

Service specification for early supported discharge

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1.0 Purpose

1.1 Aims and objectives

- To ensure that all stroke survivors (who fit the specified criteria) have access to a high quality, stroke specific, multi-disciplinary early supported discharge (ESD) service.
- To provide a seamless transfer of care from hospital to home
- To enable appropriate stroke survivors to receive rehabilitation in their own home at the same level of intensity as inpatient care
- To aid identification of patients appropriate to access service
- To enable stroke survivors to achieve mutually agreed rehabilitation goals to maximise their recovery
- To ensure stroke survivors, carers and families are involved in the process of rehabilitation
- To provide highly specialist stroke rehabilitation in a multi-disciplinary team, including rehabilitation support workers.
- To develop strong relationships with relevant agencies (statutory and non statutory) along the wider stroke pathway to support inreach/outreach models of working and smooth transitions of care

1.2 Evidence base

It is widely acknowledged in the literature that ESD can reduce long term mortality and institutionalisation rates for up to 50% of stroke survivors¹. Improved patient outcomes result in stroke survivors being more likely to be independent and living at home after six months². Published studies have demonstrated that the provision of ESD could reduce the cost of stroke care by 9 – 20%³. Trials have shown that on average 40% of acute stroke patients are suitable for ESD². Those with mild to moderate disability are most likely to benefit⁴. It is therefore recommended that every clinical commissioning group (CCG) should commission an ESD service for stroke that is comprised of a multi-disciplinary team with stroke specialist skills.

1.3 General overview

Early supported discharge forms part of the wider stroke pathway. It is aimed at enabling patients who are medically stable, have reached an appropriate level of physical and cognitive recovery and have adequate support in the community to continue rehabilitation in their own environment. ‘Early’ implies that patients can return home and receive rehabilitation sooner than would otherwise be possible, rather than being related to time since stroke onset.

¹ National Stroke Strategy Department of Health 2007

² Healthcare for London *Stroke rehabilitation guide: supporting London commissioners to commission quality services in 2010/11* November 2009

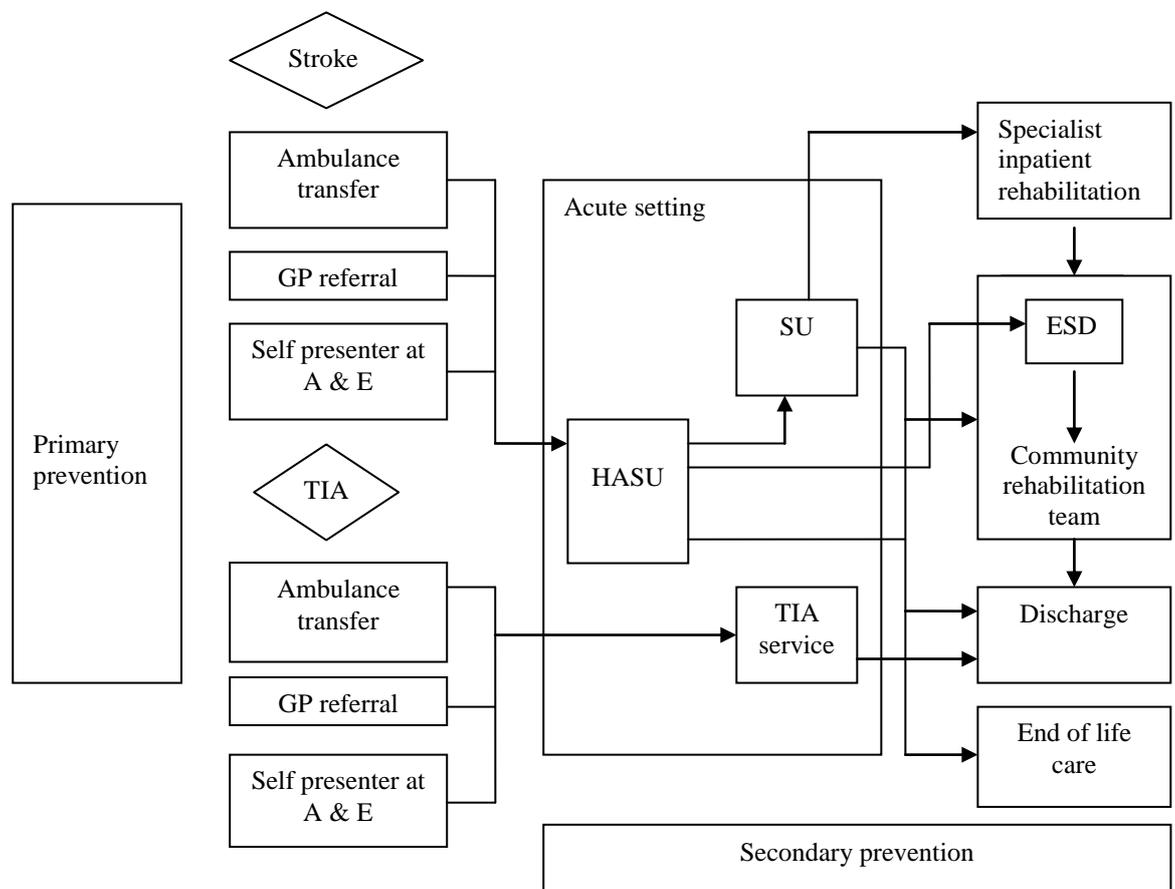
³ Beech, R.; Rudd, A.; Tilling, K. Wolfe, C. (1999) *Economic consequences of early supported discharge to community-based rehabilitation for stroke in an inner London teaching hospital*. Stroke 30:729-735

