



Addysg a Gwella Iechyd
Cymru (AaGIC)
Health Education and
Improvement Wales (HEIW)



Y Weithrediaeth
Executive



Step-down to Recover (SD2R) National Minimum Service Guidance



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1. Purpose and Definitions

1.1 This document provides information and guidance to create Step Down to Recover opportunities.

1.2 The combined health and social care system is facing unprecedented challenges from, but not limited to:

- The flow of people through hospitals and increasing demand of emergency and elective services along with an increase and more complex individuals requiring community services.
- Workforce recruitment and retention challenges for both registered and non-registered professionals across all sectors including health, social care, third sector and private providers, critical to maintaining effective and consistent service delivery.

1.3 In recognition of the current situation there is a need to identify, develop and implement a range of actions that can support individuals to leave hospital and access services that support recovery and rehabilitation. The Discharge to Recover and Assess (D2RA) pathways support the person's journey from hospital to home. "Home First" to the person's usual place of residence remains the primary outcome.

1.4 The development of community step-down to recover capacity via D2RA pathway 2, providing recovery and rehabilitation opportunities to people who are medically optimised to move onto their next stage of care, and can contribute to the rightsizing of ongoing services provided in a person's own home.

Support to recover in a bedded Step-Down facility

1.5 For the purposes of this guidance the term "step down" is defined as a facility for people who are ready to be discharged from hospital but are unable to return to their former home, require further rehab or reablement in a place other than their usual residence to reach their level of independence, or the care and support required at home is not currently available. They may require time, support, care and therapeutic interventions to enable them to be rehabilitated and re-abled.

1.6 Discharge home today should be the default pathway.

1.7 Where the capacity to support recovery and assessment at home is currently insufficient to meet the demand, as this should always be the first choice, a short-term time limited stay based on individual needs, in a Step Down to Recover facility is the next step on the pathway to home, with review and transfer to home wherever and as soon as possible.

1.8 The stay in the step-down bed for those people whose care and support requirements at home are not available must still add value to the individual by providing rehabilitation, thus potentially requiring less care and support to be commissioned at home. There is an expectation that work is underway to ensure that care and support, if still needed will be available following the stay in the step-down bed.

1.9 All individuals transferred onto this care pathway will require a discharge plan with clear goals, a rehabilitation/recovery plan, including a clear exit strategy (plan for the person to return to their own home), including an estimated date of discharge.

1.10 In all cases where ongoing domiciliary care services (short or longer term) are required as the next stage of the care pathway it is essential that the same level of priority and monitoring is in place for individuals who are in a step-down to recover community bedded facility as for those individuals in a hospital or community setting. Individuals in a community bedded facility must not be viewed as a lesser priority for access to the next stage in their care pathway.

2. Adding Value

2.1 HBs and LA's need to demonstrate they are implementing a service that adds additional sustainable value to individuals and the system, with a positive impact on the current levels of demand. Integrated models should minimise any unintended consequences, by having effective communication and integration between and within services. The NHS Benchmarking outputs will support the analysis.

3. Discharge Principles from an Acute Care Setting

3.1 The following principles reflect those identified in both D2RA and broader discharge planning guidance relevant to Wales:

- Discharge planning must begin from the point of admission using the principle of "home first" to the person's usual place of residence including what early arrangements, such as assistive equipment, can be put in place ahead of a planned, swift and safe discharge.
- Following a 'what matters' conversation with the individual, discharge arrangements should be determined by the patient/their representative with the support of the multi professional discharge team.

- Individuals, their families, carers and representatives are fully engaged with and provided information on the pathways, so all are clear on the next steps on the pathway to home
- Use a collaborative approach to discharge planning in a safe and timely way, utilising a range of professionals and where appropriate seeking more specialist involvement such as the inclusion of housing officer expertise as part of any multi- professional team/meetings.
- Third sector support should be considered to support the person, their families and informal carers.
- An enablement approach resolving potential issues should be taken for those who wish to go home with the support of their families rather than a risk averse approach. People should be fully informed and encouraged to have a voice and control in their discharge plan.
- Mental Capacity Assessments should be undertaken in line with the requirements of the Mental Capacity Act (MCA) and appropriate actions completed including best interest's decisions.

