Enter & View Visit to

In-Patient Elderly Rehabilitation Service (IERS), Mary Seacole Ward,

Queen Mary's Hospital, Roehampton

13 November 2018

Healthwatch Wandsworth

Acknowledgement

The Healthwatch Wandsworth Enter & View Team would like to thank the management, staff, patients, relatives and friends who made us welcome and assisted us in carrying out our visits and in preparing this report.

The Project Team

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Enter & View Visit to In-Patient Elderly Rehabilitation Service (IERS), Mary Seacole Ward, Queen Mary's Hospital, Roehampton: 13 November 2018

Executive summary

Background (Sections 1 & 2)

Intermediate Care (IC), which is still evolving, is intended to be a range of integrated health and social care services that promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge from hospital, and maximise independent living. The provision of effective rehabilitation services is considered essential to achieving these aims, and also in preventing premature admissions to long-term care. In practice IC, particularly bed-based care, mainly serves the needs of older people experiencing difficulty in regaining their independence after illness, falls or other injuries. In Wandsworth, IC services are not yet fully integrated but include both home-based and bed-based care.

In 2018, we accepted an invitation from Wandsworth & Merton Clinical Commissioning Group (CCG) to organise an Enter & View (E&V) visit to the IC facilities at Ronald Gibson House (RGH). Building on this experience, we decided to organise a visit to Mary Seacole Ward (MS) at Queen Mary's Hospital, Roehampton, which provides an Inpatient Elderly Rehabilitation Service. We thought that this would provide an interesting point of comparison with the services at RGH. The report on RGH is available on our website: https://www.healthwatchwandsworth.co.uk .

We recommend that readers look at both reports for information on two different models of bed-based IC provision in Wandsworth.

How we proceeded (Sections 3 & 4)

In preparation for our E&V visit we met, separately, with staff from the CCG with responsibility for commissioning integrated care and with the senior clinicians and managers from MS and the Inpatient Elderly Rehabilitation Service. We obtained a great deal of background information about the service, which is set out in Section 3.3 of our report. We decided to limit the focus of our visit to the experience of those patients who were actively engaged in rehabilitation therapy designed to recover independence (one of the primary aims of an IC service).

On November 13, an E&V team of six spent the day on MS. We interviewed 15 patients out of 19 who had been identified by staff as meeting our criteria, plus the relative of another patient. With patients' permission, we had access to their care plans so that we might assess the type of treatment goals being set, and the extent to which patients were involved in setting them.

Our findings (Section 5)

Section 5 sets out the information we gained from our interviews with patients, supplemented by additional information from staff and from our observations during the visit. It has five sub-sections: patients' pathways into care; their views of the care on MS; the rehabilitation services offered to patients; the involvement of families and carers in decisions about treatment and discharge arrangements; and the process of planning and implementing patients' discharge from MSW.

Overall Conclusions (Section 6)

Most patients were positive about the standard of nursing care and the attitude of nurses on MS. Several patients would have liked to receive written information in advance about MS and its rehabilitation facilities. Some patients expressed concern about nurses' workload. The ward was relying on a high number of temporary staff, and we wondered whether this might explain an apparent lack of relaxed interaction between patients and nursing staff.

The therapy team at MS was clearly committed to the provision of a personalised, goal-oriented and multi-disciplinary approach to rehabilitation in IC, within their constraints and client profile. However, it was not clear that information on this was fully shared with the rest of the team, and we felt more could be done to involve and inform patients, including setting out goals in plain English and sharing them more widely. A few patients told us that their rehabilitation programme seemed less intensive than expected. We found that the therapy staff-patient ratio at MS appeared to be significantly tighter than at RGH, and there was a lack of therapy staff coverage at weekends.

The environment on MS cannot be compared directly with the unit at RGH, which is able to provide a homely environment within a nursing home. MS is a 40-bedded inpatient ward, following hospital routines. Some patients commented favourably on the comparative peace and quiet on MS, following their experience of busy wards in different acute hospitals in the locality. We considered however, that more could be done to provide greater activity and autonomy for rehabilitation patients by, for example, encouraging people to wear their own clothes, and providing a range of more stimulating social activities.

Overall, we conclude that the rehabilitation service being delivered on MS is generally delivering a positive bed-based IC service. However, this is not the only service being delivered on the ward, as variable numbers of older patients who are not able to benefit from an IC service are also admitted when there are pressures elsewhere in the acute hospital sector. This provides additional challenges for the MS service and reduces the number of available IC beds.

Finally, we record our view that the right provision for intermediate care in Wandsworth would continue to comprise elements of bed-based care in both hospital-type and nursing home-type settings.

Recommendations (Section 7)

- To QMH /St George's University Hospital Foundation Trust as service provider

1. To provide an information leaflet for patients and their families before or on admission to the In-Patient Elderly Rehabilitation Service on Mary Seacole Ward explaining what to expect from their stay, including:

- general information on personalised, goal-oriented and multidisciplinary rehabilitation therapy;
- the range of different staff likely to be encountered and their uniforms;
- who to approach if patients or their families have any concerns likely to be outside the responsibility of the nurse on duty in the bay; and
- the discharge planning process.

2. To review arrangements for rehabilitation goal-setting, progress monitoring and involvement of patients and their families so as to ensure that the following standards are applied as the norm:

- individual patients are involved in setting clear and realistic overall goals designed to maximise their independence in line with their individual circumstances and wishes;
- specific rehabilitation therapy "stepping stones" towards those goals are set, meeting the SMART criteria, and kept under review;
- the goals, "stepping stones" and patients' progress towards them are recorded and accessible to the whole multi-disciplinary team in clear language;
- a copy of the goals and "stepping stones" and of any subsequent changes to them is given to the patient and/or their family;
- patients are kept informed about their progress in rehabilitation therapy.