⁴ Fisher, R.; Gaynor, F.; Kerr, M. and Walker, M. (2010) *Stroke early supported discharge consensus activity* CLAHRC (Nottinghamshire, Derbyshire and Lincolnshire)

It is vital that ESD teams have excellent links with:

- the relevant hyper-acute and acute stroke units to facilitate a seamless transfer of care from hospital to home
- local stroke specific community rehabilitation teams to ensure ongoing rehabilitation is available as needed
- local social services to ensure an appropriate level of care is provided based on the needs of individual clients.

Pan London stroke care pathway



1.4 Expected outcomes

- Improved health and well-being outcomes as measured against specific criteria (eg quality of life measures, therapy outcome measures)
- Improved patient and carer experience
- Timely discharge from acute services and seamless transfer from hospital to home
- Reduction in unnecessary hospital admissions
- Reduction in hospital length of stay
- Quality improvements and subsequent achievement of national and local performance outcome measures
- Reduced incidence of secondary risk complications (e.g. pressure sores, chest infections and contractures)

2.0 Service scope

2.1 Service description

There are a variety of models of early supported discharge across the UK. The variation is predominantly based on the landscape of existing services rather than differences in clinical practice. It is expected that CCGS will commission one of the service models subsequently described. Early supported discharge services may be provided as a function of a community stroke rehabilitation service (inreach), as a function of an acute team (outreach) or as a discrete team. ESD services should provide intensive rehabilitation (up to five sessions per week of occupational therapy, physiotherapy and speech and language therapy) for the time the client would otherwise have been receiving inpatient rehabilitation, which can range from two to six weeks. The decision around duration of intensive intervention should be based on client need rather than being restricted by commissioning arrangements.

Inreach

This model relies on co-operative and collaborative decision making between the community and acute stroke teams. Once a patient has been identified as appropriate for ESD at least one member of the community stroke team begins contact with the patient while they are still in hospital to coordinate and plan the discharge home. In some teams the relevant disciplines provide some of the inpatient rehabilitation as part of building rapport with the individual and their family, which may help to ease the transition from hospital to home.

Outreach

In this model the acute team identify appropriate patients for ESD, plan the discharge home, including home adaptations, and provide an appropriate intensity of rehabilitation in the community for a specified period of time (usually up to two weeks following discharge). After this period of time ongoing rehabilitation is provided by a stroke specific community team. Consequently close links need to be forged between the acute and the community teams to ensure that there is a seamless transition of care.

