GIG CYMRU NHS WALES | Delivery Unit Uned Gyflawni

Llywodraeth Cymru
Welsh Government

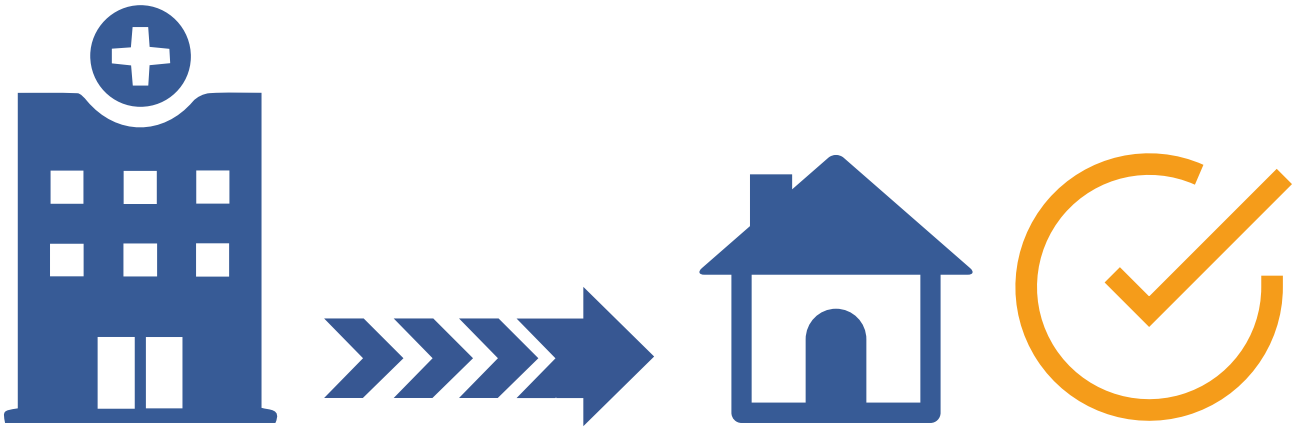
A Healthier Wales:
our Plan for **Health and Social Care**

pob dydd yn cyfri cartref yn gyntaf
every day counts home first

Home First:
The Discharge to Recover then Assess model (Wales)

A summary guide to the principles and process

December 2021



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Mae’r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

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Foreword

The principles for facilitating effective and timely discharge have been long-established in Wales[1,2].

The thinking behind the Discharge to Recover then Assess (D2RA) model is not new, but rather reflects an evolution of thinking and practice, which places even greater emphasis on 'what matters' to our citizens and how we work together with them, to achieve the best outcomes possible.

Safe and effective delivery of the D2RA Model will support implementation of 'A Healthier Wales – long-term plan for health and social care' and contribute to the whole system flow, which means that our citizens can receive right car at the right place at the right time.

The model has been in development over a number of years, encompassing the terms 'Home First'/Discharge to Assess/Hospital to Home. The progress made to date represents considerable inter-agency, multidisciplinary effort, as set out in the timeline on the following page.

A full summary of achievements to date, the challenges and support available going forward are set out in the companion document, which we recommend is read alongside this summary guide of the principles and process. Insert link to Briefing

The purpose of this document is to pull together in one place, the 'what good looks like' for practical implementation of the D2RA model, as co-produced in a series of multi-agency workshops during 2019. This work was previously published as 4 separate documents for Pathways 1 to 4[3].

As with all transformational change, embedding the D2RA model will require ongoing passion, commitment and adaptation, if we are to truly and transparently deliver the best experience for the people we serve. This document also briefly sets out proposed mechanisms to support that continuous development, with further detail to follow.

'**Together we must**'.

1. WHC cover.doc (**wales.nhs.uk**)
2. www.wales.nhs.uk/sitesplus/documents/829/Passing the Baton – Bing
3. **http://howis.wales.nhs.uk/sitesplus/407/page/36206**

Bringing ‘Home First’ and ‘Hospital to Home’ to Wales – the D2RA Timeline[4]

Drawing on the work of D2A in NHS England and in conjunction with the Institute of Public Care the DU held a national event in September 2018 to analyse how the D2A principle could be brought to Wales.

The finding of this events informed the creation of the four Pathways which are the foundation of D2RA. Notably ‘Recovery’ was embedded as a core component to the Welsh Model for D2A, hence D2RA.

Home First: Cartref yn Gyntaf’ national conference (September 2018) identified the pathways for D2RA.

DU Review of Complex Discharge: ‘Why not Home: Every Day Counts’ – November 2018.

This gave D2RA the impetus for change that it needed in Wales and the project forged connections with the A Healthier Wales ambitions for patient focused, seamless and integrated models of care.

These workshops facilitated input from experts as the pathways were being developed to ensure that they suited needs of the H2H landscape in Wales. Additionally this allowed the DU to understand what existing infrastructure there was that could be built on.

The workshops produced ‘what good looks like’ documents for D2RA Pathways 2, 3 and 4. They also identified the barriers and challenges to D2RA implementation and demonstrated the need to determine how to achieve right sized communities services.

DU Regional and National Workshops held throughout 2019.

‘Every Day Counts’ – building a social movement.

The 2019 workshops and conferences helped to create a social movement of over 500 D2RA champion practitioners including health and social care practitioners, managers, commissioners, providers and support agencies.

With continued engagement through the DU, D2RA workshops and CoP were held. Funding was allocated via RPBs via the Integrated Care Fund (ICF) and later the Transformation Fund (TF) to support D2RA.

Support, guidance and evaluation was offered to these services by the DU, and as part of the ICF and TF. (Some of these service are included as part of the case studies within this document).

Embedding D2RA Services across Wales.

Right Sizing Communities project delivered by the DU, in collaboration with Professor John Bolton and the Institute of Public Care.

The ‘Every Day Counts’ sessions helped examine the barriers and challenges to D2RA and one of the key themes picked up was having the right sized community services. To tackle this the DU facilitated a national project on ‘Right-size Community Services for Discharge’.

The findings supported the RPBs in the continued formation of the D2RA model. Two CoPs have since been established to support ongoing capacity and demand modelling for discharge and, more recently, admission avoidance.

As part of WG’s evaluation of new models of care, a H2H CoP was established in conjunction with the DU to consider best practice; challenges and opportunities; and to help identify key performance measures.

The CoP continued during 2020 and into 2021 which has meant the impact of the pandemic on services and partnership working could be captured. This was instrumental in the identification of the need to create a Pathway 0 and the later expansion of D2RA as part of the COVID-19 response.

Hospital to Home Community of Practice (2020-21).

COVID-19 additional funding (2020/21)

In 2020/21 WG provided an additional £10million to support the expansion of the surge capacity required to meet the potential demand for D2RA Pathways, arising as a result of the pandemic. As such D2RA is now a key asset in the WG’s toolkit and the discharge arrangements are embedded in to the COVID Response.

The roll out has shown to be broadly successful and as a result D2RA will now be a 2 year project designed to align existing services and continue to develop the pathways based on the feedback from the staff on the ground so that the focus stays on patient care.

The WG announced the Transformation Scaling Fund in March 2021, committing £6m in 2021/22 to assist with the scaling of hospital to home models at a regional level to help embed a national model of working.

The purpose of Scaling Fund is to build on existing H2H/ D2RA activity in order to scale within and across regions specifically supporting and enhancing the delivery of Pathways 0, 1, 2 and 4, with a view to ensuring there is a regional approach across the RPB in delivering the agreed D2RA model.

There will be an increasing emphasis on prevention and early intervention; supporting independence at home; and maximising community assets and third sector services to reduce demand on primary and secondary care.