Further guidance on MCA and Best Interest Decision making can be found at <https://gov.wales/mental-health> or

<https://socialcare.wales/service-improvement/the-mental-capacity-act-and- deprivation-of-liberty-safeguards-dols>

- Early engagement with agencies and professionals in discharge planning who will be required to support the discharge pathway. Community Resource Teams or other similar community services need to be engaged in the discharge planning process from point of admission, immediately when a potential need for support to return home is identified.
- A discharge plan is developed to support the identified pathway and includes evidence of multi-professional advice and decision making, with the person at the centre, to enable them to make the best-informed decisions for their circumstances.
- The discharge plan should have clear goals for the next stage of the patient's care pathway and include any assessment for rehabilitation or assistive equipment to maximise their ability and function, to optimise their health and wellbeing. This can also support the reduction of unnecessary prescribing of scarce community services both within a bedded facility and community domiciliary care provision.
- Discharges are expediated once any decision is made that the person no longer meets the criteria to remain in hospital.

- Follow up outpatient appointments are required to be arranged by the hospital staff.
- A supply of 2 weeks take home medication is expected to be provided for discharge. Timely arrangements should be in place to ensure there are no delays to agreed date and time of discharges.
- Primary care services must be made aware of any changes to medication to ensure that primary care can provide support following the initial 2 week supply.
- Transport to the next stage of care remains the responsibility of the Health Board, unless this can be supported by family or friends. Early engagement with the Welsh Ambulance Service Trust (WAST) including Non-Emergency Patient Transport Service (NEPTS) and third sector transportation services will enable those services to be very aware of the daily pressures and likely demand for transfers.

3.2 Where there are no identified mental capacity considerations, and the individual no longer meets the criteria to remain in an acute hospital bed but refuses to leave for the next stage of care pathway, Health Board governance arrangements should be implemented.

4. Community Bedded Step Down to Recover Settings

4.1 Step down to recover facilities need to be an integral part of the community teams or outreach / in reach teams who support the nursing and therapeutic input to the facility.

4.2 Be time limited, with the expectation to improve flow and move people to the desired pathway home as soon as possible. Where 'No' is the answer to 'Is reablement complete?' and a further period of reablement is deemed appropriate, then this can be extended subject to continued review and a defined end date for people to return to their own home.

4.3 The bedded facility needs to provide an environment that will deliver reablement/rehabilitation and the optimisation of an individual's abilities and strengths and works with the family/carers who will support the person, post discharge.

4.4 The individual is listened to, heard and understood and seen as a person first, with strengths, assets and a contribution to make, with their voice and "what matters to them" driving the interventions and decisions for their wellbeing.

4.5 The Individual should be empowered to exercise choice and control and risk enabled through informed decision making.

4.6 The bedded facility could be located in a range of properties within/or outside of the NHS.

4.7 This Service Guidance is agnostic of the provider of the bedded facility so long as they meet the requirements within.

4.8 The requirement of the Service Guidance is that these facilities provide therapeutic reablement / rehabilitation interventions.

4.9 Consideration needs to be given to the available space at the step down to recover facility. The facility must have space to:

- Support people to maintain relationships
- Provide assistive equipment for therapeutic reablement / rehabilitation

4.10 It is expected that facilities include access to domestic laundry and kitchen areas to support individuals to self-manage as they recover and/or their skills increase to include food preparation, personal care, laundry etc and the therapeutic rehabilitation needs such as self-medication management, kitchen and personal care assessment, and mobilising around the facility and in the local area / grounds.

4.11 An outcomes measure should be used such as the Barthel Index and EQ5DL, to record individual outcomes by the professional lead.

4.12 Where follow on services are required the professional lead, along with the facility leads (operational management structure), will need to engage with the receiving community teams to agree the arrangements for the pathway to the next stage of care. This includes the commissioning of any identified ongoing services.



5. Step Down to Recover Bedded Facility Principles

5.1 The following principles should be reflected in any regional/locally developed service models designed to meet the specific needs of the local population:

- Have a clear agreed leadership model in place that is owned by all partners with an Executive Lead.
- The default should be that the service:
 - Is delivered by the multi-professional team with appropriate leadership reflective of a Rehabilitation model of care and is embedded through service delivery.
 - Has a strong sense of professional identity; confidence and competence in role and skill accompanied by good professional reasoning.
 - Readiness to adapt and be flexible to meet individual's needs and adapt service to those needs i.e., to be able to provide person-centred care
 - Delivered by professionals with appropriate skill levels in rehabilitation and recovery, advantageous to include Occupational Therapists/Physiotherapists, Assistant Therapy Practitioners, Speech and Language Therapists, Dieticians, Nurses, Social Workers and Care and Support Workers.
 - Sets out access arrangements for specialist care/ advice for complex care interventions for example, diabetes, skin integrity, wound care, dementia support, podiatry, poly-pharmacy, mental health and wellbeing, for example through the temporary registration of individuals with local GP/Primary Care services to ensure access during their short stay.
 - Have clear arrangements in place to access medical services and review as required.
- Professional leads will develop personal individual rehabilitation and recovery plans, which reflect the underpinning ethos that rehabilitation is everyone's business and include:
 - Co-produced clear goals
 - Monitoring and reviewing with the individual
 - A clear exit strategy, an estimated discharge date, agreed prior to admission to any onward care pathways as they emerge. As

the intervention strengths-based rehabilitation is reviewed the discharge date is adjusted accordingly i.e., brought forward where progress is made sooner than originally anticipated.

- A clear strengths-based rehabilitation model is in place.
- Focus on providing sufficient active rehabilitation and reablement that seeks to optimise all individual's abilities.
- In reach services need to focus on the pathway, actions and any ongoing support in the person's own home to ensure a smooth transition and clear message the placement is temporary, and the goal is home.
- Community teams/other enabling teams in-reach into the bedded facility using a pull-out approach (a link to community services such as Reablement which can provide ongoing support and ensure the person returns home as soon as possible) to ensure a supported, timely return home and connection to the local community services.
- Multi-professional induction, training and a competency-based learning model is in place, for all staff responsible for oversight or delivering rehabilitation at the facility, that is focused specifically at reablement and rehabilitation.
- Ensure bedded facility staff are trained and competency signed off to respond to falls at scene. Models such as "I Stumble" or other similar suitable, serviced equipment to be available and accessible on site.
- Have clear and comprehensive protocols that ensure timely assessment for, and access to any required equipment and technology to support the individual during the service provision and on their onward care pathway.
- Safe systems are in place to ensure the oversight, storage and audit of medicines management, including where individuals self-administer.
- Informal carers/families are supported to be part of the team delivering rehabilitation and recovery programmes, where they are able and wish to do so.
- Utilise the third sector, volunteers and local community to support the bedded facility to enable individuals to engage in activities to support their emotional and wellbeing needs and the pathway to home.
- Where local models include the provision for people with a cognitive impairment or a dementia, all staff receive appropriate training.

- Staffing levels within a Registered Step Down to Recover community bedded facility must align with statutory requirements and the assessed care needs of the individuals residing there.
 - Where registered under RISCA regulations the service provider must ensure that at all times a sufficient number of suitably qualified, trained, skilled, competent and experienced staff are deployed to work at the service, having regard to:
 - (a) the statement of purpose for the service
 - (b) the care and support needs of the individuals
 - (c) supporting individuals to achieve their rehabilitation goals
- Multi-professional induction, training and a competency-based learning model, that encompasses quality assurance process, is in place that is focused specifically at reablement and rehabilitation.
- Clear governance arrangements are in place for delegated duties by a professional registrant to a suitably trained support worker.
- Clear pathways onto the next phase of care or out of formal care services are in place such as referrals onto non statutory community services to support the reduction of social isolation and support individuals' health and wellbeing, or provide services such as welfare benefits advice.
- Individuals receive an active offer of Welsh language service i.e., can communicate in Welsh if they wish.
- The service provider must ensure the statement of purpose for the service is updated to reflect the current service provision.

5.2 The local model chosen may require other professionals or services to provide additional input into the bedded facility to support the assessment of the person's ongoing holistic needs as appropriate.

5.3 Medical Cover. A clearly articulated process regarding how the full range of primary healthcare services will be accessed including:

- Continuity of care with the persons own GP services. However, for some people it will not be possible to maintain contact with their own GP practice and so will require registration as a temporary patient with the relevant GP practice.
- Continuity of care with the community nursing team should be provided by the person's own practice maintained wherever possible and the maximum benefits of e-scheduling should be utilised to ensure continuity of care is maintained. However, for some people it

will not be possible to maintain contact with their own practice and so will require registration as a temporary patient with the relevant practice.

- Weekend and out of hours medical/nursing cover should be provided by the usual out of hours routes.
- Access as needed to community dentistry, podiatry, optometry or audiology.
- Where interventions are required from Community Mental Health teams, interventions by these teams will need to be under the clinical/medical governance of the care coordinator and responsible professional during a person's stay. SD2R is unlikely to be an appropriate place to support someone experiencing an acute mental health crisis.



