BEDDED COMMUNITY SERVICES TOOLKIT (WALES)

CORE BUNDLE: APPLIES TO ALL BEDDED COMMUNITY SERVICES

'Home First' remains the primary consideration. Individuals should only be transferred to bedded community services when treatment and support at home has been ruled out, due to the complexity of their needs at that time. Work undertaken by the NHS Wales Delivery Unit (DU) with Prof. John Bolton of the Institute of Public Care indicated that the 'reasonable' proportion of people discharged from hospital requiring support in a bedded facility would be circa 15%. In Wales we currently operate in a range between 5% and 90%, with a national average of 30%. This suggests that we should challenge ourselves to ensure that only those who need, and will benefit from, a time-limited stay in a bedded community service are transferred.

For those who do need this support, the aim should still be to support the individual to return back to their home at the earliest opportunity. Close relationships and regular communication e.g. via board rounds, with Community Resource Teams and other community providers (including third sector colleagues), will be key to facilitating this in practice.

Be serious about 'what matters'[1]. Every individual transferred to the bedded community service must have clear, co-produced goals and an 'exit strategy' from the outset; ideally prior to transfer.

Access, with associated agreements across services, to digital architecture will support such planning, including understanding of anticipatory conversations and progression along the 'care tariff'.

Commissioned support providers and third sector partners can play a valuable role in continuing the 'what matters' conversations, supporting discharge and enhancing statutory support for family carers. The plan should be recorded and owned by the individual e.g. via 'My Personal Transfer and Recovery Plan'.

[1] https://socialcare.wales/service-improvement/what-matters-conversations-and-assessment

Ensure equity of access. Restrictive criteria should be avoided. In most cases, the wishes of the individual, their family / carers and the expertise of the multidisciplinary team (including paramedics) should be used to determine whether transfer to the bedded community service is the right route for that person.

All community bedded services must be dementia-friendly in their design[2] and operate in a manner that supports the dignity, and respects the human rights of, the people they serve. In Wales, this will include the active offer and right to communicate in Welsh (see Annex 3: Resources for Welsh at work).

Ensure timely transfer (within 48 hours) to the bedded community facility. Once the decision has been made with the individual that the bedded community service is the right place for their next phase of care, transfer should be facilitated promptly to maximise the window of opportunity.

Maintain independence and adopt a proactive approach to recovery and rehabilitation from the outset. Recovery and rehabilitation must be considered everybody's business[3]. For rehabilitation to be effective and efficient it must be provided seven days a week, to avoid deconditioning and stalling of progress over the weekend.

Every member of the team (which includes informal carers) must be focussed on supporting the individual's strengths, avoiding deconditioning and preventing loss of confidence, with care plans integrating active recovery and rehabilitative goals.

To achieve this, the bedded community service should create an environment that replicates, as far as possible, how the individual wishes to function at home and promotes activities that support them to be 'home ready'. Such activities should include:

- Self-management of medication;
- Self-care ('get-up, get dressed, keep moving');
- The ability to make own drinks and snacks;

[2] Dementia-friendly design | Social Care Wales
[3] Health and social care services rehabilitation framework 2020 to 2021 | GOV.WALES

- Meaningful and purposeful activity, e.g. involving creative therapies and use of outdoor space; and
- Maintenance of community connections e.g. via open visiting, use of assistive technology and third sector support.

Implement Strengths-based Assessment[4]. Assessment for ongoing care and support should focus on maximising the individual's strengths, local support mechanisms and consequently independence. No-one transferred to a bedded community services should ever feel that they have 'failed' an assessment.

Close alignment with community and third sector teams will support a balanced attitude to risk. Consider staff rotation opportunities to assist in embedding this ethos and positive, co-produced risk management.

Provide flexible and agile responses to changing needs. Many of the individuals who require bedded community services will be older and/or have several co-morbidities. It is likely that they may need to receive more than one of the stated core functions at any given time. Flexible and agile responses to manage frailty and fluctuating need, must be clearly described in local clinical governance arrangements. This will avoid the risk of repeat transfers back and forth to the acute setting, which are costly, distressing to the individual and carry their own risks of harm.

Provide strong local leadership. Leadership plays a key role in shaping the culture of organisations and the leaders of community bedded facilities need to demonstrate understanding of, and be able to communicate and influence across, the whole system (secondary, primary and community healthcare, social care, independent and third sector providers, and housing). This will facilitate the co-ordination of health and social care services seamlessly, wrapped around the needs and preferences of the individual and reflect the ambition of 'A Healthier Wales'.

With Allied Health Professionals (AHPs) practising in most clinical pathways, working across organisational boundaries and the five identified core functions for bedded community units, there is opportunity to think beyond traditional leadership roles to achieve this, including for example therapist-led units or nurse-led models of care.

[4] https://www.scie.org.uk/strengths-based-approaches

Deliver holistic care through multi/inter/trans-disciplinary working[5]. As part of the modernisation agenda, there is opportunity to develop specialist generalist roles that empower practitioners to 'work at the top of their license', taking on blended roles and acting as trusted assessors.

