Title: Early Stroke Discharge Team : A participatory evaluation

Category: Research

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Abstract

Aims: International evaluation of Early Stroke Discharge (ESD) has concentrated on measuring the impact of service provision. This research aimed to address the question, ‘How did the ESD team members and external stakeholders experience the service implementation process?’

Methodology: Between October 2009 and February 2010, six team members and four external stakeholders were interviewed as part of a participatory evaluation. Interviews were used to explore the experiences of the process of inception and implementation of the team. Transcripts were subjected to thematic analysis.

Results: Five themes related to the experiences of the introduction of the ESD team: Setting up the team; Team working experience; Team within the context of other services and professionals; Effectiveness in achieving aims; Learning for the future. Within the themes issues relating to funding, leadership, team management and working were highlighted.

Conclusions: It is clear that at the inception of a new ESD service it is crucial to engage all stakeholders in the development of the service and review the interface with existing care provision requires reviewing. Decisions regarding the management and leadership of the team and professionals within it are also required and should be guided by an understanding of the patient care pathway.

Key words

Early Stroke Discharge, participatory evaluation, multi-disciplinary team, health and social care interface
Introduction

In developed countries the traditional stroke care pathway often includes acute and rehabilitation care in the hospital setting, followed by discharge into the community where the provision of ongoing rehabilitation is variable (Langhorne, 2003). The introduction of Early Stroke Discharge (ESD) teams has challenged this model of care delivery, bringing the time of discharge forward and providing a continuing rehabilitation period, commencing in hospital and continuing into the home and community (ESD Trialists, 2005). International evaluation of ESD has concentrated on measuring the impact of service provision (Langhorne, 2003). Currently there is limited research exploring the implementation of ESD teams for members and external stakeholders.

This paper presents a participatory evaluation that asked the question, ‘How did the ESD team members and external stakeholders experience the service implementation process?’ and explored the experiences of ESD team members engaged in the implementation of rehabilitation care in one community and of those key stakeholders associated with the change. The evaluation team leading the project were based at the local university and collaborated with ESD team members in developing the project design. The ESD team were established with funding from the closure of ten hospital beds and included specialists from occupational therapy (OT), physiotherapy, speech and language therapy, dietetics and nursing. The team had completed an interim evaluation (Cooke et al, 2009) that reported reduced length of stay by an average 13.5 days, saving 1094 bed days and increasing patient satisfaction, with 86% of patients being satisfied/highly satisfied with the ESD service. The inception of the team coincided with a peer based clinical review of stroke services designed to identify compliance with the National Stroke Strategy (Department of Health (DH), 2007).

Literature review

Internationally, stroke is a major cause of death and disability (Young and Forster, 2007). Consequently, stroke has a major impact on patients and families and creates high costs for the health and social services, ‘estimated at £2.8 billion a year’ (Young and Forster, 2007, p. 86).

The National Service Framework for Older People (DH, 2001) set out a goal of ensuring stroke survivors have prompt access to integrated stroke care services for acute care and rehabilitation. In this context rehabilitation is viewed as actions that limit the effect of brain damage caused by stroke and maximise the patient’s ability to continue daily living (Duncan et al, 2005).

In 2001, a review of inpatient data showed improved outcomes where patients received specialist care, such as that provided by a multidisciplinary specialist team in a stroke unit (Stroke Unit Trialists Collaboration, 2001). A further Cochrane review showed that, if suitably resourced and co-ordinated, early supported transfer of care using specialist stroke teams can reduce the length of stay, improve mortality and dependency outcomes and increase patient satisfaction (ESD Trialists, 2005).
Early supported discharge aims to provide a seamless transfer of care from hospital to home and gives stroke patients the opportunity to continue rehabilitation and be supported in their own surroundings with input from a specialist ESD team (Rodgers, 2008). Langhorne et al (2005) provide a meta-analysis of patient data from eleven ESD trials and conclude most of the evidence of benefit appears to be for patients with moderate disability. Despite initial concerns that there might be an increase in burden on carers, there were no significant differences in carer mood, health and satisfaction outcomes between groups of patients discharged earlier and those not.

