'Sub-acute care' is often used as a generic term to cover any 'step-down' or intermediate care support[1]. In the context of the discussions in 2016 and 2020 however, sub-acute care represents a step-down phase of treatment or intervention, which still requires clinical oversight and/or registered nursing intervention e.g. intravenous drug therapy.

Due to rurality and challenges regarding prompt access to secondary care advice and support, this function remains largely aspirational in Wales. However, advances in the use of technology, such as 'Consultant Connect' and other virtual solutions for access to specialist support, mean that it could become more common in future.

SPECIFIC CONSIDERATIONS (in addition to the Core Bundle for all bedded community services)

Clinical cover. Individuals requiring sub-acute care are more likely to be frail and have complex needs on transfer to the bedded community service. Ongoing clinical supervision and active treatment will be required during this sub-acute phase, and the arrangements for providing this must be clearly set out in local Standard Operating Procedures (SOPs).

The professionals providing the clinical cover will need to reflect the level of complexity that the bedded community service intends to cater for, as determined by the local needs assessment.

This could include for example, any combination of:

- General practitioners (in and out of hours);
- Geriatricians attached to Community Resource Teams;
- Secondary care clinicians;
- Advanced Practitioners; and
- Physicians Associates.

[1] See https://www.nice.org.uk/guidance/NG74 for further information

In order to facilitate safe clinical transfer (and minimise disruption for the individual), decisions and arrangements for the move to the bedded community service should be made as early as possible in the day. Night-time transfers must be avoided.

Contingency Planning.

The staff working in bedded community services providing sub-acute care will be skilled and trained to manage this cohort of patients.

However, in view of the anticipated acuity and complexity of individuals requiring sub-acute care, contingency planning must form part of the transfer conversation and communication. Wherever possible, the contingency plan should aim to avoid transfers back and forth to the acute setting, in order to manage the associated risks of harm and distress to both the individual and their families.

Mechanisms to support contingency planning can include:

- Prompt access to secondary care and/or community specialist opinion e.g. using Consultant Connect and other technologies;
- Virtual In-patient models;
- Access to pharmacy support 'out of hours'; and
- In-reach support from community acute response teams.

LOCAL BEDDED COMMUNITY SERVICES PLANNING & COMMISSIONING CHECKLIST: SUB-ACUTE CARE

 **Core Function 1: Sub-acute Care** **Specific requirements in addition to the overarching principles and requirements for bedded community services**		
Expectation	**Action required to fully deliver:**	**Priority level:** High/Medium/Low
The SOP/Service Specification sets out: • The complexity and acuity of need that the service intends to cater for; • Clinical cover arrangements to meet those needs, in and out of hours.		
Transfer conversations include, and record, contingency plans for fluctuations in condition. Consider: • Mechanisms for prompt access to secondary care/community specialist advice and support (e.g. Consultant Connect); • Virtual In-patient models; • Out of hours pharmacy support; • CRT in-reach.		

SUGGESTED PERFORMANCE IMPROVEMENT MEASURES FOR CONSIDERATION

 **BEDDED COMMUNITY SERVICES : SUB-ACUTE CARE (in addition to over-arching measures)**	
HOW MUCH DID WE DO?	**HOW WELL DID WE DO IT?**
Number of community beds available for sub-acute care Number of referrals for sub-acute care received Number of individuals receiving sub-acute care in bedded community services	% individuals transferred with clear contingency plans in place to prevent avoidable transfers back % individuals readmitted to acute care from the bedded community service % practitioners reporting prompt access to secondary/specialist advice when required Staff retention/sickness/satisfaction PREMS
IS ANYONE BETTER OFF?	
Number of individuals who return to usual place of residence	% individuals returning to usual place of residence % individuals reporting that they feel 'home ready' at the end of their stay in the bedded community service PROMS