Transformation Scaling Fund (2021/22)

4. Delivering Home First – Hospital to Home Community of Practice: key learning and practice examples (Welsh Government, May 2021)

The Discharge to Recover then Assess Model (Wales) 2020

Pathway 0	Pathway 1	Pathway 2	Pathway 4	Pathway 3
				
Discharge or admission avoidance through short-term third sector support	**Is this person fit to admit?**	**Why not home? Why not today?**	**Home first when your home is a care home**	**Support to recover in a bedded intermediate care facility**
Preventative services delivered in collaboration with third and voluntary sector organisations. Aim to avoid further referral and admission.	Multidisciplinary Team assessment within hospital 'front door' units to avoid full admission. Arrange treatment and supported recovery at home, whenever it is clinically safe to do so.	Initiated as soon as treatment, which can only be delivered within an acute hospital environment, is completed. Supports people to recover at home before being assessed for any ongoing need.	Similar to Pathway 2, but acknowledges specific considerations to be addressed in the existing care home environment. Individuals should be allowed a period of recovery, followed by assessment in their usual environment.	Should only be considered where the needs of the individual rule out recovery & assessment at home. Review and transfer to Pathway 2 wherever, and as soon as, possible.

D2RA (Wales): Overarching Principles

1. **Think 'Home First' and keep the individual at the centre of all discharge considerations.**

   The primary motivation for implementing the D2RA model in Wales is to achieve the best outcomes for each individual we serve.

   Those outcomes will only be achieved if we truly respond to 'what matters' for them.

   As professionals we need to recognise that 'what matters' is highly likely to include more than the medical management of their conditions alone[5].

2. **Balance risk and agree co-produced, clearly documented plans.**

   With the best intent, health and social care professionals can be 'risk averse' and aim for their view of perfection in an individual's condition, circumstances or environment, before a safe discharge from hospital can be completed.

   The reality is that life is rarely perfect and the individuals we serve will each have their own tolerance of risk.

   It is essential therefore that D2RA plans are developed with the individual, following an initial strengths-based assessment and mature conversation regarding positive risk taking. The plans must include the contingencies to be implemented promptly if the individual's needs or circumstances change.

   The plan should be documented, using the 'My Personal Discharge & Recovery Plan' for example (see Annexe 1) and a copy held by the individual themselves (or their family/carers).

3. **Have the community services infrastructure in place** to ensure that proportionate 'wrap around' support and/or equipment to aid recovery is provided in a timely and consistent manner, wherever the individual may live in Wales. The national right-sizing community services for discharge project supported the Regional partnership Boards to 'know their numbers' for the planning and commissioning of such services.

4. **Communicate.**

   Even the best plans are meaningless unless they are communicated and shared with the people (including unpaid carers) who will be providing support once the person is home.

5. See for example **https://www.kingsfund.org.uk/sites/default/files/mike-nolan-patient-centred-care-senses-framework-nov12.pdf** and **https://www.youtube.com/watch?v=hl07iA9-6qs**

The building blocks for effective discharge, recovery, then assessment

What Matters to Me conversations

Prompt access to home-based or bedded intermediate care services

Trusted Assessor models and multi/interdisciplinary working

Trusting relationships and clear communication

Active recuperation and strengths-building

Proportionate, strengths-based & co-produced assessment

Tolerance: Perfection is not required, no assessments are 'failed'

Optimal use of 3rd independent sector & housing options

D2RA Pathway 0:
Third Sector Support

Evidence suggests that around 20% of older people who are discharged from hospital (wards and 'front door' assessment units) may require some short-term support with the practicalities of discharge[6], for example:

- Making sure their home is accessible and warm on discharge
- Transport home
- Support with shopping and meal preparation
- Follow-up checks and building confidence after hospital admission
- Making the links to more formal community services if required; and
- Re-building or initiating community connections to support recovery and well-being.[7]

One of the key findings from the national Right-sizing Community Services for Discharge Project (2019/20)[8], was that there is significant opportunity to utilise such third sector support more effectively in Wales, thereby potentially avoiding over-referral to intermediate care 'to be on the safe side'.

Third sector partners must have the ability to make prompt referral into other D2RA Pathways, if (once settled in their home environment) the individual is not recovering as anticipated and/or has additional needs to those initially anticipated on discharge.

This should be via the Local Social Care Community Co-ordination Hub/Single Point of Access, of which third sector partners will be key members.

6. Some_key_messages_around_hospital_transfers_of_care.pdf (brookes.ac.uk)
7. E.g. see Support at home | British Red Cross; Age Cymru Gwent ¦ Hospital Discharge Service (ageuk.org.uk); Care and Repair: Hospital to Home service
8. Right-sizing Community Services for Discharge.pdf (adss.cymru)

PIVOT (West Wales)

1. About the person

A seventy-five-year-old individual, living alone on the outskirts of a main town.

They have adult children, none of which live locally but they do visit when they can, and keep in touch using Skype.

They have several friends and some of their neighbours are extremely kind and helpful. They have a car and still drives, but their health precluded them from driving during most of the 6 weeks of support that PIVOT offered.

On discharge from hospital, they felt weak and unsteady on their feet, having suffered a heart attack, and this was affecting their mood and wellbeing.

2. What was the situation?

The individual was referred to PIVOT for some home from hospital support as they were finding some daily activities, such as cleaning too tiring. They were not using the shower to wash as they did not have the energy and had no grab rail for support.

A stair-lift had been fitted but they wanted to get back to climbing the stairs normally; they just did not have the strength to do so. They were concerned about leaving the house as there are quite deep steps to the front door and they did not feel safe.

The individual found all these new limitations frustrating but did try pushing themselves each day to aid their recuperation and build their strength and stamina up.

They were frustrated that they could not wash their own hair, and the carers who had initially been supporting them had assessed that they did not require further formal help, as they could have a strip wash, dress themselves and put a ready meal in the microwave.

They were not in receipt of any financial help towards paying for a private carer and could not afford it on their existing income.

They were worried about eventually going out to the shops as they would not be able to walk very far.

Their friend was doing their sundries shopping until they felt well enough, and they had Wiltshire Farm Foods delivered regularly, but they were concerned about further along in their recovery.

3. What did pivot do to make a difference?

PIVOT helped with practical tasks, keeping the home clean and helping with bed making etc. but were unable to help with personal care due to not being regulated at that time.

The support worker contacted the care team who had been involved and tried several avenues to arrange some support with bathing/showering for, but they were all declined on the grounds that they had been assessed as having no eligible needs.

PIVOT referred the individual to Care and Repair for a home safety check, to have a grab rail installed over the bath and by the front door, and a benefit check to see if they would be eligible for Attendance Allowance.

PIVOT also arranged for an Occupational Therapist to risk assess their safety getting in/out of the bath to use the shower, so that a support worker could be present for confidence once the service was regulated.

PIVOT made enquiries regarding obtaining a blue badge for disabled parking to make life easier when they was able to go out by themselves.

4. What outcomes were achieved?

As time went on the individual regained some of their strength and confidence. By the end of the support period they were able to walk a couple of hundred meters and had even visited the local supermarket, having driven there themselves.

Care and Repair had assisted in applying for Attendance Allowance, which they were awaiting the outcome of, and had fitted shallower steps and grab rails to the front door and a grab rail over the bath.

The Occupational Therapist had provided a bath seat so they could sit down to shower and PIVOT had offered to be present the first few times (as the service had become regulated) but the

individual's strength and confidence had grown sufficiently that they no longer felt that they needed someone there.