The importance of early discharge is increasingly recognised in DH policy documents, ‘Mending Hearts and Brains’ (DH, 2006a), ‘Our Health, Our Care, Our Say’ (DH, 2006b) and the ‘National Stroke Strategy’ (DH, 2007). In 2008, however, the Stroke Improvement Programme reported that only a third of stroke services had an ESD service, a model strongly supported by the stroke strategy (http://www.improvement.nhs.uk/stroke/).

The literature suggests models for ESD have varied in terms of the organisation and membership of the teams, the services offered and the patients catered for, issues that are important to consider in reviewing the implementation of an ESD team. For example, Young and Forster (2007) suggest physiotherapy is highly valued by patients and refer to two reviews confirming its effectiveness (Van Peppen et al, 2004; Pollock et al, 2007). Speech and Language is often affected by stroke and specialist therapy is offered, though the impact of this is not understood (Greener et al, 1999). In addition to these specialists; OTs, nurses and physicians are reported team members (Donnelly et al, 2003; Fjaersto et al, 2004). Rodgers’ (2008) expert summary of published studies finds, a typical ESD team had 2.8 whole time equivalent (wte) staff per 100 new patients per year. A typical service included: 1.0 wte physiotherapist; 1.0 wte occupational therapist; 0.4 wte speech and language therapist; 0.25 wte assistant staff; and 0.1 wte stroke physician. Some teams also had additional nursing and social work input, enhanced home care services and administrative support. In 2010 an ESD consensus report suggested the team should include physiotherapist, occupational therapist, speech and language therapist, nurse physician and social worker (Fisher et al, 2010).

The following examples (DH, 2009) demonstrate some of the different models used in different areas. In Portsmouth, the Community Stroke Rehabilitation Team provides specialist and intense interdisciplinary support 365 days a year from nurses and therapists. The Blackburn with Darwen Community Stroke Team is an example of joint working between the health service and the local authority and has four pathways to cover patients of all levels of need, including those in residential and nursing care. The Knowsley team includes a social worker alongside health professionals and can access transitional beds within residential care homes. The Nottingham ESD team delivers a 7/7 multidisciplinary model of rehabilitation for up to 6 weeks. In Devon a services provides early supported discharge, post discharge and late community rehabilitation for stroke and other neurological services.

Given the emphasis on ESD team development and implementation and the lack of evidence reporting the team member experience and that of stakeholders, it is important to report the findings from this participatory evaluation.
Methods

Qualitative participatory research is committed to change the balance of power held by the researcher and actively engage the community being researched (Northway, 2010). The approach supports the engagement of participants as part of the research, empowering those taking part in the research process (Moule and Goodman, 2009). This was seen in the research as though led by University staff, the project involved members of the ESD team in the decision-making process about the methods of data collection to be adopted, the composition of the sample group, both with regard to the ESD team itself and wider stakeholders, and the topics to be included in the interview guides. The evaluation commenced in July 2009, was completed in May 2010.

Ethical issues

Ethical approval was obtained from the Faculty Ethics Committee and the project was registered with the Trust Research and Development unit. Informed consent was obtained from all participants. They were given an information sheet about the evaluation and all signed a consent form.

Issues of anonymity were discussed with the team at the outset. It was acknowledged that it might not be possible to ensure anonymity, it was agreed that the evaluation team would pay particular attention to presenting data in a way that would not be attributable to individuals but that this could not be fully guaranteed. As part of this process, key themes were returned to the participants for comment and all participants were offered the opportunity to check drafts of the final report.

Participants

Potential participants were either members of the ESD team or key external stakeholders from different disciplines. In total, a purposive sample of the key six ESD team members were interviewed including; the Team manager, the Physiotherapist and the OT (who also had team leader roles at an early stage of the team’s initiation), the Nurse, the Speech and Language Therapist and the Dietitian.

As the ESD team worked across institutions and community areas, it was necessary to include key stakeholders from these areas. These were identified by the ESD team members as being key external partners. Those interviewed included four staff in health and social care sectors; an NHS Commissioning Manager in the Primary Care Trust, an Intermediate Care Service Lead for Health, an Intermediate Care Services Lead for Social Care and the Team Manager for Hospital Social Work Services.

Data Collection
Data collection was completed in two phases; an initial qualitative interview captured the experiences and learning of the inter-disciplinary ESD team members about this development of the service. A second phase of qualitative interviewing, following on from the interview of ESD team members, explored external key stakeholder perspectives on team development.

