Early Supported Discharge

The challenges in setting up and delivering a ‘true’ Early Supported Discharge (ESD) Service

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In the beginning…

- Key Challenges
  - Scoping and Developing the new service
  - Managing change
  - Marketing the service
  - Demonstrating success against key performance indicators

Scoping and Developing the New Service – Introduction

- **Pilot service**
- Started in role end of March 2009
- Aim to be set-up and seeing clients by June 2009 from St Helier +/- St Georges

- **Staffing Levels**
- Team lead (1 x Band 7, physio)
- Occupational therapy (1 x Band 6)
- Speech and Language Therapy (1 x Band 6)
- Physiotherapy (1x Band 6)

- No Rehab assistants initially (1.5 x Band 3)
- No nursing input

- **Remit to deliver ESD service meeting Healthcare for London (HfL) standards**

Scoping and Developing the New Service

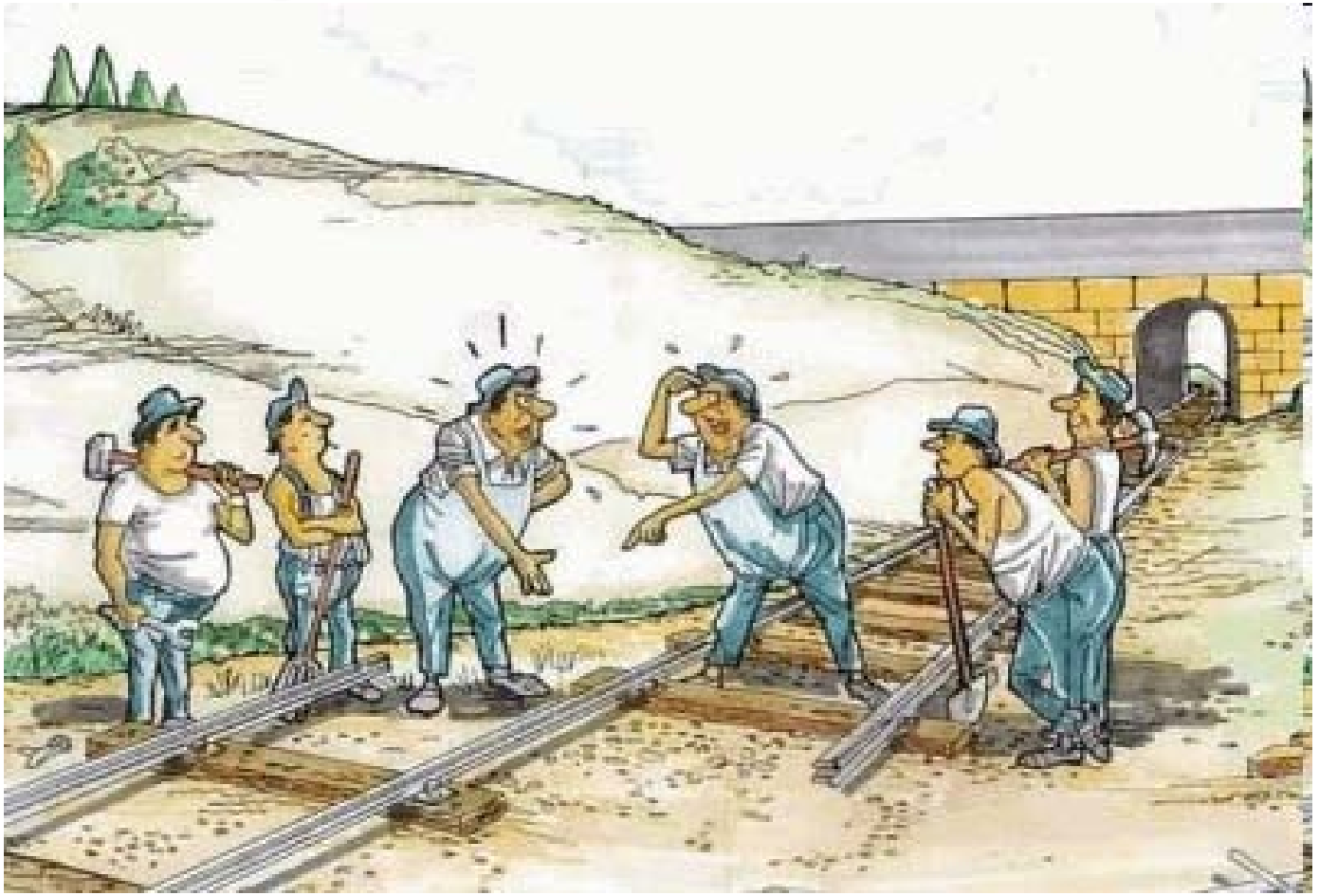
- Integration with current Community Services
  - Establishing links with acute hospitals
  - Social Services teams for Packages of Care (PoC)
  - Establishing nursing role/input
  - Onward referral pathway

- Developing Criteria
  - Policy guidance and research
  - Other ESD Services
  - Considering differences between models

Criteria

- Registered with a GP within Sutton and Merton PCT.
- Confirmed diagnosis of new stroke (either from scan or Consultant diagnosis)
- Medically stable and fit for discharge
- Deemed to have adequate cognitive ability and appropriate level of communication to be safely at home with or without care
- Able to transfer with assistance of 1 (nurse/carer) ± equipment
- Achievable rehabilitation goals can be identified.
- Referral to facilitate discharge and client requires intensity of rehab (3hrs 45mins of each therapy a week)
- The patient and their family/carer are agreeable to rehabilitation at home and intensity level.

Managing Change
Marketing the Service



Pathway

- Weekly attendance at MDT meetings to screen for patients
- Accept MDT or direct referrals
- Visit by ESDT therapist in hospital prior to D/C
- Seen at home within 24hours of D/C
  - Link in with SS teams as needed
  - Referral to Community Matrons
- 6 week intervention period
- Intensity
  - 3hrs45mins (weeks 1-2)
  - 2hrs 15mins (weeks 3-6)
  - *Use of diary sheets and timetabling*
- Onward referral – link into CNTT meetings

Demonstrating Success

- Early development of Audit/Recording Tool
- Team and disciplinary outcome measures
  - Stroke Impact Scale
  - Barthel Index
  - Caregiver Strain index
  - Therapy Outcome Measures (TOMs)
- Gaining relevant data for financial implications
  - Length of stay
  - Long-term PoC
- Comparability with other ESD services?

Achievements

- Involvement and communication with referrers and other services
- 16 referrals with 6 clients completing intervention
  - Delivering intensity
  - Positive clinical outcomes
  - Good patient feedback
  - Low number of onward referrals
  - ?Impact on length of stay
- Systems in place to manage changing staff

What Now?

- Change in working
  - Concept of ‘true’ Early Discharge
  - Demonstrating financial savings
- Caseload Management
  - Balance
  - Staffing levels
  - Capacity

Key Learning Points

- Understanding what Early Supported Discharge is
  - Role of strong ESD team
- Communication with services
  - Strong link with referrers
- Setting criteria for available service level provision