6. The Step Down to Recover bedded facility

Criteria

6.1 Individuals who are

- medically optimised for discharge,
- no longer meet the criteria for an acute hospital bed,
- require care and support services which cannot be provided in their own homes
- require a short-term stay as they are deemed unsafe to return to their home pending a start date for community packages of care

6.2 Individuals will be over 18 (most will be over 60).

6.3 Individuals with a cognitive impairment or a Dementia should not be excluded, with consideration based on individual need and circumstances. (More specialist intervention such as Dementia/Memory Rehab should be provided to meet any individual identified need). Assessments may need completing under the Mental Capacity Act 2005 and if required a Best Interest Meeting should be arranged.

6.4 Individuals who are awaiting assistive equipment and minor adaptations to their home and will benefit from a discharge to recover community bedded facility.

6.5 Individuals who are homeless/have no right of recourse to public funds/no place to safely discharge to and will benefit from a discharge to recover community bedded facility. This should not hinder the process to resolve their ongoing housing needs.

6.6 No condition is excluded; however, individuals will need to meet the criteria set out above and in line with the bedded facility regulatory requirements such as the Statement of Purpose.

Exclusions

- 6.7 Acutely unwell patients who require treatment in a hospital facility.
- 6.8 Individuals whose level of brain health and associated cognitive impairment, where the step-down facility model does not include resources to support this, i.e., appropriate therapeutic intervention.
- 6.9 Individuals on end-of-life care pathways.

Discharge Process

- 6.10 MDT/Discharge Team complete the “What Matters” conversations with the individual their families and carers as appropriate and draft the discharge recovery plan with clear goals identified for the short-term, step-down bedded facility stay.
- 6.11 Discharge Team/Identified Discharge Lead engages/refers to local community arrangements such as a Single Point of Access/Common Access Point or local arrangements to access the community bedded facility to support the discharge.
- 6.12 The discharge plan is shared with the step down to recover bedded facility and any other supporting paperwork provided, the facility representatives agree they are able to meet the person’s needs. (Appropriate information sharing protocols should be in place).
- 6.13 Any specialist equipment, medication, transport or other requirements for discharge are sourced and provided.
- 6.14 Discharge arrangements i.e. day and time of transfer is arranged and agreed 7 days a week.

(Community bedded facilities could also use a “pull out” approach with hospitals)

The Step Down to Recover/Rehabilitation/Recovery bedded facility will:

- 6.15 Review all referrals via the designated referral route, agree where needs can be met with the referring team, provide an agreed transfer/start time and date.
- 6.16 Provide an environment where an enabling ethos is embedded in all activity to support individuals to achieve their goals and return to their usual place of residence.
- 6.17 Provide a positive experience of recovery and rehabilitation which improves the outcomes for individuals.
- 6.18 Provide a safe environment and protect people from avoidable harm while supporting the independence goals and positive risk taking.
- 6.19 Have appropriately trained and sufficient staffing and support to deliver the service.

Workforce

- 7.1 The workforce requirements will depend on the chosen option for regional commissioning.
- 7.2 Step Down to Recover Bedded facilities will be required to have or be supported with the following roles:
- **Manager/ Lead** – (must be trained on rehabilitation principles).
 - **Senior/Supervisor** – (must be trained on rehabilitation principles).
 - **Care and Support Workers** (must be trained in rehabilitation competencies)
- 7.3 All care and support staff must be trained in rehabilitative competencies from a recognised competency training framework.
- 7.4 It is expected local authorities and health boards will enable/facilitate training and support where step down to recover is provided in a commissioned care home.

7.5 AHP professionals:

- Occupational Therapists and Physiotherapists and Assistant Therapy Practitioners to support:
 - Rehabilitation service delivery, including support to oversee/sign off care and support worker competencies
 - Develop and review rehabilitation plans, goals and onward plans for home.
- (Other AHP roles with appropriate skill sets can be used providing they use a rehabilitation/reablement approach. (OTs trained in supporting rehabilitation for people with a cognitive impairment will be required to support those individuals)).
- Other roles may be required depending on local development such as nurses trained to deliver rehabilitation.
- Dietetics and Speech and Language Therapists will be required to provide support in their area of specialty

7.6 It is for the facility to ensure the staffing levels meet the needs of the people residing there.