Before each interview participants received an interview guide consisting of sample questions. This was used to help them reflect on experiences of working as part of, or with, the ESD team.

Topics addressed with the ESD team respondents included:

- The formation and development of the team and how this linked with local, regional and national policies and frameworks
- The functioning of the team; rôles, hierarchy, organisation, strategy
- Relations with others; including patients, carers, staff outside the team, wider organisations
- Difficulties and challenges faced
- Successes and areas for improvement

The topics raised with the external stakeholders related to their experiences of working with the ESD team and included:

- The rôle of the respondent’s own organisation in supporting stroke patients and carers
- The respondent’s involvement in the working of the ESD team and the functioning of the team in relation to existing services and care delivery processes
- Feedback received from patients and their carers
- The effectiveness of the team in achieving their objectives
- Lessons to be learned and areas for further development/improvement

The interviews were conducted between October 2009 and February 2010 and lasted approximately one hour each. Though guided by the semi-structured interview framework, the interviews were conducted as conversations to allow the participants to fully shared their experiences and reflections (Moule and Goodman 2009). The ESD team interviews either took place at the team members’ place of work, at the University or in one case, in the respondent’s home. Key stakeholders were interviewed in the work place, at the University or when a face-to-face meeting was not possible, by telephone. The interviews were digitally recorded and transcribed.

**Data Analysis**

The interviews from the evaluation were transcribed and subjected to thematic analysis (Miles and Huberman, 1994). Individual transcripts were read through repeatedly while
listening to the tapes and coded individually by the research team. Members of the university based evaluation team reviewed each other’s initial analysis and code production. Data analysis proceeded with the team coming together to generate and agree upon themes across the interviews. These themes were then written up and returned to the participants for member checking. The participants were invited to read through the themes and their transcript and confirm accuracy of both the discussion and the interpretations. This process addressed some of the ethical requirements of the study and supported trustworthiness.

Trustworthiness

Lincoln and Guba (1985) developed criteria for establishing the rigour and trustworthiness of qualitative research; credibility, dependability, confirmability and transferability. A number of steps can be taken to support claims for credibility; these include including expert review processes, member checking, peer review and interviewing techniques. Researchers used expert reviewers as objective peers to establish credibility. They reviewed the process of sampling, data collection and analysis. What Maxwell (1992) refers to as ‘descriptive’ and ‘interpretative’ validity can only be provided by the participants themselves through member checking. Member checking was used to provide descriptive validity by verifying the factual accuracy of the account and interpretative validity to confirm what the participants meant in what they said. This process decreases the chance of misrepresentation and increases the believability of the data and its overall worth.

Providing an audit trail of the research supports the dependability and confirmability of the findings (Guba and Lincoln, 1985). The strategies of expert and member checking support this, as does the digital recording of interview data. Peer examination increases the credibility. Each member of the research team checked some of the transcripts to examine whether the issues identified were a representation of the original data. This process of peer review supported the credibility of emerging themes.

The interviews were guided by research questions developed in conjunction with the ESD team members who had experienced the service innovation and were able to use their familiarity to support question development. The provision of the interview guides ahead of the interview helped the participants focus and prepare for the discussion. All those interviewed were engaged in some way with the ESD team development, either as members or external stakeholders. They were therefore well placed to address the questions and provide rich data of their experiences, although it should be acknowledge that each may have brought their own biases to the interviews reflecting the agendas of the employing organizations and personal beliefs. Transferability is aided through the provision of description of the research design and methods used.

Findings

Five themes are presented that relate to the experiences of the introduction of the ESD team. Figure 1 includes a schema of the themes that will be presented with supporting verbatim data.
Theme 1: Setting up the team

The participants were aware of the growing evidence base supporting ESD;

“it is more cost effective with lower mortality, better outcomes and patient satisfaction”.

They also recognized that ESD addressed the broader agendas on patient choice and patient goals. More generally, the project was perceived by one person as;

“fitting into the national drive around getting patients home, having rehabilitation in their own homes”.

There was no new funding for the project and the nature of the funding from acute care was thought to have influenced the way the project was conceived and developed.

“the financing was based on the ten hospital beds closed”.