PIVOT had informed them that applying for a disabled parking badge now had to be done online and offered assistance, but they said they had a neighbour who could help, so was happy to do that themselves. They were feeling much more positive as they could see the progress they had made over the 6 weeks and knew they had to be patient with themselves, and would get there eventually.

The regular visits from PIVOT had meant they could concentrate on getting better rather than expending energy trying to clean etc. and having someone to talk things over with and give support and encouragement had been very beneficial to their wellbeing.

5. QUOTES/FEEDBACK

The individual expressed gratitude for the support and practical assistance received from PIVOT.

They said that they were glad to have had the support as they had "felt so low when I came out of hospital and your visits really helped me keep motivated to get better".

Swansea Council for Voluntary Services (SCVS)

Reason For referral (from referral form).

Discharge from Hospital: Emotional support and support with shopping.

Support needs identified.

The individual referred used supplementary oxygen and collapsed whilst out doing shopping, causing their admission to hospital. They reported that they were scared to go out and walk very far in case it happened again.

They did not have any means to pay for shopping via card payments although they had applied for a pre pay credit card.

They also stated that they were desperate to move house, as they wanted a mobility scooter which couldn't be stored in their current home, and living by a main road, they felt the air quality was also badly affecting them. They had said they had registered for a council property and requested a move with their housing association, who had thus far been unable to help.

Support and referrals arranged.

They were provided with an emergency food parcel and the Morrisons care line number for when they had their payment card.

Referrals made;

- Christians Against Poverty for advice on financial support
- SCVS befriending support to help with the isolation they were feeling
- Swansea Council Housing Options confirmed the individual was not on their list, so requested an application form, which was completed with support from family
- Housing Association – Landlord
- Social Services - however they confirmed he was not eligible for support from them.

Several weeks later the individual called to say they had received their credit card and had used the Morrisons care line, however they had been back in hospital and were getting increasingly worried about their health.

Referrals were made to the Tenancy Support Unit (TSU) and further attempts to contact the Housing Association made. Also made a referral to Citizens Advice Bureau (CAB) for housing advice.

The TSU contacted me and suggested he really needed support from the Housing Association in the first instance. CAB suggested Shelter may be able to support him.

Contact was made with the Housing Officer (HO) who knew them well and was in regular contact. From this conversation with the HO, it appeared that a transfer to a new property might be possible.

A week later the individual from hospital (he had been re admitted) to thank the SCVS worker for speaking to the housing association and confirmed they would be looking at the potential new house (in a less busy area and with space for a scooter) when they were discharged. They were very relieved and grateful.

Comments.

The support needs were far greater than those initially identified at the time of referral.

It has been a long struggle getting what mattered for this individual.

Contact from the SCVS Hospital Discharge Support has resulted in the chance for them to get their move to an improved environment for their longer-term health and well-being, and potentially reducing the risk of repeat readmission to hospital.

This case also highlights the complexity of need that the third sector can provide support with.

D2RA Pathway 1:
Front Door Turnaround

First of all, an explanation of what we mean by 'the hospital front door'. When the people we serve feel they need urgent medical attention they can present, or be referred to, any of a number of hospital 'entry points'.

Across Wales we use a variety of terms to describe these areas of the hospital, where people receive urgent assessment and decisions are made as to whether they require an acute hospital admission, or can be safely treated at home/in their community. Such units include for example:

- Accident & Emergency Departments
- Same Day/Ambulatory Emergency Care Units
- Clinical Decision Units
- Medical Assessment Units; and
- Surgical Assessment Units.

D2RA Pathway 1 is designed to provide multidisciplinary team (MDT) assessment within these units, to avoid full hospital admission and to arrange treatment and supported recovery at home, wherever it is clinically safe to do so. It must be available for people with **physical and/or mental health needs**.

Many people will of course, be able to be safely turned around at the hospital front door without the need for additional multidisciplinary support; they will not need to be placed on D2RA Pathway 1.

D2RA Pathway 1 is designed to support combined interagency efforts and existing workstreams for the prevention of avoidable hospital admission, w*here additional wrap-around support is required to do this safely*. This is most commonly required for individuals with more complex needs and frailty.

D2RA Pathway 1 aligns with and complements other conveyance/admission avoidance initiatives being undertaken by the Welsh Ambulance Service Trust (WAST), Emergency Department Quality & Delivery Framework (EDQDF), Welsh Emergency Department Frequent Attenders Network (WEDFAN) and Same Day Emergency Care.

Context: The national review of urgent care admission avoidance services in Wales (Winter 2019/20)

Many acute hospital sites in Wales already operate some form of Urgent Care Admission Avoidance (UCAA) Service across some or all of their front door entry points. There is variation in what they are called, their scope and location. For clarity, 'UCAA Service' will be used as the generic term in this paper to describe the multidisciplinary front door turnaround model.

Stay Well @ Home is an exemplar of the model, implemented by partners in the Cwm Taf region, and awarded in two categories in the NHS Wales Awards in 2018. A national review was subsequently commissioned by Dr Andrew Goodall, the Director General for NHS Wales, to scope the potential of upscaling Stay Well @ Home as the urgent care admission avoidance model for Wales. The Review was undertaken with the support and endorsement of the Directors of Therapies and Health Sciences, and its findings[9] were used to inform the debate at the workshop, in order to produce the 'what good looks like' document for D2RA Pathway 1.

The Review identified **7 Key Principles** that all hospital front door turnaround (UCAA Services) should abide by, and these were unanimously endorsed by the D2RA Pathway 1 workshop participants.

1. Integrated working

The teams operating the admission avoidance services should be a designated, co-located resource, with shared (ideally single) assessment processes. Trusting relationships and the blurring professional and organisational boundaries were identified as key success factors for these integrated teams.

Clear operating models (see Principle 6) will support this culture and ensure that the flexibility is focussed

9. *All Wales Urgent Care Admission Avoidance Services: Winter 2019/2020* (Author: Emma Ralph, commissioned by NHS Wales Directors of Therapies & Health Sciences)

on supporting the individual safely, i.e. within agreed boundaries and competencies. The Welsh Regional Partnership Boards were identified as being vital in supporting the planning and sustainable resourcing of all four D2RA pathways going forward.

2. Information sharing

Time is of the essence when working together to safely prevent an avoidable admission, and teams report lost hours undertaking detective work across agencies. As a minimum UCAA services require 'read only' access to information systems across health and social care, though preferably this should be full read/write access.

Fully integrated systems across health and social care remain the ultimate goal. The Welsh Community Care Information System (WCCIS) continues to work towards achieving this goal, though workshop participants felt that there is still some way to go before the system reaches its full potential.

3. Relationships between urgent care and community services

The national report highlighted the variety and extent of acute and community services available to support D2RA Pathway 1, with elements of innovative practice happening in every area of Wales. Many areas now have a UCAA presence at the front door, Community Resource Teams (CRTs), Acute (Nursing) Response Teams (ART), Mental Health Liaison and Crisis Teams, some form of rapid domiciliary care response and third sector options. However, a perceived 'disconnect' between secondary and community care can persist, particularly where referral mechanisms are complex and response times variable.

To be fully effective the hospital 'front door' and community teams must share the same ethos and work seamlessly together for the people we serve. Adoption of these seven principles will support focus and provide local practical solutions to overcome potential barriers, and deliver vital timely responses.

4. Universal evaluation measures

The UCAA services operating across Wales have each developed their own measures to demonstrate activity and impact, though it was observed that there is sometimes confusion between the two.

This lack of standardisation presents a challenge in terms of benchmarking and shared learning across Wales. There was an expressed desire from workshop participants to develop a small number of meaningful and jointly-owned outcome measures (including patient experience) for UCAA services/ D2RA Pathway 1.

