BEDDED COMMUNITY SERVICES TOOLKIT (WALES): BUNDLE C – DISCHARGE TO RECOVER THEN ASSESS PATHWAY 3

'Discharge Planning' is the second most commonly cited reason for transfer to bedded community services and can be the default pathway in some areas, with a focus on patient flow from acute hospital sites. The adoption of the Discharge to Recover then Assess (D2RA) model in Wales places clear emphasis on this moving to an active recovery model and stresses that bedded facilities should only be considered where complexity of need (NB need for overnight support or intervention) rules out support for recovery and assessment in an individual's own home.

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

- **Deliver an active recovery model.** Pathway 3 should only be implemented where the individual's needs rule out support for recovery and assessment in their own home. These needs are likely to be medium to high level and include overnight assistance greater than could be provided by short-term night-sitting or periodic calls.

  Individuals on this Pathway should be regularly reviewed by the multi-disciplinary team and, where appropriate, transferred onto Pathway 2: support for recovery and assessment in their own home (or Pathway 4 where their own home is in a care home or other supported living setting), as soon as their recovery permits.

  Where it appears likely that an individual will require a care home placement, for example where an extensive package of care at home is no longer meeting their needs, they should still be offered the opportunity to recover and optimise their potential for independence in a calmer, more conducive environment than the acute hospital. This will provide a more accurate assessment of their level of need and important time for psychological/emotional support (for the individual and their carers), if placement is determined as the most appropriate discharge destination from the D2RA pathway.

The need to provide an environment that replicates home and usual routine as closely as possible, is even more imperative for D2RA Pathway 3. Particular attention should be given to the type of furniture and equipment available, and adaptations for individuals with physical, sensory and/or cognitive impairments.

Consider the use of assistive technology to support assessment and manage risk.

No individual should be denied the opportunity for supported recovery due to their cognitive impairment, and this should be reflected in the skill mix of the bedded community service.

Where D2RA Pathway 3 is delivered in a commissioned bedded facility (e.g. from an independent care home provider), block contracts are recommended to provide assurance that:

- The provider's regulatory requirements are being met;
- Strong, trusting relationships are built with the provider and the in-reaching support team (usually the Community Resource Team);
- Staff access the training and development opportunities described above.

LOCAL BEDDED COMMUNITY SERVICES PLANNING & COMMISSIONING CHECKLIST: D2RA PATHWAY 3

Core Function 3: Discharge to Recover then Assess Pathway 3

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
Implement an active recovery model. Nobody should be transferred for passive 'discharge planning'.		
Replicate home environment and routines as much as possible. Consider: • The furniture provided; • Adaptations for individuals with physical / mobility, sensory and cognitive impairment • Assistive technologies		
The staff skill mix ensures that no-one with cognitive impairment (including learning difficulties) is excluded from the opportunity for supported recovery.		
If commissioning this service from the independent sector, block contracting is utilised to ensure: • Compliance with regulatory requirements; • The development of good relationships with the community in-reach teams who will support the active recovery model; • Access to the same range of training as that offered to community hospital staff.		

SUGGESTED PERFORMANCE IMPROVEMENT MEASURES FOR CONSIDERATION

BEDDED COMMUNITY SERVICES : DISCHARGE TO RECOVER THEN ASSESS PATHWAY 3 (in addition to overarching measures)

HOW MUCH DID WE DO?	HOW WELL DID WE DO IT?
Number of people transferred from hospital to the bedded community service on Discharge to Recover then Assess Pathway 3 Proportion of people discharged from hospital requiring further support, who are transferred to a bedded community facility (should be no more than circa 15%)	% people transferred within 48 hours of the decision being made (aim 100%). % people transferred with a co-produced 'My Transfer & Recovery Plan' (aim 100%) % people readmitted to acute hospital from the bedded community service % people transferred from D2RA Pathway 3 to Pathway 2 (support in their own home) or Pathway 4 (support in their home environment, where this is a care home or other supported living facility) within (4?) weeks % staff from independent sector who access the training programme Number/% of people entering D2RA Pathway 3 who have cognitive impairment or learning disability (increase) Satisfaction rates (individual and their family/carers) with the D2RA Pathway 3 experience PREMS
IS ANYONE BETTER OFF?	
Number of people who return to their usual place of residence following a time-limited stay in a bedded community service. Services required by people transferring out of D2RA Pathway 3	% people who return to their usual place of residence from D2RA Pathway 3 (should be circa 80%) % people reporting that their confidence has improved as a result of the D2RA pathway 3 service/PROMS % people readmitted to hospital from home within 28 days of discharge form the bedded community service.