The creation of a multi-disciplinary team was seen as revolutionary for the Trust at the time, though there were inception issues recorded by one individual as;
“the management of the project was one of the fine details that there was no time to work out”.

A steering group brought together the heads of the professions represented in the team with a general manager who had a remit covering two hospitals and consequently insufficient time for the project. No single person gave the team a sense of clear direction. Within the team the four Band 7s attempted to manage by consensus. The team leadership was rotated through the Band 7 staff with each taking a three month turn. As well as orienting to the multi-disciplinary team, there was a desire for each of the professions to maintain a professional identity and be managed within their profession. The allied health professions drew support through clinical supervision in their professional teams, this model however left the nurse isolated and lacking support.

In the early stages of the project, the budget was not integrated, meaning that any review and alteration to the skills mix would require negotiation with several. Although the team needed to work closely with each other as a truly multi-disciplinary team with interdisciplinary practices and a clear identity, it was recognized that the team was not big enough to operate in isolation and needed to be fully integrated with other parts of the Trust for mutual provision of cover when needed.

Although most of the respondents felt the right health care professions were represented in the team, the concentration of staff at high bands left gaps which could have been filled more economically at support worker level. From outside the Trust, there was a strong feeling by all that the lack of involvement of Social Care undermined the team’s ability to provide holistic support, expressed by one individual;

“It was set up with quite an expensive team of therapists and a nurse but no actual social care input or anyone to carry out personal care which meant that if the idea was that you take people out who’ve had a stroke earlier than they would otherwise one would expect that in between the therapists visits they might need some degree of support but that wasn’t available, that wasn’t thought about and put into the team.”

Theme 2 : Team working experience

A number of factors impacted on team working. Being located in one physical space, enable the team to work well, talk about patients and gain support. The team members worked well together and one felt;

“it’s the passion for Stroke that’s done it”.

There was a perception that the desire to make the team work for stroke patients was behind the success. The team also had processes in place that facilitated multi-professional working such as;

“weekly staff meetings where we would talk through any day-to-day issues and concerns. We also had timetabling every week where we would table patients and ensure that if we needed joint sessions we could cover them. We also had
our own multi-disciplinary team meeting where we would talk about unified goals and when we had seen the patient come up with a joint plan”.

It was also clear that the team members offered a range of skills and expertise, one example being the noted IT skills of a member of the Team.

Rotating the Team Leader role and management of team members created issues expressed by all in different ways with one example below;

“I think it worked well for those that were full time, but for those of us who were part-time, like myself, we shared it.. and my gut feeling is that the team at that time ..may have found it a bit disjointed”. The lack of external management was also an issue, ‘but there wasn’t a recognised hierarchy above’. One member reported, “When we were a pilot, we didn’t really have any clear lines of communication or responsibility with professional leads, in other words the OT department, Physio department, nursing etc. And it was just something we worked with”.

Theme 3 : Team within the context of other services and professionals

At inception the all team members perceived themselves as still very much relating back to their own professional groups. They were still essentially managed from within their own disciplines:

“To start with I think we were very much within our professions and we went to our own line managers with issues.”

For a number of the team members, they experienced the line management and clinical supervision provided by their own profession as supportive and understanding. However, all acknowledged that this system could give rise to tension, in that issues of importance to the team were being dealt with in the professional departments outside it:

“So we were reporting to our professional managers and the team lead didn’t have much power over things like annual leave, study leave those kind of things which would have been much better controlled within the team, that was still going out to our individual professions which tends to complicate things a little bit…in the same way appraisals and objectives and thing, they were still quite professions specific…”

Within the hospital setting, the team needed to relate to the existing ward staff, both nursing and therapeutic. Because of the way in which the team had been created, sometimes misconceptions arose among ward staff and the team members reported the need to educate others as to their role and function and to make clear their criteria to ensure that appropriate patients were being referred to them:

“We did quite a lot of teaching sessions on the wards to explain what we were and where we’d come from and what our criteria were basically..”
The ESD team members also perceived that their specialism in stroke rehabilitation created tension between them and the Community Rehabilitation Team (CRT):

“I mean that’s potentially another issue I guess that they might have felt that we were kind of taking all their interesting patients um which is a difficult one isn’t it because all the recommendations say that people should be treated by stroke specialist staff so that’s one argument for the team in the first place um but I think they found it frustrating to think that what they were doing would differ from what we were doing.”