Discrete

The separate nature of this team would result in an increased number of interfaces between teams providing rehabilitation to stroke survivors. This would necessitate exceptionally high levels of cooperation and communication between teams to ensure seamless care provision. Consequently it may be advisable for the ESD and community teams to be located together to ensure excellent communication and handover and to allow sharing of resources such as psychology and speech and language therapy.

Stroke specialist rehabilitation provides assessment of, treatment for and advice on issues relating to stroke including:

- Mobility and movement
- Communication
- Everyday activities – washing and dressing, meal preparation
- Emotional and psychological issues
- Swallowing
- Nutrition
- Impaired cognition
- Visual disturbance
- Continence
- Relationships and sex
- Pain
- Secondary prevention and lifestyle advice
- Driving
- Return to work

2.2 Accessibility

ESD services are accessible to all adult (aged over 16 years) stroke survivors living within a defined geographical area that meet agreed eligibility criteria based on the latest research evidence. Traditionally to be eligible for ESD individuals should be able to transfer safely from bed to chair with the help of one person if they live with an able bodied carer or partner, or independently if they live alone⁴. A consensus statement by ESD trialists suggested that the most effective ESD services operated a degree of flexibility in admission criteria allowing expert decision making rather than disability measures to identify individuals who would benefit⁵. This would allow individuals who require more support to transfer or to facilitate gait practice to go home earlier with intensive therapeutic input. Services should not discriminate on grounds of race, disability, gender, sexual orientation, religion, belief or age.

⁵ Fisher, R.; Gaynor, C.; Kerr, M.; Langhorne, P.; Anderson, C.; Bautz-Holter, E.; Indredavik, B.; Mayo, N.; Power, M.; Rodgers, H.; Ronning, O.; Holmqvist, L.; Wolfe, C. and Walker, M. (2011) A Consensus on Stroke: Early Supported Discharge. *Stroke*. 42:1392-1397

2.3 Whole System Relationships

ESD services will establish key relationships with the following organisations, agencies and staff:

- Local Hyper Acute Stroke Units (HASUs) and Stroke Units (SUs)
- Inpatient rehabilitation units
- Social Care Services
- Community Nursing Teams/Intermediate Care Teams
- Community Therapy Services
- General Practitioners
- Voluntary organisations (eg The Stroke Association; Connect – the communication disability network; carer organisations)
- Practice nurses and nurse practitioners
- Community Mental Health Teams
- Psychological Therapies in primary care
- Counselling Services
- Clinical Nurse Specialists (Primary and Secondary care)
- Out of hours services
- Podiatry
- Dietetics
- Dental Services
- Orthotics
- Wheelchair and Equipment Services
- Spasticity clinics
- Exercise groups/ gyms

2.4 Interdependencies

Systems and processes must be in place to ensure collaborative working with primary care, secondary care, social care and all relevant services to avoid patients falling through the gaps between agencies. This will also support seamless transition of care for the stroke survivor along the pathway.

This might include:

- Staff attending hospital stroke unit MDT meetings to assist with discharge planning and discuss patient goals
- Inreach/outreach between hospital and community providers prior to discharge
- Named keyworker responsible for onward referral, co-ordination of review meetings and sharing relevant information
- Regular Community Stroke MDT meetings

3.0 Service delivery

3.1 Assessment

- Each patient will be assigned a key worker whose role is to monitor the implementation of the care plan, progress of onward referrals to other services and review of needs.
- The stroke survivor's needs are assessed with family and carers involvement if consent is provided. Assessment and goal setting is designed according to specific needs and priorities of the individual. Personalised assessment results, goals and a rehabilitation programme/care plan should be provided to the stroke survivor. The care plan should identify any social care needs and liaison with Social Services as appropriate. Where a patient has an informal carer, the carer must be offered a referral to social services for a Carers Needs assessment.
- The team must ensure that the patient (and where possible the family and/ or carers) understand what has happened to them and what they can expect.
- Specialist stroke rehabilitation and support will address stroke related issues (outlined in 2.1) either directly or by onward referral where required.