5. Use the Trusted Assessor Model

The National Review referred to the NHS Improvement (2018) definition of trusted assessment as follows:

"A trusted assessment involves a trusted assessor – someone acting on behalf of and with the permission of multiple organisations – carrying out an assessment of health and/or social care needs in a variety of health or social care settings."

Trusted assessors can come from any agency and should have direct access to services and equipment.

Use of the model has grown in Wales, but to varying degrees in different regions. The experience of the COVID-19-19 pandemic has expedited use of the trusted assessor model, with many areas reporting positive results. Workshop participants highlighted that the model must always:

- Be undertaken within professional competencies;
- Protect patient safety
- Have clear boundaries; and
- Be designed around achieving the best outcomes for the individual, not as a mechanism for filling service gaps.

6. Clear operating models

The National Review highlighted the complexity of operating models for UCAA teams across Wales. Workshop participants concurred with the review findings that to optimise effectiveness and outcomes for patients, teams supporting the implementation of D2RA Pathway 1 should:

- Operate 7 days per week, across health, social care and third sectors
- Have Standard Operating Procedures and simple processes
- Adhere to agreed response timeframes (potentially for inclusion in the proposed outcome measures)

- Have clear and preferably single, management structures, to support collaborative, person-centred care
- Be supported by sustainable, integrated funding pots.

7. Timely access to community services

The multidisciplinary team (MDT) based at the hospital front door, will only be as effective as the community services it interfaces with to support the individual to be treated, recover then be assessed, in their own home.

In order to safely prevent avoidable hospital admission timely (7 days per week) responses are needed from:

- The UCAA team itself
- Community Resource Teams
- Care & Support Teams (integrated into CRTs in many areas)
- Community Nursing (including ART)
- Mental Health teams
- Community medication support
- Third sector schemes, including advice and support providers meeting the Welsh Information and Advice Quality Framework[10]
- Community equipment stores.

Identifying individuals for whom D2RA Pathway 1 may be the best option

Linked to the Principles highlighted above, access to a range of timely and accurate information was identified as key to identifying individuals for whom D2RA Pathway 1 may be the best option. Sources of such information include:

- The What Matters to Me conversation with the individual;
- WAST transfer documentation;
- This is me documents NB for individuals with cognitive impairment, learning disability and other mental health needs;
- Anticipatory Care Plans;
- The Red Bag system for individuals who are conveyed to hospital from a care home[11];
- Initial conversation in phone first models; and
- Frequent attender information.

The decision as to whether the individual can be safely treated and supported to recover then be assessed at home, requires careful consideration of the balance of risk. Important factors in such decision making include:

- The individual's perception of risk and their choices
- The accessibility/availability of the wrap-around community services to manage this person's needs safely at home; and
- The overarching balance of risk and professional responsibility.

MDT members should take a pro-active approach at board rounds for example, and challenge each other to adopt the Home First ethos. 'This person already has a bed; it's their own and potentially the best place for their treatment and recovery. What do we need to do to get them back to their own home today? Every Day Counts.'

We need to be clear in communicating that this is the modern way of delivering care, based on evidence that we can achieve the best health and wellbeing outcomes for people by working to this model.

Working in this way and balancing risk alongside the individual is often more comfortable for professionals who routinely work in community settings (because they see the outcomes), but represents a culture shift for those more accustomed to working in secondary and other acute care environments.

Suggested mechanisms that may support confidence-building in co-production and managing risk included:

- Undergraduate training;
- Community rotations;
- Community team in-reach; and
- Allied Health Professional (NB OT, physio, Dietetic and Speech and Language Therapy) involvement at early stage of screening/streaming.

10. https://gov.wales/information-and-advice-quality-framework
11 E.g. https://www.nice.org.uk/sharedlearning/hospital-transfer-pathway-red-bag-pathway

D2RA Pathway 1/ucaa service: professional inputs required

Workshop participants identified the following as dedicated UCAA service members:

- Social Worker
- Occupational Therapist
- Physiotherapist
- Nurse (Discharge or District Nurse Liaison).

The following were identified as practitioners who should either be within the UCAA service or be readily accessible to it:

- Geriatrician
- Mental Health Practitioners/Liaison
- Psychology
- Speech and language therapists
- Dietetic support for nutrition and hydration
- Pharmacy
- Third sector NB advocacy and community navigators
- Housing and homeless support
- Substance misuse services
- Care home co-ordinators/relationship managers.

The team as a whole, will need to have extensive knowledge of local community services.

PIVOT: West Wales

1. About the person

The individual was 76 years old and lived alone, with no family nearby, but had a good neighbour. Normally in good general health, managed well and independently. Presented as low in mood due to loneliness with COVID-19 restrictions.

2. What was the situation

They had a fall at home and ended up going to A&E, where they said that they had started to struggle at home. They were quite anxious after the fall, in regard to their independence going forward. Also, quite low as they has not seen visitors due to COVID-19.

3. What did pivot do to make a difference?

PIVOT got involved after A&E referred the individual to us.

We were able to discuss appropriate options to them, as they were keen to stay living in their home, but wanted some sort of help/support to enable this to happen safely.

Their mobility was deteriorating although they could manage in the house, with a frame. They were very worried that involving any outside agencies would result in them being put into a care home. They were reassured that was not the case and there was plenty of support to be accessed to help. Also due to COVID-19 restrictions times are difficult for personal visits by anyone at the moment.

4. What outcomes were achieved?

PIVOT's involvement resulted in a benefits update and they got extra money per week so a cleaner was sourced, who would also help with shopping.

There were also options for ready meal companies to be contacted to deliver regularly and the local shop would accept phone orders if needed.

A home safety check from Care and Repair got handrails fitted in a couple of areas, to help with falls prevention.

A friendship group was also contacted and they now get a regular phone call, which helps with loneliness, and they will visit when COVID-19 restrictions allow.

5. Quotes/feedback

The individual was over the moon with PIVOT's help.

They felt safer at home and happier that the fear of going into a care home was allayed, as they can cope at home with the services that PIVOT has helped to put in place.

This has given them a renewed outlook and they said they were amazed at the support available. They were grateful to PIVOT that their life was made so much easier and they did not feel alone.

His neighbor also commented on how much brighter they are of late they were so happy there was help available for him.

West Glamorgan

80 year old individual, known to community services, presented at the Emergency Department (ED) following a fall in their drive. They live in their own home, which is a 3 storey residence. Referred for three single-staffed calls via Discharge to Recover and Assess Pathway 1.

They presented at ED with complaining of pain diagnosed with right fractured clavicle head wound laceration and general bruising to ribs.

Previous status

Independent at home, living with spouse, for whom they are the main carer.

Usually manage all activities of daily living independently; no services provided.

ED Occupational Therapy (OT) assessment

Individual was very tearful, worried about how they would manage at home, in significant pain from injuries, difficulty with dressing and toileting due to arm being immobile in sling. They had concerns about meals, stairs and pain issues and were feeling dizzy from their head injury.

A request was made to the rapid discharge team for 3 care (reablement) calls a day, in order to prevent admission to hospital.

Outcome

Same day discharge was facilitated. The individual was contacted by Home First triage on the same day; the OT assessed at home and supplied with 2 perching stools for bathroom and kitchen. Physio attended to change sling as the original was not providing sufficient support (altered to a collar and cuff).

Home First nurses visited to review pain relief and check wounds. They liaised with the individual's GP to prescribe alternative analgesia, as those provided by ED were not appropriately managing pain. A follow-up call to remove sutures and review pain was arranged and carried out by the nurses. The individual's pain improved with the change in medication.