The impasse over payment for social care was a major issue for the team and impacted on their dealings both with community services and social care agencies. Both the ESD team members and stakeholders interviewed acknowledged the difficulties created by the question of payment for social care and the way in which this negatively affected the working of the team. In the words of a team member and a stakeholder respectively:

“I think the difficulty is, is actually no service can operate in isolation and particularly a service like this that has to refer onwards a patient, it’s that whole kind of pipeline thing isn’t it?”

Theme 4 : Effectiveness in achieving the aims

The team reported external feedback had been positive, based on patient satisfaction surveys. It was also noted by all stakeholders and the team that the home based rehabilitation seemed to be effective for carers and relatives.

“Our patients’ general feedback was that they were just really pleased to be at home”.

Additionally, the team reported meeting aims to reduce the length of hospital stay. It was also recognised that the team had provided care in a secondary setting that had enabled the closure of hospital beds and broadly delivered on the ‘Stroke’ strategy;

“I think it does reflect the National ‘Stroke’ Strategy in terms of a) having the function of an Early Stroke Discharge Team, but b) that function being delivered by Specialists, highly competent staff and the care of people with ‘Stroke’, so from that perspective, em....I think it’s done a good job”.

“...from a Trust perspective it’s shortening the length of stay, so those people are actually in the hospital for less time”.

The discussions also highlighted some limitations in the team’s abilities to achieve their aims. There was concern that the team were working to a lower than expected capacity and were limited in the cases they could accommodate. The team only ever had seven or eight patients. This arose because they couldn’t work with people in nursing homes or who had existing packages of care. This situation reflects the difficulties of working across health and social care in delivering the service and it was felt that,
“with more Health and Social Care type resources, they could get even more people home”.

Theme 5: Learning for the future

The key message related to the organisation of the steering group and development of the model of care. It was felt by a number of respondents that it was important to,

“involve all the stakeholders, consider others and existing service and the impact on those existing services as well as how you could work with them.”

It was seen that operational issues and the pathways needed to be talked through and the various stakeholder from health and social care needed to be part of the development process, agreeing the model of care and then using this to determine the team composition and functioning. An approach like this may have helped to get social care input facilitated so that the capacity of the team could be increased.

There were also comments made about the team composition. One person suggested,

“it would have been good to have had two Healthcare Assistants attached to Intermediate care that could have provided hand-on support sometimes for those people going home”.

This would increase the capacity of the team and may have widened the scope of referrals.

Discussion

In examining the findings it should be remembered that this project considered a local service development. The views were limited to those staff engaged in the ESD team and external stakeholders. However, the findings provide key learning in a previously neglected area, exploring the experiences and ESD team member and key external stakeholders in ESD team implementation that could be transferred to inform similar service development.

It is clear that the factors driving the ESD team development reflected local and national policy. The initial development and operationalization was led by the Trust and funded through hospital bed closures in stroke care, as seen in previous developments in Walsall (Robinson, 2009). The Trust were keen to reduce the length of hospital stay, lower the costs of care delivery and provide more individually focussed rehabilitation that was delivered in the patient's home. The development of an ESD team composed of specialists in stroke care also supported the National Stroke Strategy (DH, 2007).

Whilst the initiative was welcomed by external stakeholders, they felt that the ESD operational policy would have been better informed had social care been engaged in the development and operation of the team, as seen elsewhere (Rodgers, 2008). It was apparent that the operational policy had not fully considered the need for collaboration and impact of charging policies associated with delivering the stroke care pathway.
The team composition varied from those typically seen, where a service would include assistant staff, stroke physician and social care support (Rodgers, 2008; Langhorne et al, 2005). It was suggested by team members and external stakeholders that including nursing assistant roles would have strengthened the team, particularly if these had been linked to Intermediate Care provision. This, along with social care input to the team, would have increased the scope of referrals, especially with regards to supporting the discharge of patients to nursing homes and with packages of care. Teams do exist where health professionals work alongside social workers, who enable access to transitional and residential home beds (Rodgers, 2008; Langhorne et al, 2005; DH,2009). Whilst the ESD team did have access to two transitional care beds, these were underused, a position that might have been reversed had social care support been included in the team.

