://ipc.brookes.ac.uk/publications/Configuring_Preventive_Services_v1.0.pdf
- Tools like the Day of Care survey can help to determine the level of unmet need for intermediate care. http://www.qihub.scot.nhs.uk/quality-and-efficiency/whole-system-patient-flow/day-of-care-survey.aspx
- Tools to support commissioning include the RCN's Integration Toolkit for Nursing Leaders. https://www.rcn.org.uk/professional-development/publications/pub-005910 and resources in the HIS Strategic Commissioning resource. http://ihub.scot/a-z-programmes/strategic-commissioning-improvement-support/
- Scottish Government. 2016. Guidance on the Procurement of Care and Support Services. http://www.gov.scot/Topics/Government/Procurement/policy/SocialCareProcurement
- HIS Resource on Organisational Capacity for Transformational Change. http://ihub.scot/a-z-programmes/evidence-and-evaluation-for-improvement/

Questions to consider	Comments and reflections
What is the reason for commissioning this service?	
Is the purpose of this service rehabilitation and recovery?	

Questions to consider	Comments and reflections
Can you describe the objectives of the service?	
How are these objectives reflected in the contract/service level agreement?	
Does the integration authority have an intermediate care strategy or plan?	
If so, how does this service fit within the strategy or plan?	
What are the standards and regulatory frameworks that the integration authority will need to consider when commissioning this service, and are they explicit?	
What is the process for regularly monitoring against those standards?	
Is there a local agreement in place with the NHS or local authority on how support will be provided by a multidisciplinary health and social care team, and which agency will fund this support?	

Questions to consider	Comments and reflections
How will the service support the integration authority to meet its strategic outcomes?	
How will the service improve health and wellbeing outcomes for the target service user group(s)?	
What are the measures and indicators of success that will demonstrate that the service is delivering on those outcomes?	
Do measures include service user experience?	
How will the service be monitored to ensure that it is delivering on those outcomes?	
Is the service sustainable over the medium to long term?	
If not, why?	

2. The bed-based intermediate care service is accessible and well-signposted 24/7, and both service users and health and social care staff are aware of the point(s) of access

Access to an intermediate care bed should be fast and direct, avoiding multiple referrals or complex pathways. There must be good communication and smooth handover processes with wider services, in conjunction with joint working built on strong and well-established relationships. Key connections will include: home care and care home services; primary care teams; hospital teams; the local third sector agencies that can help people maintain their wellbeing and independence on return home; mental health services; and unscheduled care teams.

Background and resources

- Joint Improvement Team. 2012. Maximising Recovery, Promoting Independence: An intermediate care framework for Scotland. http://www.gov.scot/Publications/2012/07/1181
- For a description of commonly reported issues for bed-based intermediate care service users, see Ariss, Steven. 2015. National Audit for Intermediate Care: Patient Reported Experiences. For example, Ariss et al found that people using services and their carers did not always have consistent and accessible information about available intermediate care services, and the purpose of services.

Questions to consider	Comments and reflections
Is the bed-based intermediate care service accessible 24/7?	
Has the partnership considered a single point of access for all intermediate care services?	
How are points of access/a single point of access clearly signposted within the local health and social care system?	
Are all people who would benefit from intermediate care aware of the option of bed-based intermediate care service and its purpose?	

Questions to consider	Comments and reflections
Are intermediate care service users supported with information about local services (including the third sector) to access after discharge from the service?	
Is the referral process designed to minimise the number of contacts a person needs to make before moving into the intermediate care bed?	
Are relevant staff across health and social care aware of the service and its purpose?	
Is there formal agreement on which health and social care professionals have the authority to refer people into the service?	

3. The model of care is based on a single, holistic assessment process and identification of the individual person's goals and personal outcomes

The integration authority should be assured that a single, person-centred joint assessment process – for both health and social care needs – is undertaken at the point of admission and throughout an admission. This can help ensure the service can deliver appropriate care and the individual outcomes that have been identified by the person receiving care.

Background and resources

- The draft NICE Guideline on Intermediate Care (including reablement) sets out detail of what should be included in the assessment process https://www.nice.org.uk/guidance/indevelopment/gid-scwave0709/documents
- Resources on how to develop a person-centred service include the HIS Person-centred health and care resource http://ihub.scot/a-z-programmes/person-centred-health-and-care/
- HIS Anticipatory Care Planning resource: http://ihub.scot/a-z-programmes/lwic-anticipatory-care-planning/

Questions to consider	Comments and reflections
Is there a single, shared assessment process that is comprehensive and consistent, and addresses both health and social care needs?	
How are service users' personal outcomes and goals taken into account?	
How are carers and those with power of attorney involved in decision making?	
Is anticipatory care planning part of the model?	
How are the contract/service level agreement and the service able to adapt to service users' changing needs?	

4. Criteria for admission to and discharge from the bed-based intermediate care service are clear

Intermediate care is one point on a person's journey through the health and social care system. When someone is admitted to intermediate care, it should be clear that they will benefit from a period of rehabilitation and reablement, and are also medically fit to move to the service. It must also be clear that the intermediate care service chosen is clinically the most appropriate setting for the person's care.

