



## Early Supported Discharge Service: Countess of Chester Hospital NHS Foundation Trust

The Early Supported Discharge (ESD) Service enables acute hospital patients to be discharged in a timely way by making sure care packages are in place to support their rehabilitation at home. An important feature of the service is the strong partnership with the local community trust.

The Countess of Chester Hospital NHS Foundation Trust is a large district general hospital in Chester with over 600 beds, providing services at an acute hospital site and at an intermediate care site.

### Aims

ESD aims to allow patients to be discharged from hospital earlier and receive the rehabilitation they need in their own homes. By increasing the patient's functional independence at home, ESD also aims to help them avoid readmission. It is one of several schemes designed to support the trust's A&E performance.

### Origins

The foundation trust and the local community trust set up ESD at the Countess of Chester acute site in November 2012 as a joint service for adult patients. Many patients aged over 65 were occupying Countess of Chester beds despite being able to receive care and support outside hospital.

### Structure

**Multidisciplinary team** The team comprises nurses and therapists, including occupational therapists and physiotherapists, as well as a social care assessor. Increasing numbers of community support workers can provide care, rehabilitation and support in the patient's home while awaiting social care packages. Staff are employed by an integrated community and acute therapy service.

### Characteristics

- 7-day service
- nurse and therapy led
- patients stay up to 14 days on the ESD pathway and are referred to social care if applicable at day 3
- serves up to 90 patients a day
- supports 14 new discharges a day

**Acute-based** Multidisciplinary meetings take place daily at the acute hospital to discuss patients on the ESD pathway and plan their care.

## How patients benefit

**The service takes patients who are medically stable but need further therapy.** Patients are referred from A&E and intermediate care, and identified from medical wards. A typical patient has been hospitalised following a fall.

### Enabler: single therapy lead across the locality

ESD relies on downstream services being available to which patients can transfer from the ESD pathway. The trust reports that joint working with the local community trust has enabled patient flow through the service. One person is responsible for therapy services across the local community and acute providers, which has particularly helped develop successful working relationships.

**MDT meetings take place daily** at the hospital where staff discuss patients on the virtual ward. The hospital-at-home team provides additional medical support to ESD.

**Short-term input** ESD can care for 90 patients in the community each day, offering therapy, bridging social care support and providing short-term medical care at home. Patients stay with the service 10 days on average, receiving a maximum of three visits a day before transferring into community care (eg ongoing community services, integrated care teams run by the local partnership trust, or primary care). Social care assessment is made on day 3 for patients who the team predict will need ongoing care.

**The trust has responded to increasing demand on the service.** Since it was set up, the service has supported 4,000 hospital spells and 3,000 unique patients. The trust has invested in additional staff for the service. ESD's length of stay has shortened due to the development of pathways with social care, which enable increased throughput.

## Impact

**The trust says ESD helps it cope with the pressures of increased demand.** Specifically, it helps shorten length of stay, freeing beds for patients with acute health needs and relieving pressure on A&E.

**ESD could save money** as the trust, in partnership with the community trust, is now looking after three times as many patients in the community as it was in the acute hospital, for the same cost. The trust achieved this by reinvesting in community teams the savings made from bed closures.

## More information

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This is one of a suite of case studies designed to increase awareness of the impact of moving healthcare out of hospital. For more materials see [Moving healthcare closer to home](#)