It appeared that traditional across disciplinary working practices were transferred from the ward environment into the ESD team, losing an opportunity to develop multi-disciplinary working for a stroke care pathway. It was also clear that in developing the nursing role; of ways of working in the community, resourcing care delivery, training to meet community care delivery and the need for clinical supervision required further consideration.

All team members discussed concerns about the initial leadership model adopted for the team where a rolling team leadership model emerged. On reflection this model did not work well when the team leaders held part-time posts, as the other team members had a ‘disjointed’ experience. Rotating the leadership role amongst the Band 7 staff also meant it was restricted to the therapists and excluded the nurse. The team also felt that the positioning of the team as part of Trust structures was not clear. For example, lines of responsibility and communication with professional leads and departments were not set out.

Despite some difficulties, there were identified strengths of the team working. The team had a range of skills used to mutually support the service delivery, including IT skills and were also stroke specialists who had a passion to deliver the best care to patients. Whilst previous research has highlighted the importance of specialist care delivered by multidisciplinary teams for patients (Stroke Unit Trialists Collaboration, 2001; ESD Trialists, 2005), these findings identify its importance for team functioning. Team members felt the desire to make the ESD team for stroke care was important to the success of the team working. Further factors also supported multidisciplinary team working. The shared work space was seen as key to effective working as it offered scope to discuss care needs and delivery. A range of other team processes also supported effective working. For example, staff meetings to talk through any issues, multidisciplinary team meetings to develop joint care plans to meet patient needs and joint assessment visits.

The aims to reflect the National Stroke Strategy (DH, 2007) had been achieved through having the ESD team and delivering care for people with stroke through a highly specialised team. Initial uncertainty about the ESD team’s role meant that the CRT did not appreciate the ways in which the ESD service was different and that they were not fulfilling an identical function to any existing team. The development of the ESD team,
with its focus on stroke, sometimes resulted in the perception on the part of the more
generic CRT that the ESD team worked with the “interesting patients”. However, the
ESD team attempted to conduct joint sessions with the rehabilitation staff wherever
possible to share their specialist knowledge and expertise.

The evaluation identified a number of considerations for ESD team development and
implementation and the multidisciplinary professions working within the teams. Initially,
funding should be agreed and consideration given to how the team access equipment
and resources. Service development would benefit from a planned approach that is
based on benchmarking and starts from the care pathway. It should include input from
all stakeholders from both health and social care and service users and carers. The
care pathway, as well as existing literature, should be used to inform decisions on team
composition, operational aims and policies. It may be cost effective to include assistant
roles in the team, particularly for nursing and physiotherapy. The care pathway should
also be used to inform decisions about the location of the service and its impact on
existing provision. Staff delivering existing services that interface with new ESD teams
will need preparation for the change and information about the service.

Management of the new team will need to be agreed and provided within existing
structures and should support the maintenance of professional identities whilst fostering
multidisciplinary working. The ESD suggested having one full- time leader was
beneficial to members and to external stakeholders.

Conclusions

Despite the limited scope of the research, the findings highlight learning for the current
service and that might inform future new service development of other ESD teams. It is
clear that at the inception of a new ESD service it is crucial to engage all stakeholders
in the development of the service. This process should also ideally include the service
user and carer voice, as stakeholders in the process, and be continued throughout
development and implementation.

In developing the new service, the interface with existing care provision requires
reviewing. This scoping should take into account the intended funding mechanisms for
the provision and location of the service. Decisions regarding the management and
leadership of the team and professionals within it are also required and should be
guided by an understanding of the patient care pathway. Neglecting these aspects can
have a negative impact on the ultimate achievement of aims and service delivery.

In considering future research in this area, it would be beneficial to undertake a wider
evaluation of new ESD teams that preferably commences with the inception process
and maps the development and implementation of the service and encompasses the
multiple perspectives and experiences of all stakeholders. This would add to the current
limited understanding of the process of service development and implementation.
Conflict of interest: None

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Key phrases

- A participatory evaluation demonstrated that it is crucial to engage all key stakeholders in setting up an ESD service.
- Ideally service user and carer voices would be represented at ESD team inception and implementation.
- Decisions about team composition, leadership and management should be guided by the patient care pathway.
- It may be cost effective to include assistant roles in the ESD team.

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