Integration authorities will have a range of services in place to support people to transition home from hospital more rapidly, or to avoid hospitalisation. The integration authority should ensure that there are clear criteria for admission to each service – including intermediate care beds – and that referrals are based on the person's individual requirements including capacity, level of dependency and health condition(s).

Background and resources

- Reasons for rejection might include disruption to other service users and residents, or that the care required is outwith specific staff expertise. The process of rejecting inappropriate referrals will be facilitated by a service level agreement. There is a need to ensure the safety of other service users and residents, as well as – in care homes – their right to a homely environment.
- Indicator of Relative Need (IoRN) is one tool for understanding a person's functional needs and level of dependency: http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Dependency-Relative-Needs/In-the-Community/

Questions to consider	Comments and reflections
Are there clear criteria for admission to the service?	
How are decisions made about whether people are ready to leave, either to go home or to other care settings?	
Which senior staff working within the service have the authority to reject inappropriate referrals?	
How can the integration authority be assured that the bed-based intermediate care service is appropriate for people being admitted to the service?	

Questions to consider	Comments and reflections
What are the levels of dependency and acuity – both physical and mental – that the service is expected to support?	
What are the expectations of the service to care for people with behavioural difficulties?	
How are information systems used to track the changing dependency levels and clinical need of service users?	
How can the integration authority be assured that staff in the service are competent and confident to meet the specific needs of people in their care?	

5. The contribution of the bed-based intermediate care service within the broader health and social care system is clear. There is coordination and multidisciplinary team working across health and social care

Intermediate care services must be complementary to other health and social care services, and there is a wide range of agencies to which the bed-based intermediate care service should be connected.

Joined up thinking is necessary for bed-based intermediate care services to meet the needs and preferred outcomes of people using the service (NHS Benchmarking Network. 2015). This can be supported by formal agreement on how support will be provided and by which agencies and teams, to ensure access to expertise which meets the needs of people using the service – for example in mobility assessment, physiotherapy, mental health support and interventions, exercise and self care.

Background and resources

- Joint Improvement Team. 2013. Intermediate Care: Readiness to Scale
- Healthcare Improvement Scotland. 2017. Intermediate Care & Reablement Scoping Atlas 2017. http://knowledge.scot.nhs.uk/media/CLT/ResourceUploads/4083483/c9bd24e0-cb47-44d7-b33d-05e3232b3fe2.pdf
- NHS Benchmarking Network. 2015. National Audit of Intermediate Care. http://www.nhsbenchmarking.nhs.uk/partnership-projects/National-Audit-of-Intermediate-Care/year-four.php
- Health boards are highly motivated to reduce delayed discharge, and where both step-up and step-down beds are available, step-up capacity can come under pressure from the demand for step-down from hospital.

Questions to consider	Comments and reflections
How does this service fit within service user care pathways?	
How do staff working in the service access support from an active multidisciplinary network of professionals with complementary knowledge and skills?	
How can those professionals be clear what the expectations are in terms of their response time?	

Questions to consider	Comments and reflections
How can those professionals be clear what support and training they are expected to provide?	
How do patient information systems enable the appropriate and timely sharing of information?	
How are health and social care providers working together to ensure that care staff have the information they need?	
If there are both step-up and step-down beds in a service, what is in place to ensure that step-up beds are available when needed?	
What measures has the integration authority put in place to enable adequate step-up capacity?	

6. The team delivering the bed-based intermediate care service has an appropriate staffing and skill mix to meet complex needs and deliver safe and effective care

As the commissioner, the integration authority must be clear on what workforce is required to meet the specific needs of people who fit the admission criteria for the service, and to achieve the identified individual and system outcomes.

Staff working in a bed-based intermediate care service require specific skills, including in communication and rehabilitation support, promoting independence and supporting a successful discharge home. As noted above, they will also need support from a multidisciplinary network of health and social care professionals.

Background and resources

- Validated and consistent tools should be in place. The RCN toolkit on Safe Staffing for Older People's Wards, while looking specifically at acute settings, is designed for a similar service user group as bed-based intermediate care https://www.rcn.org.uk/professional-development/publications/pub-004301
- RCN Scotland's The Contribution of Registered Nurses in Scotland's Care Home Teams https://www.rcn.org.uk/about-us/policy-briefings/sco-pol-nursing-in-care-homes
- A wide range of knowledge and improvement resources are available at the Care Inspectorate's online hub (http://hub.careinspectorate.com/) as well as the HIS iHub site (http://ihub.scot)
- RCN resources, relating to the care of older people are available at https://www.rcn.org.uk/clinical-topics/older-people
- There is good evidence on the contribution of multidisciplinary team working to better outcomes for intermediate care service users. See Ariss S, et al. 2015. Secondary analysis and literature review of community rehabilitation and intermediate care: an information resource. Health Services and Delivery Research.
- See also Nuffield Trust. 2017. Shifting the balance of care. https://www.nuffieldtrust.org.uk/research/shifting-the-balance-of-care-great-expectations
- The most common theme area for improvement identified by bed-based intermediate care service users and carers in the 2015 Audit of Intermediate Care (England, Wales and Northern Ireland) was 'Short staffed, too busy, under-resourced'. See: Ariss. 2015. National Audit for Intermediate Care: Patient Reported Experiences, 2015

Questions to consider	Comments and reflections
Does the funding available enable the service to have appropriate numbers and skill mix of staff, with the right knowledge and skills?	
Does the contract set requirements for skill mix which are commensurate with the care needs of people using the service?	