A Third Sector referral for Wellbeing was sent for support with a hot meal delivery service, a private cleaner and picking up medication.

As a result of all the input only 1 call was required in the morning to support personal care.

A Care and Repair referral made by the community OT for rails for shower and stairs, to improve confidence and promote independence.

It is recognised that many of the people we may be supporting have multiple or long-standing conditions and will never be fully medically fit or medically optimised.

D2RA Pathway 2:
Supported recovery then assessment in a person's own home

D2RA Pathway 2 should be initiated as soon as treatment, which can only be delivered in an acute hospital environment, is completed.

The pathway is designed to support people to recover at home before being assessed for any ongoing need.

D2RA Pathway 2 should be the default pathway for any individual deemed likely to need new or additional support at home during their recovery period, and/or on a longer-term basis. The model devised by Prof John Bolton and utilised in the national Right-sizing Community Services for Discharge project, suggests that about one third of older people leaving hospital should need some care and support and most of those (around 85%) can be helped at home on this pathway.

The principles and building blocks underpinning this pathway are set out on pages 5 & 6.

The what good looks like process for D2RA Pathway 2 is as follows:

1. Any *existing plans*, including Anticipatory and Advance Care Plans, will be conveyed to hospital with the patient or electronically. These plans will be actively used in the discharge planning process.

2. An *early What Matters to Me conversation* will take place as soon as possible during admission, ideally at the front door of the hospital (Emergency Department/Assessment Unit). What matters to the individual will be clearly communicated and will form the basis of all multi-disciplinary discussions regarding discharge.

3. During the hospital admission, the ward team will use the information provided to *minimise risks of deconditioning*.

4. The principles of good discharge planning[12] will be adhered to, including ongoing dialogue with the individual and their families (answering the 4 Questions[13]) and the implementation of the SAFER patient flow bundle[14].

5. D2RA Pathway 2 will be *the default pathway* for any individual deemed likely to need new or additional support at home during their recovery period, and/or on a longer-term basis.

6. In addition, around 20% of older people discharged from hospital may *need short-term practical support* to get back on their feet (**D2RA Pathway 0**). This can include for example, putting the heating on, settling back in, shopping, washing etc. and is often commissioned from third sector organisations. Individuals in this group do not need to be placed on D2RA Pathway 2, but the individual or the provider organisation should be able, as part of the contingency plan, to access it from the community if required.

7. A *trusted assessor* will attend MDT Board Rounds and, using the clinical criteria for discharge (CCD) and Estimated Date of Discharge (EDD), will assess the minimum requirements needed to take the individual home on Discharge to Recover then Assess Pathway 2. That assessment will:
   - Centre on what matters to the individual
   - Be strengths-based; and
   - Encompass positive risk-taking.

8. The assessment will be used to co-produce the individual's Discharge & Recovery Plan, alongside the community team that will be providing the wrap-around support.

9. The full plan will be developed once the individual is at home. However, the following information must be clearly conveyed to the

12. http://www.wales.nhs.uk/sitesplus/documents/829/Passing%20the%20Baton%20-%20Chapter%201%20%28English%29.PDF
13. https://www.england.nhs.uk/urgent-emergency-care/reducing-length-of-stay/reducing-long-term-stays/discharge-decisions/
14. http://howis.wales.nhs.uk/sitesplus/documents/407/30263%20SAFER%20Patient%20flow%20Guidance_English_WEB.pdf

individual/their family/carers prior to discharge, to provide reassurance and allay any anxieties. Communication should be via conversation, with a brief written summary including:

- immediate advice on self-support
- which member(s) of the MDT will attend the first visit at home, and when
- contact number for queries.

10. The wrap-around support will be:
    - Timely (i.e. available within 48 hours of the individual no longer requiring in-patient treatment)
    - Proportionate and focussed on recovery (there is evidence that care and support is currently often over-prescribed[15])
    - Time-limited; and
    - Funded via intermediate care.

11. The type of support provided can include a range of services, such as those listed below, and therefore the plan will need to be co-ordinated by the trusted assessor or other named individual, who will need up-to-date knowledge of what is available locally:
    - Community Resource Teams
    - Virtual Wards
    - District Nurses
    - Community-based therapies
    - Community Pharmacy
    - Equipment services (statutory and third sector)
    - Reablement teams
    - Assistive technologies
    - Community Mental Health teams
    - In-house support provided by social housing.

12. The nature of the support, including the enablement approach, should be clearly communicated to the individual and their family/unpaid carers (where appropriate).

15. https://ipc.brookes.ac.uk/publications/pdf/Some_key_messages_around_hospital_transfers_of_care.pdf

‘Get Me Home plus’ (Cardiff & Vale)

Get Me Home plus (GMH+) is a rapid discharge process from hospital for patients with complex care needs, who would normally have a referral for a social worker to be allocated and assessments completed prior to discharge. This can often lead to lengthy delays for patients waiting for Packages of Care to support their discharge.

GMH+ aims to discharge patients back to their own home and to have assessments completed of their long-term care needs in a more appropriate environment. Care needs may be intense on discharge and these care needs will be right sized following the assessments.

95-years-old individual was admitted to hospital with multiple co-morbidities, falls, decreased mobility/function and struggling to manage at home and lived alone. Their family was very supportive.

Some immediate assessments were completed by the Multi-Disciplinary Team (MDT) on the ward:

- The dietician assessed and due to the individual’s poor oral intake supplements were prescribed and to continue on discharge.
- The physiotherapist assessed and the individual was able to mobilise and transfer with a Zimmer frame and the assistance of 1 carer but only short distances.
- The Occupational Therapist assessed and the individual required assistance of one carer with washing and dressing and meal preparation.

The MDT assessments identified that the care needs on discharge required support with Personal Care, Medication Prompts and Meal Preparation.

A referral from the ward was sent to the Single Point of Access Team (SPA) for care and support on discharge.

‘Get Me Home plus’ (Cardiff & Vale) (continued)

Point of Contact	Outcome	Time Scale
SPA team referral screened and completed within 48 hrs. Discharge Planned Date with the ward.	• GMH+ predicted care needs QDS double handed and medication prompt. • Discharge arranged the next day following completion of screening.	6 days from receiving referral to supporting discharge.
GMH+ discharge visit with Occupational Therapist and Home Care Manager was completed on the day of discharge from hospital. Assessments commenced.	• Identified care needs twice a day single handed only. • Identified equipment needs (referral sent). • Referral to Physiotherapy sent.	• Care started the same day. • Equipment provision the same day.
Occupational Therapy personal care assessment completed within 1 week of GMH+ commencing.	• Identified assistance of one carer required long term. • Discussed long-term care needs and the process. • Patient wished to think about long term care due to the financial implications.	6 days from discharge home to personal care assessment.
Physiotherapy assessment completed on day 7.	• Referral to Physiotherapy Technicians for ongoing intervention.	7 days from discharge home to Physiotherapy assessment.
RFI (Request for long- term care) Needs completed within 2 weeks of GMH+ commencing.	• Occupational Therapist requested long- term care for twice a day calls going forward with the patients consent.	13 days from discharge home to requesting long- term care.
Social Worker allocation completed within 20 days of GMH+ commencing.	• Arrangements made for twice a day calls with a long –term with care agency.	19 days from discharge home to allocation of Social Worker.
Care agency commenced within 4 weeks of GMH+ commencing.	• Transferred over to care agency long- term Twice a day care calls. • All Occupational Therapy assessments and intervention complete. • Discharged from Occupational Therapy and homecare.	32 days (4 weeks) from discharge home to under long- term care agency and all Occupational Therapy intervention complete.
Outcome The individual engaged with Occupational Therapy and Physiotherapy intervention well. They had a previous history of falls but no further falls were reported since being home. They were very happy to be at home and happy to be able to see family and settled in well. At the end of the D2RA support, they were independent with self-medicating, mobility and all transfers and able to keep some form of independence, despite needing long term care for personal care and meals. They were set up in a micro-climate on discharge to home but were soon able to progress to previous environmental set up. Overall, successful MDT intervention and personal service user goals have been achieved.		