Highly skilled generalists at all levels, are key to the delivery of the enabling approach and social model of care.

The staff supporting bedded community facilities must be valued and developed using a combination of formal and experiential practical learning (see **Annexe 3** for examples of the resources available). Such learning should encompass the formation of therapeutic relationships and the enabling ethos.

Members of the multi/inter/trans-disciplinary team can provide vital sharing of expertise e.g. dieticians delivering practical teaching sessions on nutrition for staff and patients.

Any bedded community service must abide by national staffing guidelines.

[5] https://www.aomrc.org.uk/wp-content/uploads/2020/05/Developing_professional_identity_in_multi-professional_teams_0520.pdf

LOCAL BEDDED COMMUNITY SERVICES PLANNING & COMMISSIONING CHECKLIST

Name of bedded community service:

Core functions that Local/Regional Needs Assessment states this service should deliver:

- **Core function 1: Sub-acute Care** ☐
- **Core function 2: Rehabilitation** ☐
- **Core function 3: Discharge to Recover then Assess Pathway 3** ☐
- **Core function 4: Palliative and End of Life Care** ☐
- **Core function 5: Step-up Care** ☐

Bedded Community Services: Overarching Principles and Requirements

Expectation	Action required to fully deliver:	Priority level for implementation: High/Medium/Low
Clear discharge and step-up pathways are in place, that emphasise that transfer to bedded community services must only be arranged where 'Home First' has been ruled out due to complexity of need at that time.		
Decisions to transfer are determined by MDT, following 'what matters' conversation with the individual.		
Access to shared information systems is available to support this decision-making process.		
Transfers take place early in the day and within a maximum 48 hours of the decision being made.		
All individuals are transferred with a plan and exit strategy, co-produced with them and their family / carers.		
All individuals hold a copy of their 'My Personal Transfer & Recovery Plan'.		

Bedded Community Services: Overarching Principles and Requirements (continued)

Expectation	Action required to fully deliver:	Priority level for implementation: High/Medium/Low
Community Resource Teams meet regularly with bedded community service staff e.g. at board rounds, to identify individuals ready to return home (with support if required)		
Community bedded services are dementia-friendly		
Individuals receive an active offer of Welsh language service i.e. can communicate in Welsh if they wish.		
Individuals can self-manage their medication. Consider: • Safe storage • Pharmacy requirements • Risk assessment and management		
Individuals are supported to self-manage their personal care. Consider: • Facilities/ equipment already available in the home environment; and / or • The need for provision of aids and adaptations to support readiness for discharge.		
Individuals can access facilities to make their own drinks and snacks. Consider: • Patient kitchen • Hydration stations • Breakfast clubs		
Individuals have access to meaningful activities. Consider: • Creative therapies • Use of outdoor space		

Bedded Community Services: Overarching Principles and Requirements (continued)

Expectation	Action required to fully deliver:	Priority level for implementation: High/Medium/Low
Individuals can maintain/develop connections with their community. Consider: • Open visiting • Assistive technology • Third sector in-reach		
7 days a week rehabilitation and reablement are provided. (Can be delivered by highly skilled Health and Care Support workers.)		
Strengths-based assessment is the norm.		
Compliance with national staffing guidelines.		
Bedded community services are led by individuals, who can communicate and influence across the wider health and social care system. Consider non-traditional models e.g. therapy or nurse-led.		
Bedded community services are staffed with highly skilled generalists, who can work at the 'top of their license'.		
Staff access a mixed programme of formal training and experiential, competency-based learning. This must include: • The enabling ethos (focus on what matters to the individual and their personal well-being outcomes & goals); • The building of therapeutic relationships.		
The health and care workforce have the opportunity to participate in rotation schemes (secondary/community/bedded/independent sector)		

SUGGESTED PERFORMANCE IMPROVEMENT MEASURES TO CONSIDER

BEDDED COMMUNITY SERVICES : OVERARCHING (ALL FUNCTIONS)	
HOW MUCH DID WE DO?	**HOW WELL DID WE DO IT?**
Number of community beds available Number of referrals for bedded community services received Number of individuals receiving bedded community services	% individuals transferred with co-produced plan and exit strategy % individuals whose choice to communicate in Welsh is facilitated % facilities with dementia-friendly design features % individuals supported to manage their own medication in the bedded community service % individuals transferred to bedded community service within 48 hours of the decision being made % individuals transferred to bedded community service before 3pm (excluding urgent step-up transfers) % staff undertaking training to support the enabling ethos and the formation of therapeutic relationships % individuals with a length of stay in the bedded community service of 4 weeks or less % individuals readmitted to acute care from the bedded community service Staff retention/sickness/satisfaction PREMS
IS ANYONE BETTER OFF?	
Number of individuals who return to usual place of residence Number of individuals reporting that they feel 'home ready' at the end of their stay in the bedded community service	% individuals returning to usual place of residence (should be circa 75%) % individuals reporting that they feel 'home ready' at the end of their stay in the bedded community service PROMS