Questions to consider	Comments and reflections
Are there fit-for-purpose workforce and workload planning tools in place?	
How are registered nurses skilled and empowered to provide professional judgement on staffing levels and skill mix, based on service information on dependency and acuity and other evidence sources?	
How can the integration authority be assured that the staff working within the service are confident and competent to provide the care required?	
Has a skills audit and training plan been completed to ensure staff have the right skills to provide intermediate care?	
Is there funding in place to deliver this training plan, including backfill?	

7. The bed-based intermediate care service is designed and delivered to support reablement

The purpose of a period of intermediate care must be to provide interventions and support that enable the person to rebuild their confidence, optimise their function, and support their return home wherever possible. While the care must be designed around the needs of the individual, it should also be time limited and delivered with discharge in mind. Evidence suggests that the benefits of intermediate care slow after approximately six to eight week.

Background and resources

- Involving service users and carers in collaborative decision making about the objectives of and place of care is central to achieving the aims of intermediate care. Pearson et al. 2015. Providing effective and preferred care closer to home: a realist view of intermediate care. Health and Social Care in the Community. 23, 6
- Service users should have opportunities to use the same or similar equipment and aids which will be available to when they return home. It should be clear to all involved which agency is providing the equipment required and how equipment is sourced and resourced.

The building in which bed-based care is delivered should itself enable reablement and recovery, for example, by providing a kitchen in which people can prepare their own meals.

- NHS Benchmarking Network. 2015. National Audit of Intermediate Care http://www.nhsbenchmarking.nhs.uk/partnership-projects/National-Audit-of-Intermediate-Care/year-four.php
- Lack of reablement support was a common issue reported by bed-based intermediate care service users in England, Wales and Northern Ireland (Ariss, Steven. 2015)

Questions to consider	Comments and reflections
How does the service support service users to meet the individual health and wellbeing outcomes they have identified for themselves?	
Is a plan for discharge in place from the time a person is referred into the service?	
Do the interventions provided by the service build the capacity of individuals and optimise function?	
How do staff and the person receiving care use shared decision making to determine their package of care?	

Questions to consider	Comments and reflections
How does the physical environment support individuals to optimise function?	
Does the environment meet the standard for the delivery of safe, high quality care?	
Are appropriate equipment and adaptations available?	
How does the integration authority measure the service's effectiveness in meeting health and wellbeing outcomes, in comparison to other care pathways?	

8.The bed-based intermediate care service has appropriate clinical governance arrangements in place, and clinical leadership and supervision are agreed

Clinical and care governance is the process by which the quality of health and social care is monitored and assured. It provides a framework so that staff are clear about their responsibilities and accountability in any action or decision they may take to ensure the provision of safe quality care.
All staff working in a bed-based intermediate care service must be enabled to make decisions independently, at an appropriate level, but also have confidence in knowing where to seek advice and how to escalate issues to an identified senior clinical decision maker, 24/7.

Background and resources

- Scottish Government. 2015. Public Bodies (Joint Working) (Scotland) Act 2014: Clinical and Care Governance Framework.
- RCN Scotland Clinical Governance and Integration Guide. https://www.rcn.org.uk/about-us/policy-briefings/sco-pol-clinical-governance-guide
- RCN Guide to Accountability and Delegation. https://www.rcn.org.uk/professional-development/accountability-and-delegation
- RCN Employing Nurses in Local Authorities. https://www.rcn.org.uk/professional-development/publications/pub-004680
- Scottish Government. 2015. Independent Review of Primary Care Out of Hours Services, Models of Care Sub-group recommendations. Not available online

Questions to consider	Comments and reflections
Are appropriate clinical and care governance arrangements incorporated into the service specification?	
Are there clear organisational structures for clinical and care governance? Does everyone understand their role?	
How can the integration authority be confident that there are processes in place within the service which assure quality and safety?	
How can the integration authority be assured that professional nursing advice informs decisions?	

Questions to consider	Comments and reflections
Can you describe the lines of professional accountability within the service?	
What are the protocols for defining the senior clinical decision makers who are responsible for the care of people using the service?	
Are all nursing staff able to escalate to a senior clinical decision maker,24/7?	
What are the arrangements to support the requirements of delegation?	
How are staff supported and developed?	
How does the service level agreement/contract provide funding for supervision and continuing professional development?	

RCN Scotland is interested to hear how you have used this tool and whether it has been useful for you. If you have any examples to share, or feedback to make on the tool, please contact the RCN Scotland policy team via email at: policyscotland@rcn.org.uk

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