Wrexham ICF Occupational Therapy Service

The individual was wheelchair dependent following an amputation of their leg. The what matters conversation highlighted that they were keen to return back to their cottage as soon as possible, to recover at home.

Within 24 hours of referral, the Occupational Therapist (OT) undertook an environmental visit at the cottage, and the individual was discharged that same day.

In this OT-led discharge, a follow-up telephone call was made the next day, with further visits regarding adaptations and equipment to support independence at home.

This approach meant that:

- There was no delay in hospital discharge or waits for community OT review
- Recovery and independence were maximised
- What mattered to the individual was achieved and this had a huge positive impact on their well-being
- They are now managing well at home, with no care package required.

West Wales D2RA

Individual was discharged from acute hospital on a D2RA basis.

Contact was made within the 48 hour window and a date agreed for assessment within seven days.

The referral had stated that this individual would require long-term care, but their spouse was willing to bridge as an interim measure.

The outcome of the assessment at home was that they did not need, and were not eligible for, long-term domiciliary care.

A hot meal delivery service was arranged via a local café, and the individual was signposted utilise their already agreed attendance allowance.

A referral was made to delta wellbeing for a tracker watch and falls wrist detector.

No further intervention was required but contact details for the local authority were provided, should circumstances change in the future.

West Glamorgan

56 year old admitted with Cauda Equina Syndrome and acute onset of immobility. Lived with their family and had been managing independently without services, despite palliative diagnosis.

Referred via Pathway 2 process for four double-staffed calls and reablement at home with all care delivered in bed.

Previous Community Status

Before this acute hospitalisation, lived with spouse and managed well despite diagnosis, and was symptom controlled, still running their own business. Attended oncology department as an outpatient.

Presenting Complaint

Immobile due to exacerbation of condition and pain due to progression of underlying pathology. Very positive individual eager to get back home and continue running their business.

They were initially moved to a step-down regional hospital bed for further support.

Whilst there, they were visited by the Community Discharge Liaison Nurse (DLN), to support discharge, reassure and inform them of the process for discharge from hospital, due to their complex needs.

During visit DLN established that the individual was in mainly nursed in bed on the ward and was only managing to sit out for a short period. They were in receipt of regular physiotherapy and were making some progress. The referral for Pathway 2 was appropriate and discharge was expedited from the step-down bed.

Equipment needs were identified for home, which were discharge dependant. The individual was well-informed about their needs to go home to optimise resilience and ability to manage, but expressed that they did not want to return home without the right equipment in place. Medication and symptom management was discussed, as well as their wishes and goals for home.

The in-patient therapist supported the supply of the discharge-dependant equipment and a manual handling plan. The Community DLN liaised with the reablement community team to expedite discharge.

Outcome

The individual was discharged with 4 double-staff calls per day as planned.

Hospital Therapists/community DLN liaised with community teams to support D2RA via Pathway 2.

The individual was visited by the Community Physiotherapist and Occupational Therapist (OT) while at home, to review and support goal setting.

A specialist chair and wheelchair had been provided to support sitting out and transfers but they struggled with the equipment supplied.

Sitting balance and strength were worked on with tailored exercises and goals, which were reviewed regularly.

The individual achieved mobility with a frame and now transfers independently, being able to leave the house and get into their car. The OT was also heavily involved in the provision of equipment.

The Physiotherapist adopted a coaching role with the individual regarding the emotional/adaptive aspects of their condition and prognosis.

They progressed with full MDT support and their own very determined attitude. They were subsequently discharged from all services. Specialist outpatient Neuro Physio has been maintained, as they are now able to access services outside the home.

D2RA Pathway 4:
Supported recovery then assessment in an existing care home placement

This is technically the same as D2RA Pathway 2, but acknowledges that there are specific considerations to be addressed in the existing care home environment. Where an individual has been admitted to hospital from a care home, and it looks as if their needs may have changed, they should be allowed a period of recovery, followed by assessment, in their usual (and familiar) environment.

The anticipated outcomes of this approach for the individual are:

- Limits on the impact of the deconditioning and infection risks associated with prolonged hospital stays.
- Less disruption to their physical and mental well-being and more chance of retaining their previous level of independence.
- Reduced mortality risk by avoiding a change of home.

The consensus view is that prompt discharge from hospital for recovery and assessment in an individual's existing care home (i.e. their home), where staff already know them and their family well, is the best option for the vast majority of people.

There will of course be occasions, for example following a catastrophic event such as major stroke, where it is apparent that long-term care needs have changed and other rehabilitation and assessment options will need to be considered.

However, in general, Discharge to Recover then Assess Pathway 4 should be the default for anyone admitted from an existing care home placement.

Reliable wrap around in-reach services will be required during this recovery and assessment period, and care homes will need to be assured that they remain compliant with their regulatory framework.

The overarching principles and building blocks set out on pages 5 & 6 apply equally here, with the additional requirement that hospitals must:

- **Understand that care home providers are required to balance the needs of all their residents** when accepting an individual back on this pathway, taking into account the impact on other people living in the home and the risks to the well-being of other individuals to whom care and support is provided. The co-produced plan will need to consider any additional input/staffing required to mitigate such impact.

Specific **challenges** in implementing D2RA Pathway 4 identified in workshops, are:

1. *Honest and early dialogue* between hospital teams and care home providers. This includes the need to recognise that hospital and care home staff are all part of the same system, needing to work collaboratively to achieve the best outcomes and experience for the individual.
2. *Shared understanding of the pathway* by NHS hospital and community services, social care managers, care home managers, individuals and their families. This includes clarity regarding accountabilities and contingencies, should the recovery and assessment period not go to plan.
3. Care home providers' *lack of trust* that the promised wrap-around support for recovery and assessment will be delivered. Examples given included:
   - Variation in the community services provided NB hours of operation (many operate during office hours only) and exclusion criteria.
   - Capacity of community services to respond in a timely manner. Particular challenges were noted in relation to mental health support in some areas.
   - Inconsistency in the rules around District Nurse support into dual-registered homes, or into nursing homes where staff are not trained to give intravenous (IV) fluids and IV medications; and
   - Supplies of equipment, medication and disposables required to support early discharge.
4. Concerns that accepting individuals back whose care needs may have changed beyond the home's capability to meet them, even on a temporary basis, could place providers in breach of their *conditions of registration*.

The what good looks like process for D2RA Pathway 4 is as follows:

1. An *early conversation* will take place between the ward staff and the care home manager, within 48 hours of admission. This will be a mutually respectful and transparent discussion, recognising that hospital and care home are partners in delivering current and ongoing support to the individual. Essential information, including Advance Care Plans and 'What Matters' to the individual, will have been conveyed to the hospital with the patient e.g. using the Red Bag Scheme[16]. The ward team has a responsibility to familiarise itself with this information and to abide by the individual's recorded wishes or best interest decisions.