3.2 Interventions

- Patients who have had an acute stroke and are assessed as being suitable for ESD will receive up to five sessions per week for the first few weeks of Occupational Therapy (OT), Physiotherapy (PT) & Speech and Language Therapy (SLT), as required.
- Intervention will be tailored to meet the needs of each individual. Some people may require just one or two visits from a single therapist while others may require the full six weeks of therapy from multiple therapists.
- Patients who have had an acute stroke and where nursing has been agreed as part of the care plan should be visited at home by the community nursing team within 24hrs.
- Some interventions may be carried out by trained rehabilitation support workers or carers under direct or indirect supervision of qualified therapists.
- For patients who have short term personal care needs that will not require long term support from Social Services trained rehabilitation support workers from within the ESD team can be used to facilitate personal care. Southwark community stroke team provides an example of the effectiveness of this model of care.

3.3 Review of progress

- Review systems are a core part of rehabilitation services during the intervention period in order to determine progress towards goals. This is achieved through regular multidisciplinary team meetings as well as patient and family meetings.
- Following review patients may continue ESD rehabilitation with newly identified goals, be handed to the community team for ongoing rehabilitation or be discharged. Where appropriate a patient may be referred onto another service.

- Standardised outcome measures should be applied on entry to and exit from ESD to provide an indication of intervention effectiveness. These should include measures of:
 - dependence or stroke severity
 - activities of daily living
 - patient satisfaction
 - carer satisfaction
 - the patient's subjective health status score/ quality of life
 - the patient's mood

3.4 Staffing

Based on 100 patients per annum the team should consist of:

- Co-ordinator or Team Lead
- 1.0 WTE Specialist Nurses (SN),
- 1.0 WTE Physiotherapists (PT),
- 1.0 WTE Occupational Therapists (OT)
- 0.4 WTE Speech and Language Therapists (SLT)
- 1.0 WTE Clinical Psychologist/ Neuropsychologist (band 8a for up to 100 patients, band 7 for additional caseload. Need to ensure access to consultant psychology support is available)
- Rehabilitation Support Workers or Enablement Workers trained in Stroke Rehabilitation
- 0.5 WTE social worker
- Administration and Clerical staff

The team should also have easy access to podiatrists, orthotists and ophthalmologists.

3.5 Equipment and Resources

- The service will have a base from which to work with desks, chairs, access to IT and filing cabinets for safe storage of records. They will also have a dedicated phone line with answering machine, safe fax machine and printer. Each member of clinical staff should carry a mobile phone for receipt of urgent referrals and communication. When carrying out home or community visits, each member of staff will carry infection control equipment to ensure compliance with hand washing and infection control policy and basic manual handling equipment.
- The environment must meet Health and Safety requirements in accordance with legal and NHS standards.

- The Provider is responsible for the provision and maintenance of stroke rehabilitation equipment
- The prompt provision of appropriate equipment for patients is vital if they are to be maintained safely in their own homes. All clinical staff must be able to prescribe equipment for patients in their homes. More expensive or specialised items may require authorisation by the team leaders.

4.0 Referral, access and acceptance criteria

4.1 Geographic coverage/boundaries

For local determination. In areas where stroke incidence is lower adjacent CCGs may wish to consider jointly commissioning an ESD service that covers a wider geographical area.

4.2 Location of Services

Community rehabilitation can take place in a variety of settings, such as a patient's defined residence, in the local neighbourhood or in a social environment such as the local gym. The service should be flexible to meet the specific needs of each individual, where practically possible.

Days/Hours of operation

To be determined locally. However, the current drive across the NHS to seven day working would suggest that thought should be given to commissioning and providing a seven day service, with the understanding that this should not compromise the weekday service. One example of an effective and efficient seven day service in London is the Tower Hamlets stroke ESD and community team. This team provides full multi-disciplinary intervention Monday to Friday. At the weekend care tasks and therapy tasks which have been set by the appropriate professional are practiced by individuals with the assistance of therapy support workers.

4.4 Referral criteria & sources

Referrals can be made by any health or social care professional in the hyper –acute or acute stroke unit.

Stroke patients should only be discharged early (before the end of the acute rehabilitation) from hospital if there is a specialist stroke rehabilitation team able to continue rehabilitation in the community from the day of transfer and if the patient is able to transfer safely from bed to chair, and if the problems can be safely managed at home (National Clinical Guidelines for Stroke, 2008).

