Cwm Taf University Health Board Early Supported Discharge Service

Marie Evans

Overview of Service

The redesign of stroke services in Cwm Taf University Health Board was driven by the need to improve the quality of services in line with local and ever more challenging national clinical standards. March 2015 saw the culmination of a comprehensive redesign of stroke services in Cwm Taf, incorporating:

- Creation in November 2014 of a new community based rehabilitation service (5 days a week, Monday to Friday) enabling Early Supported Discharge for stroke patients.
- Centralisation of longer term inpatient stroke rehabilitation services at Ysbyty Cwm Rhondda, which took place in December 2014.
- Centralisation of hyper-acute, acute stroke and early stroke rehabilitation services at Prince Charles Hospital, from 30th March 2015.

The Health Board were successful in securing additional investment from the Welsh Government’s Intermediate Care Fund to establish the Stroke Early Supported Discharge (ESD) Service. The Early Supported Discharge Team received their first patients in November 2014. Since then the team have continued to focus on improving both the quality of care and the performance of the team, with quarterly reporting on performance indicators developed to monitor and evaluate the service.

The team was established using experienced staff working within our stroke care pathway, with a mixture of permanent and rotational staff across the stroke service i.e acute, rehabilitation and community provision. The organisation of care was based on the Cochrane systematic review of the evidence base. The aims of the service are to achieve patients' carer outcomes as per evidence base by:

- Providing appropriate, patient centred rehabilitation at home.
- Facilitating early discharge home from the Acute Stroke Unit at Prince Charles Hospital.
- Maximising rehabilitation within home environment and community.
- Providing a rehabilitation programme up to 6 weeks.

In addition the service supports patient flow by:

- Reducing transfers to inpatient rehabilitation beds in community hospitals.
- Reducing length of stay for those mild to moderate stroke patients who are eligible for ESD.

The ESD service is integrated into our community hospitals, with the use of a gym, once a week to provide a circuit based exercise group for patients currently in the service, thus prompting a gradual return to exercise, social interaction and additional peer support.

The team has also been successful in obtaining local funding to support the setting up of a Family Stroke Café which aims to provide emotional and psychological support and psycho-education to families and carers. This service is currently being evaluated in order to ensure carers are receiving optimum support to improve and maintain physical and psychological well being.

The ESD team consists of:

- Two Nurses (Band 7 & Band 6)
- Two Occupational Therapists (Band 7 & Band 6)
- Two Occupational Therapy Technicians (Band 4)
- Two Physiotherapists (Band 7 & Band 6)
- Two Physiotherapy Technicians (Band 4s)
- One Assistant Clinical Psychologist (Band 5)
- One part time Speech and Language Therapist (Band 7)
- One ESD Community Team Coordinator (Band 3)

With rapid access to:
- Dietetics
- Stroke consultants

With good established working relationships with General Practitioners, the Stroke Association, Special Ophthalmologists, Social Service Reablement Services in Merthyr Tydfil and Rhondda Cynon Taff, therapy outpatient services across Cwm Taf and a range of Public Health Wales locally provided services such as smoking cessation.

**How the service operates and has improved service provision**

The ESD Team is based on the centralised Acute Stroke site at Prince Charles Hospital. This co-location has facilitated good communication, working relationships and working practices which have led to provision of excellent patient care as well as improvements in performance.

There are robust processes in place to respond promptly to referrals received “electronically” via email on a daily basis. A duty rota is in place where one qualified therapist from the ESD team (the duty therapist) attends the acute ward round every day to identify patients in advance of discharge, as well as potential patients to be discharged during the coming week. The duty therapist undertakes the following role:

- Ensures there is good communication and processes to guarantee safe and timely discharge after screening.
- Will ‘accept’ referrals and will arrange a first home visit for the day following discharge (unless it is a Friday).
- Meets the patient face to face prior to discharge to introduce the service, provide an overview of expectation and to ensure continuation of care.
- Provide all patients with a contact name, telephone number and date and time of their planned first visit prior to them being discharged from hospital.
- Provide the patient with an information leaflet is also provided to every patient.

All referrals received Monday to Thursday (before 3 pm) are screened, and if appropriate, the patients are then seen within 24 hours of discharge from hospital. For patients screened and planned on a Friday or a weekend, the discharge screening ensures these patients are safe and well enough to manage with support until the ESD team can prioritise a visit on the Monday following the week.

**Summary of benefits of the service for patients and their families:**

- Decreased length of stay in hospital – increased mood, decreased anxiety for both the patient and their family and carers.
- Increased participation in rehab in own environment, assist lifestyle changes and secondary prevention.
- Increased integration back into the community.
• Improved social participation, ownership of rehab and family involvement in rehab process.
• Rehab at home in a familiar environment promotes functional recovery and better able to provide person centred holistic care.
• Continuity of care over a 6 week period.
• Education of family and carers.

Results have been consistently high with the last quarter (1st January 2017- 30th March 2017) showing:

• 69.73% of the stroke population within Cwm Taf UHB being accepted by ESD for assessment and programme (national average 40%)
• Improvement on the SAQL - stroke aphasia quality of life measure (patient self rating)
• Significant improvements on the standardised measures
  o PASS – postural assessment scale for stroke
  o The Berg balance scale (BBS)
  o MOTOM – Morriston Occupational Therapy Outcome Measure
  o Nottingham extended “Activities of Daily Living Scale” (ADL) measure
  o Reduction in depression using the HADS – Hospital anxiety and depression scale

Additionally

• The acute average length of stay for eligible patients in the most recent performance review is 7 days. The pre service length of staying being 11 days.
• 100% patients referred were seen by the ESD for assessment in the acute hospital within 6 hours of the referral.
• 75.5% of patients referred to ESD had their home programme started within 24 hours.
• 24.5% had their home programme started within 72 hours. This is in part due to referrals happening prior to the weekends, bank holidays.
  (13 Patients, 11 weekends discharges, 2 were delayed due to further medical investigations)

Patient satisfaction

Patient satisfaction rates are consistently high and we are confident we are capturing and reflecting the views of the majority of our patients with a current 69% return rate to our questionnaires. Some comments received from our patients are included below:
Patient Satisfaction

"Excellent support was given to both of us which has enabled my husband to regain independence, and reduced my anxiety regarding his safety when I am out of the house."

"I felt the praise given by the team regarding how well I was doing encouraged me to try the driving assessment. Unfortunately I failed, but everything else was fine, no problems."

"Felt everyone was very friendly and patient. Always had time to listen."

"Thanks for all your support and help to me and my family. You all made me feel at ease and built my confidence so much throughout my recovery. I can't thank you enough, you are all a credit to your job."