2. During the hospital admission, the ward team will use the information and advice provided by the care home to *minimise risks of deconditioning*. The principles of good discharge planning[17] will be adhered to, including ongoing dialogue with the individual, their families and the care home, and implementation of the SAFER patient flow bundle.[18]

3. D2RA Pathway 4 will be the default pathway for any individual admitted from an existing care home placement (their home). In this context, Estimated Date of Discharge becomes *'estimated date of transfer back to care home on D2RA Pathway 4'*. This will be the date when the individual is expected to be ready to commence recovery and assessment.

4. *A named point of contact will be identified* to co-ordinate the transfer on this pathway. These co-ordinators will need to build trusting relationships with their local care home providers, individuals and their families. They may already be in Trusted Assessor roles and could include Discharge Liaison Nurses, Nurse Assessors, Community Resource Team leaders or posts created for a specific focus on D2RA Pathway 4.

5. The need to access advocacy should always be considered as per national policy.

6. Prior to transfer, the individual, co-ordinator and care home manager will co-produce an agreed plan.

   As a minimum this plan will include:

   - Diagnosis and treatment given in hospital.
   - Latest test results and NEWS score.
   - Any new/revised Best Interests decisions and/or Safeguarding issues.
   - The support services that will be provided, when they will be provided (start date and frequency of visits) and by whom. This must include arrangements outside normal office hours, over weekends and bank holidays.

     Particular attention must be taken to ensure that individual's health needs will be fully met when they live in a residential care home i.e. a home that does not employ registered nurses. This may, according to the individual's needs, require intensive input from community nurses. If this cannot be reliably provided, then D2RA Pathway 3 (in a bedded intermediate care facility with nursing) may need to be considered in order to safely manage those risks.
   - Contact details for the co-ordinator, social worker and planned support services.
   - Follow-up appointments.
   - Details of roles and responsibilities for the recovery period and, following this, the assessment of need. Care home staff will have a key role to play in the assessment process, using the strengths-based approach.
   - Contingency plans. These should provide clear detail about who to contact if the care home and/or the community services feel that the individual's needs are not being adequately met on this pathway. Contingency plans may include for example, transfer to a bedded intermediate care facility, community hospital or (only if clinically necessary) readmission to acute hospital. Readmissions in this scenario should not necessarily be regarded as failure; it is often better to have given the individual the opportunity to benefit from this pathway than to have prolonged hospital stay, with the associated risks that can bring.

16. https://www.england.nhs.uk/publication/redbag/
17. http://www.wales.nhs.uk/sitesplus/documents/829/Passing%20the%20Baton%20-%20Chapter%201%20%28English%29.PDF
18 http://howis.wales.nhs.uk/sitesplus/documents/407/30263%20SAFER%20Patient%20flow%20Guidance_English_WEB.pdf

7. The co-ordinator will ensure that the care home is provided, before or at the time of transfer, with the *necessary equipment, medication and disposables* (e.g. giving sets for IV fluids) to support the individual whilst they are on the D2RA Pathway.

8. At the end of the pre-determined period of supported recovery and assessment, the next steps for the individual will be agreed with them, their families, the care home and the relevant support services.

9. If the assessment is that the existing care home can no longer meet the individual's changed care needs, the additional support will need to continue until transfer to the new care home of choice can be arranged, or the contingency plan implemented. NB an honest conversation should take place, as soon as the individual is placed on D2RA Pathway 4, that this may be the outcome.

D2RA Pathway 4: Case example

92 year old frail individual, with multiple-co-morbidities including vascular dementia.

They had been well-settled in their general nursing home placement for three years, prior to being admitted to hospital with a fractured neck of femur, which had been sustained following a fall.

Following surgery, they were non-compliant with personal care, therapy and treatment in general and could be aggressive when approached by staff. They were refusing diet and fluids, were nursed in bed with cot-sides in situ and became doubly incontinent.

Concerned that this represented a sustained deterioration and an increase in need, it was decided that an assessment for Continuing NHS Healthcare (CHC) was required. The care home and family were keen that this assessment should take place in their familiar environment, with staff who knew them well. As the local health board did not commission CHC from this care home, if their needs had changed, a transfer to another care home would be required (with all the inherent disruption and risk).

The individual was transferred back to their usual place of residence (existing care home placement), co-ordinated by the Nurse Assessor, with additional psychiatry liaison support on stand-by, to advise on management of the new aggressive behaviours.

On arrival back at the care home, greeted by staff they knew, the individual got up from the wheelchair and made their way, independently, to their favourite chair. On the way, they put an order in for their favourite cake and a cup of tea.

Within 48 hours of transfer, mobility was back to previous levels, as was diet and fluid intake. Within 2 weeks continence had also returned, though pads were still required at night. There was no further incidence of aggression.

The assessment confirmed that the individual's level of need was for funded nursing care, not CHC. They remained at their nursing home and an anticipatory care plan was developed. They died peacefully in that familiar environment, surrounded by their family, seven months later.

D2RA Pathway 3:
Supported recovery then assessment in a bedded intermediate care facility

Continue to think 'Home First'; only use Pathway 3 if Pathway 2 has been ruled out. The motivation for implementing this pathway is to achieve the best outcomes for the individual, and it should only be used where their 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.

D2RA Pathway 3 must not be used as a decant option for acute hospitals under pressure, as this will act as a constraint on transferring the people who will genuinely benefit from receiving this service in a timely manner.

The model devised by Prof John Bolton and utilised in the national Right-sizing Community Services for Discharge project, suggests that about one third of older people leaving hospital should need some care and support and of those, only around 15% will need to be supported to recover in a bedded intermediate care facility.

Individuals on this Pathway should be regularly reviewed and, where appropriate, transferred onto Pathway 2 as soon as their recovery permits.

The overarching principles and building blocks set out on pages 5 & 6 apply equally here, with the additional requirements that acute hospitals must:

Agree goals and develop co-produced plans prior to transfer. The What Matters to Me conversation will be used to agree a clear recovery plan, including realistic goals set with the individual and held by them.

Intermediate Care facilities must provide the right environment to maximise recovery and independence. Bedded intermediate care can be delivered in a Community Hospital or in beds commissioned from independent/third sector providers. It is essential that the chosen environment truly supports recovery by:

- Providing the opportunity for self-care, including independent access to kitchen, beverage stations, and areas for walking etc., and
- Employing staff who are suitably trained and experienced in rehabilitation, and who have an enabling ethos. This must include appropriate therapeutic input, which may be provided on an on-reach basis. Regional Partnership Boards will need to ensure that rehabilitative/therapeutic staff are reliably available for this purpose, so that recovery can maximised for the individual.

The National Strategic Programme for Primary Care has developed a Toolkit for Bedded Community Services, which includes specific consideration for commissioning services to deliver D2RA Pathway 3. This is reproduced at **Annexe 1**.

The Process

1. Any existing plans, including Anticipatory and Advance Care Plans, will be conveyed to hospital with the patient or electronically. These plans will be actively used in the discharge planning process.

2. An early What Matters to Me conversation will take place as soon as possible during admission. What matters to the individual will be clearly communicated and will form the basis of all multi-disciplinary discussions regarding discharge.

3. During the hospital admission, the ward team will use the information provided to minimise risks of deconditioning.

4. The principles of good discharge planning will be adhered to, including ongoing dialogue with the individual and their families (answering the 4 Questions) and the implementation of the SAFER patient flow bundle.

5. The MDT, using the What Matters conversation, clinical criteria for discharge (CCD) and Estimated Date of Discharge (EDD), will identify that the individual will benefit from D2RA Pathway 3.

6. D2RA Pathway 3 will only be considered once Pathway 2 has been ruled out. Potential reasons for ruling out Pathway 2 include:
   - The individual requires closer observation and/or more frequent intervention than can be provided by drop in calls during the day.
   - The individual has night-time needs greater than could be met with drop-in calls or short term night-sitting.