ESD patients must meet the following criteria:

- Over the age of 16 years
- Registered with a local GP.

- Diagnosis of a new stroke following a clinical decision made by a consultant and/or CT scan result.
- Medically stable for discharge home.
- Consents to ESD with agreement from their carers (where applicable).
- Compliant with rehabilitation programme and goals identified prior to discharge.
- Able to transfer independently or with support from trained carer. However, expert opinion suggests that operating a degree of flexibility in this allows appropriate patients who require more support to benefit from the service.
- Able to manage continence
- Able to call for help
- The condition may require single or multi-therapy
- Suitable home environment as assessed by MDT.

4.5 Referral route

Referrals can be picked up by attendance at the relevant multi-disciplinary meeting by a member of the ESD team or via phone to a single point of contact and followed up with the appropriate paperwork as agreed locally.

4.6 Exclusion criteria

The following exclusions apply:

- Under 16 years of age.
- Patients who do not meet criteria for ESD as specified in section 4.4

4.7 Response time, detail and prioritisation

- Once a patient is identified as suitable for ESD the team should become involved within 24 hours of the referral being made and before the patient leaves hospital.
- Patients should have outcome measures recorded and a key worker identified and recorded within 3 days of admission to the service.
- Goals to be set and agreed within one week of admission to the service
- All stroke patients should receive cognitive / perceptual screening within one week of admission to the service and full assessment within two weeks if required.
- All stroke patients identified as requiring assessment or intervention to meet adjustment, behavioural or psychological needs to be seen within 1 week of referral. Needs greater than those that can be provided by the team will need to be referred on.

5.0 Discharge criteria and planning

Following the appropriate period of ESD the patient will either be discharged or referred to the stroke/ neurorehabilitation specific community team. If this team is separate from the ESD team then a detailed and timely handover will need to take place. Community teams will need to be informed in advance of patients who are due to leave ESD so that there are no unnecessary gaps in care provision. If the individual does not require ongoing rehabilitation a formal discharge summary report should be written and copied to the referrer, GP and client within seven days of discharge. This should contain information about the outcome of assessments, input, discharge status and details of any services the client was referred to.

6.0 Information provision and self-management

- Patients should be supported and encouraged to self-manage their long term conditions wherever possible (eg self-management plans for patients and carers, signposting to expert patient programmes).
- Patients and carers should be involved in setting goals and care planning
- Services should encourage people to be involved in broader decisions about service development and delivery.
- The service should provide translators whenever required in order to support the patient. Documents should be translated into other languages as required.
- Information and education packs should be available for stroke patients and carers along with support and advice to understand and use it (eg lifestyle advice, healthy eating, weight reduction, alcohol and smoking cessation).
- Many patients within the service will have significant cognitive and language difficulties as a consequence of stroke (eg aphasia). The service should tailor any information given to patients to suit their individual communication needs (eg use of pictures or diagrams).
- Transport, benefits advice, group/peer support/online support, long term support

7.0 Quality requirements

CRITERIA	STANDARD	EXAMPLES OF EVIDENCE	ACTUAL EVIDENCE ATTACHED	RAG RATING
A.	<p>Presence of a stroke skilled Early Supported Discharge Service (ESD)</p> <p>Definition: A comprehensive stroke skilled MDT who manage patients at their place of residence and who are able to provide rehabilitation at a similar intensity to that of a stroke unit.</p>	<p><i>Yes/No</i> <i>If yes please include copy of commissioned service /pathway details</i></p> <p><i>If no but intention to provide please include copy of business case or service specification.</i></p>		
B.	<p>ESD Service includes access to stroke specialist team</p> <p>Definition: Composition of the team would usually include a co-ordinator/manager, physiotherapist, occupational therapist, speech and language therapist and rehabilitation support workers with support from nursing and social care and agreement regarding medical cover. (Based on ASI 9)</p>	<p><i>Team structure/job plan</i> <i>Operational policy</i></p>		
C.	<p>40% patients have access to early supported discharge services</p> <p>Note: Target includes</p>	<p>SSNAP</p>		

