Early supported discharge: an essential part of stroke care

The evidence for early supported discharge services is compelling, but progress towards widespread implementation is patchy even though the early rehabilitation of stroke patients at home has been a national priority since 2007. This article explores why this is the case.

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Stroke is the largest single cause of disability in a community setting with direct care costs for the NHS of over £3 billion annually.[1] The early rehabilitation of stroke patients at home following their care in hospital has become a national priority, driven by the availability of an ever-increasing evidence base in stroke rehabilitation.[2,3]

Key policy documents focusing on the transfer of care from hospital to home, and rehabilitation of stroke patients at home, have recommended the implementation of early supported discharge (ESD) services.

There is robust research evidence for the effectiveness of ESD, and a unique opportunity to investigate the translation of research findings into clinical practice by investigating the implementation of ESD services.

Given such a strong policy drive, we argue that it is hard for any stroke service to justify the absence of an ESD service as part of their clinical stroke care pathway.

Policy drivers

Facilitating early discharge of stroke patients from hospital and providing early rehabilitation and support at home was recommended in 2007 as part of the National Stroke Strategy.[4] Both this and the Royal College of Physicians (RCP) National Clinical Guideline for Stroke recommended the implementation of ESD services.[4,5]

The National Stroke Strategy was intended to provide a quality framework to secure improvements to existing and developing stroke services. Quality Marker 10 within the strategy recommends "early supported discharge to a comprehensive stroke specialist and multidisciplinary team (which includes social care) in the community, but with similar level of intensity to stroke unit care".[4]

This was supported by recommendations in the RCP guideline for stroke which recommended that "domiciliary rehabilitation services should be commissioned as part of an early supported discharge scheme to deliver specialist rehabilitation at home in liaison with inpatient services, as well as in the long-term".[5]

Renewed impetus to set up ESD services has developed following a recent "accelerated" initiative by the Stroke Improvement Programme (established to implement the National Stroke Strategy 2007) and the introduction of a 2011 audit of the proportion of eligible patients supported by an ESD team (http://bit.ly/ddpMZl).

Financial incentives are to be gained for stroke services in reducing the length of hospital stay for patients. National stroke tariffs associated with stroke patient care, part of the payment by results scheme, define payments to hospital trusts that equate to a period of stroke patient care.[6,7] A length of stay in hospital shorter than the tariff period results in both a higher turnover of patients and money savings for the hospital trust.

Community services and rehabilitation were excluded from the payment by results scheme. However, there is renewed

pressure on hospital trusts to be mindful of the whole stroke pathway and take a more patient focused, stroke care pathway perspective. In June 2010, Andrew Lansley stated the Government was "sending a clear message that patient care doesn't end when patients walk out of the hospital door".[8] In fact the Department of Health has introduced plans for financial penalties on hospitals if a patient has to be readmitted for emergency treatment within 30 days of discharge.

Financial issues associated with ESD services have proved complex, with debate as to whether the savings from a reduction in hospital length of stay is actually realised in the form of financial support for ESD services. Although splitting up or "unbundling" of the national tariff for stroke care has yet to be formalised on a national level, some local commissioning initiatives have made steps to unbundle the stroke tariff.[7,1] An unbundled tariff means that savings made from a reduction in hospital stay are used to fund additional services focused on the care of stroke patients during the transition of care from hospital to home, and to rehabilitation during their first weeks at home. This provides the financial support necessary to implement stroke ESD services.

The evidence base

Research evidence supporting the implementation of ESD services has been cumulative. In 2005, an individual patient data meta-analysis (11 trials, n=1597), confirmed in a later review (12 trials, n=1659), concluded that appropriately resourced ESD services provided for a selected group of stroke patients can reduce long-term dependency and admission to institutional care as well as reducing the length of hospital stay.[9,10] No adverse impact was observed on the mood or subjective health status of patients or carers. The greatest benefits were seen in services providing a coordinated ESD team and with patients who had mild-to-moderate disability. In trials in which an economic analysis had been carried out, opportunity savings from hospital bed days released tended to be greater than the cost of the ESD service.

To date, little research has been conducted into the health and cost benefits when ESD services are implemented in local areas. A failure of the NHS to put research evidence into practice was identified by Tooke in 2006.[11] As a consequence the National Institute for Health Research (NIHR) has commissioned collaborative partnerships, known as CLAHRCs (Collaborative Leadership in Applied Health Research and Care) between academic partners, healthcare providers, patients and commissioners. The stroke rehabilitation theme of the Nottinghamshire, Derbyshire and Lincolnshire CLAHRC focuses on the relatively unexplored area of the implementation of stroke rehabilitation services such as ESD services and facilitation of the use of research findings when setting up ESD services in practice.

The first phase of this CLAHRC research programme has been to develop a consensus around ESD. Despite robust research evidence, confusion remains as to what an ESD service actually comprises and the best model to use to set up such a service.

Research findings within the 2005 meta-analysis were published as a Cochrane systematic review and deal with the basic question of whether a policy of early hospital discharge with support could be as effective or efficient as conventional care.[9] Guidance can be gleaned from the review, such as the number and type of staff typically needed for a new patient caseload of 100 per year.

However, key messages from the research literature remain inaccessible to commissioners and service providers. Our CLAHRC research team, in collaboration with ESD trialists who contributed to the Cochrane systematic review on ESD, has developed a list of statements about ESD to guide commissioners and service providers.[12] The aim is to ensure that the Cochrane review of ESD evidence is appropriately used to develop and implement evidence based stroke services.

The Stroke Improvement Programme features our ESD consensus report on its website, ensuring guidance is available nationally (http://bit.ly/auyGAN).

The ESD consensus document clearly states that ESD teams should be stroke specific and multidisciplinary, offering co-ordinated and planned discharge from hospital and continued rehabilitation when patients are settled at home. The intervention is beneficial for a subset of the patient population; those of mild-to-moderate stroke severity. Strong links are required between the acute service and the ESD team, with both hospital staff and ESD team

members identifying patients. To measure effectiveness, ESD teams should use standardised assessments to monitor stroke severity, dependency, activities of daily living and satisfaction as well as the impact of the ESD service on length of stay and readmission rates.

Research into implementation

ESD services provide an ideal research paradigm for exploring the implementation of stroke services. Reasons for the lack of translation of the evidence base into clinical practice are complex and are likely to have organisational, financial, professional and political origins.[13] CLAHRCs were set up as collaborative partnerships across organisational and professional boundaries with key stakeholders informing the design and execution of the research. As such we are ideally placed to address why gaps between research and clinical practice still remain even when research evidence is readily available and accessible.

Our research builds on definitive randomised controlled trials and moves into the implementation phase of complex intervention research embracing all the challenges currently facing service provision in the NHS.[14]

Although our current research focuses on ESD services, many of the findings will apply to the implementation of other stroke services. It is important to remember that ESD services need to be viewed as part of an evidence based stroke care pathway, and ultimately can only operate effectively in collaboration with other health and social care providers.

Stroke care currently remains high on the Government agenda. The need for commissioners and service providers to consider the whole stroke care pathway has never been so important. The transfer of care from hospital to home is a challenging and distressing time for patients and carers.[15] ESD services should be implemented to focus on this critical period as delivering an evidence based stroke care pathway is the only way to better patient care.

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