7. Pathway 3 is designated as intermediate care and will be funded accordingly; ideally via local or regional pooled budget arrangements, to avoid any delay in transfer.

8. A clear Recovery and Assessment Plan will be developed, including goals and outcomes agreed with the individual. The purpose of the transfer on to D2RA Pathway 3 will be clearly communicated, ensuring that the individual and their family understand that this is a period of supported recovery, designed to help them retain as much independence as possible. They will hold a copy of their plan.

   The Trusted Assessor/Care Co-ordinator will liaise with the Intermediate Care facility to ensure that all parties agree that: The individual's needs can be met in that environment; and The Recovery and Assessment Plan can be delivered, with in-reach from community services, if commissioned from an independent/third sector provider.

   Note: Where D2RA Pathway 3 is to be delivered in a care home environment, registered providers will be required to meet their regulatory requirements and undertake the relevant assessments before agreeing transfer.

   The detail of any in-reach support will be clearly articulated, and include:
   - The professions involved.
   - The frequency of input.
   - Dates for review.

9. The Trusted Assessor/Co-ordinator will ensure that all the necessary arrangements (including transport, medication, dressings etc.) are in place for transfer to take place within 48 hours (maximum) of the completion of in-patient treatment.

10. The Trusted Assessor/Co-ordinator will also be responsible for ensuring that the arrangements are clearly communicated to the patient, their family, the Intermediate Care facility (Community Hospital or commissioned care home) and any services providing in-reach support.

11. It is recommended that all individuals on D2RA Pathway 3 should be reviewed by the MDT after 2 weeks, so that the input can be modified in response to changing need/recovery.
    Home First transfer to Pathway 2 (recovery and assessment in the person's own home) must be a consideration wherever possible. The in-reach team will follow the individual home and provide continuity of support and relationships.

12. Regular reviews throughout the recovery and assessment period will ensure that a clear exit strategy is in place, to avoid the person becoming stuck in the intermediate care facility.

13. At the end of the period of supported recovery and assessment, the next steps for the individual will be co-produced with them, their families and any ongoing support services.

West Glamorgan Partnership

89-year-old individual, was an acute admission to trauma and orthopaedics following a fall at home, sustaining a fractured neck of femur.

They underwent surgery and were making very slow progress in hospital with their mobility due to loss of confidence, and were even considering a care home placement due to fear of going home.

They were also newly diagnosed with Atrial Fibrillation during admission and were commenced on warfarin, which they were very nervous about managing independently.

Previous community status

Lived alone, with no local family. During the trusted assessment they informed the Community Discharge Liaison Nurse (DLN) that they were also very lonely, since their spouse had died, and felt isolated with no services.

Identified by in-reach community DLN for discharge, and deemed appropriate for a Pathway 3 step-down reablement bed. D2RA Pathway 2 had been ruled out due to:

- The lack of support network at home.
- Individual being very fearful of mobilising.
- Lack of confidence in managing warfarin independently.
- Fear of falling; and
- Inability to carry out activities of daily living.

Outcome:

Same day transfer to Step-down Reablement bed achieved, following screening by the community DLN. Transferred with a goal to improve confidence and mobility, to manage activities of daily living and new medication.

Goal set in bedded reablement, in collaboration with full multidisciplinary team and the individual. Low level long-term support needs were identified, to maintain independence and to facilitate discharge home. This was achieved within 3 weeks and the individual was discharged home with minimal support of care and equipment.

The nurse in reablement bedded facility supported with education on warfarin and a third sector referral was sent for befriending service. The social worker was also involved in supporting discharge home.

The Discharge to Recover then Assess Model (Wales) 2020L Flow chart

- Ensure any existing anticipatory/advance care plans are conveyed to hospital with the individual
- Have an early 'What Matters to Me' conversation
- Have an early conversation with existing care provider(s)
- Use the above to minimise risks of deconditioning, loss of independence/confidence.

- Adhere to good discharge planning principles:
- Be able to answer the 4 Questions for the individuals/their families on a daily basis
- Implement the SAFER Patient Flow Bundle
- Identify Simple/Complex Discharge
- MDT to determine which (if any) D2RA Pathway is required, at least 24 hours prior to date when acute treatment is expected to be complete. Consider in the following order: Pathway 0, 2/4, 3.

- Trusted Assessor to identify the minimum requirements for safe transfer onto the D2RA Pathway (NB with the existing care home provider for Pathway 4)
- Refer to the local Integrated Community Hub/Single Point of Access Transfer to the D2RA Pathway within 48 hours of acute treatment being completed
- Provide brief written information to the individual/their family/care home re:
  - immediate advice on self-care for recovery;
  - which member of the MDT will attend the first visit at home &
  - when contact number for queries
- Complete 'My Personal Discharge & Recovery Plan' at home/in the bedded intermediate care facility.

Embedding implementation in 2021 and beyond

Whilst significant progress has been made, it is clear that Wales still has some way to go, before it can claim to have maximised the benefits of the D2RA model, both in terms of outcomes for the people we serve, and impact on whole system flow across health and social care.

The programme for 2021 and beyond will need to build on the positive aspects of the model seen to date, whilst addressing the ongoing challenges.

This will require a concerted, multi-agency approach with clear co-ordination and accountabilities for delivery.

The DU will continue to co-ordinate implementation, within a clearly defined 2-year programme structure.

In order to avoid repetition or duplication of effort, the programme will build on existing relationships and alignments. It will need to influence at policy, strategic and operational levels of NHS, Local Authority, Third and Independent Sector organisations.

It is proposed that a three-pillared approach is taken to ensure the progress made to date 'sticks' and is developed further, as the evidence and understanding grows (see Page 27 for further detail).

Continuous monitoring and improvement are essential, and will commence with the 5 key measures below and qualitative assessment using the D2RA Progress Matrix. The Home First: Hospital to Home Community of Practice has proposed further measures, which will be reviewed and phased in over time.

How much did we do?	Number of people transferred on to each D2RA Pathway
How well did we do it?	% of those transfers that took place within 48 hours of the decision being made (that they were ready for transfer from hospital to this pathway for supported recovery and assessment)
	% people transferred to a D2RA Pathway with an immediate discharge plan (full personal recovery plan to be co-produced once the individual is at home/in an intermediate care bedded facility)
	% people readmitted to hospital within 28 days
Is anyone better off?	% people transferred out of the D2RA Pathway to their usual place of residence

Work streams to support implementation of the Discharge to Recover then Assess model in Wales: 2021

Right Community Services

Right-sizing community services

- National Advisory Group
- Merged RSCS Community of Practice, in collaboration with the National Benchmarking Audit for Intermediate Care + NCCU.

Right Mind-Set and Processes

Training resources for D2RA – updated discharge planning

- Strategic/policy oversight group
- Will be developed in collaboration with a range of agencies. Likely to take CoP approach to involve those who will deliver on the ground.

Balancing rights & responsibilities: supporting the cultural shift

Joint H&SC training programme with Social Care Wales: pilot and roll-out.

Continuous Improvement

Home first community of practice

(follow-on from Transformation Fund H2H CoP)

Practical peer support and shared learning

Further growth of the Every Day Counts social movement.

National modelling & monitoring group

Monthly reports – COVID-19 specific at present.

Technical sub-group: Practicalities of data collection; will also act as stakeholder ref group for systemising integrated data collection with DHCW.

D2RA Implementation Oversight Group (follow on from T&F Group)

Quarterly review of the 5 key measures + 6 monthly review of Progress Matrix

Annex 1: **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.		