CRITERIA	STANDARD	EXAMPLES OF EVIDENCE	ACTUAL EVIDENCE ATTACHED	RAG RATING
	adjustment for appropriate patients.			
D.	<p>Presence of a stroke skilled Community Stroke Rehabilitation Service (CSR)</p> <p>Definition: Composition of the team would usually include a co-ordinator/manager, physiotherapist, occupational therapist, speech and language therapist, psychologist and rehabilitation support workers with support from nursing and social care.</p>	<p><i>Yes/no</i> <i>Team structure/job plan</i> <i>Operational policy</i></p>		
E.	<p>Both ESD and CSR services are appropriately resourced with access to items listed below and relevant induction/training programme.</p> <p>Specialist assessments: A range of stroke specialist assessment tools and therapy resources for OT/PT/SLT and Psychology</p> <p>Eating and drinking: Range of adaptive</p>	<p><i>Training/competency programmes or protocols</i> <i>Inventories of equipment</i> <i>Induction programme details</i> <i>Evidence of agreement between health and local authority services for supplying equipment</i></p>		

CRITERIA	STANDARD	EXAMPLES OF EVIDENCE	ACTUAL EVIDENCE ATTACHED	RAG RATING
	<p>equipment for kitchen Videofluoroscopy swallow assessments Access to eating and drinking equipment Thickening powder for modified diet trials</p> <p>Toileting and washing Commodes Range of adaptive equipment for bathroom</p> <p>Positioning and transfers: Manual hoists Sliding sheets/transfer aids Rotastands (or equivalent transferring aids) Transfer boards</p> <p>Mobility: Adaptive equipment for the home (e.g. rails/ramps) Range of wheelchairs (e.g. attendant and self propelling) Frames/walking sticks Ankle foot orthotics Botox clinics/service Functional electrical stimulation Specialist software for mobility exercises or easy to access exercise information</p>			

CRITERIA	STANDARD	EXAMPLES OF EVIDENCE	ACTUAL EVIDENCE ATTACHED	RAG RATING
	<p>sheets Information about how to access community transport options</p> <p>Communication: Access to a range of electronic AAC (Alternative and augmentative communication devices) Computer software/equipment to support paper based communication aids (e.g. Boardmaker, colour printers, laminating equipment) Patient information about inpatient unit/pathway in variety of formats relevant to local population (e.g. aphasia friendly, variety of relevant languages) Health advocacy/interpreting services</p>			
F.	All patients are screened using a validated tool to recognise anxiety, depression and cognitive problems	<i>Casenote audit Attach details of tool used</i>		
G.	Outcome measure system in place to determine progress from admission to	<i>Case notes audit</i>		

CRITERIA	STANDARD	EXAMPLES OF EVIDENCE	ACTUAL EVIDENCE ATTACHED	RAG RATING
	discharge (Based on RPS RC4)			
H.	100% patients have a named key or support worker allocated within 7 calendar days of admission for both ESD and CSR services. (Based on RPS RC5)	<i>Case note audit</i>		
I.	90% patients and carers are involved in negotiating rehabilitation goals and receive a copy of documented goals in a format appropriate for their needs within 2 weeks of admission to ESD or CSR services. (Based on RPS RC6)	<i>Case note audit</i>		
J.	90% appropriate stroke patients are offered 5 rehabilitation sessions per week within the first two weeks of an ESD service, and/or 3 sessions per week for four weeks with CSR service (including non or post ESD patients) (Based on RPS R15/NICE QS 7)	<i>Case note audit</i>		
K.	85 % of patients and carers have a joint care plan on discharge from	<i>SSNAP Copy of template discharge summary with evidence of joint</i>		

CRITERIA	STANDARD	EXAMPLES OF EVIDENCE	ACTUAL EVIDENCE ATTACHED	RAG RATING
	<p>hospital.</p> <p>Joint care plan definition: documented evidence of an assessment and management plan which takes into account the patients' and carers' health and social care needs. The content of the care plan should be jointly decided by both health and social care staff.</p>	<p><i>social and health care planning</i></p> <p><i>Copy of policy/pathway documents indication joint planning between health and social services</i></p>		