Where in the patient's interest it is not considered appropriate for one or more of these standards to be applied, e.g. for reasons of mental incapacity, this should be clearly recorded in the patient's records. These arrangements should be subject to regular management audit until they have become securely embedded.

3. To explore ways of improving arrangements for informing and updating patients and their families on the discharge timetable, e.g. by displaying the Provisional Date of Discharge (PDD) on the whiteboards above patients' beds or writing it in to their copy of their therapy goals and "stepping stones".

4.To review staffing levels for the nursing team on Mary Seacole Ward in view of the pressure which they currently seem to be under.

5. To consider the case for an increase in rehabilitation therapy staff resources available to Mary Seacole ward to increase the intensity and/or quality of rehabilitation therapy for those patients who might benefit, including the possibility of extending therapy cover to weekends.

6.To seek means of providing individual access to radio channels, TV and the internet for patients on Mary Seacole Ward, ideally without a fee.

7.To explore other possibilities for increasing levels of both activity and autonomy for patients on Mary Seacole Ward and enriching their experience during their stay.

8. To ensure that a laundry service is made available for patients' own clothing on Mary Seacole Ward.

- To Wandsworth CCG as commissioner for intermediate care

9. To support QMH to the extent possible in carrying out the above recommendations.

10. To take note of our view, following our visits to Ronald Gibson House and Mary Seacole Ward, that the right provision for intermediate care in Wandsworth would continue to comprise elements of bed-based care in both hospital-type and nursing home-type settings.

The Full Report: Contents

The Full Report

1.0 Introduction

1.1 About Healthwatch Wandsworth

Healthwatch Wandsworth (HWW) is the patient and public champion in the areas of health and social care services. At the national level, we send our reports to Healthwatch England. HWW is funded by the Department of Health through the local authority, Wandsworth Borough Council. Our staff and volunteers are managed by an independent local voluntary organisation, Wandsworth Care Alliance (WCA). HWW is governed by an Executive Committee consisting of four Trustees of WCA and four members directly elected by the community. Our activities are developed in consultation with the public at our Assembly meetings and as we collect feedback from people about their experiences of health and social care in Wandsworth. To decide on where to focus our work we look at what people have told us when taking part in our surveys or sharing experiences with us, we speak to local health and care decision makers to hear about their plans to develop services and we use information on local health data to set our priorities.

1.2 Enter & View

Healthwatch Wandsworth has the statutory authority to visit health or social care services provided in the borough, or which cater for the local population but are located outside the borough. We can observe how services are delivered. Our main aim is to talk to patients or clients, their close relatives or carers, and senior staff responsible for managing the services. Our main focus is on the service user's experience of care.

Our E&V volunteers receive full training and are DBS (Disclosure & Barring Service) checked before they can become authorised visitors. After each visit, the team produces a report containing its findings and recommendations. The reports are then sent to the service provider for comment, and to relevant bodies such as Healthwatch England, the Care Quality Commission (CQC), and those responsible for commissioning and providing the service we have visited. Finally, our report and any response from the service provider to our recommendations are posted on the Healthwatch Wandsworth website.

1.3 Our E&V strategy

One of the main aims of our current E&V strategy is to collect feedback on the experience of patients of St George's University Hospitals NHS Foundation Trust which is the main provider of acute care services in Wandsworth. The team (and its precursor LiNK) has also had a longstanding interest in services for older people in a range of settings and has visited care homes and extra-care housing as well as looking at discharge procedures at St George's and visiting Crocus Ward at Springfield Hospital. Most recently, (September 2017), we visited the wards for older people at St George's Hospital. Our reports can be found on the Healthwatch Wandsworth website[1].

[1] https://www.healthwatchwandsworth.co.uk/resources/enter-&-view-reports

We have been aware of the pressures on acute hospital beds and on the development of other options for the provision of care. We were invited by Wandsworth Clinical Commissioning Group (CCG) to visit the intermediate care facilities at Ronald Gibson House and Mary Seacole Ward, Queen Mary's Roehampton and this seemed to fit within our strategy and interests. We carried out a visit to Ronald Gibson House on 21 May 2018 and reported on this on 17 July 2018. In the light of this visit and subsequent discussion with the CCG we decided to proceed with a visit to Mary Seacole Ward.

2.0 Background

2.1 Bed-based Intermediate Care Services: National guidance

As explained in our report on our visit to Ronald Gibson House, Intermediate Care (IC) was developed in response to several reports in the late 1990s and fully defined in the 2001 National Service Framework for Older People (NSF-OP):

> *Aim: To provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living.*
>
> *Standard: Older people will have access to a new range of intermediate care services at home or in designated care settings, to promote their independence by providing enhanced services from the NHS and councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long-term residential care.*

It was intended that care should be person-centred, time-limited, focused on rehabilitation and delivered by a combination of professional groups as part of a whole system approach. Professor Ian Philp, who was the Czar for the NSF-OP, also said what Intermediate Care should not be[2]:

- *marginalising older people from mainstream services (a ghetto service)*
- *providing transitional care for older pending long-term placement (a hotel service)*
- *solely the responsibility of one professional group (a dumping service)*
- *indeterminate care (a dustbin service)*
- *a means of funding all good things for older people (a honeypot service)*

A wide variety of services have evolved over the years and they continue to evolve but the principles of avoidance of inappropriate hospital admissions or stays, time-limited multi-disciplinary rehabilitation services, free at the point of delivery remain. The National Institute for Health and Care Excellence (NICE) recently published guidance and information[3] which defines intermediate care as a range of integrated services that:

[2] Quoted in a King's Fund Guide https://www.kingsfund.org.uk/sites/default/files/Developing-Intermediate-Care-guide-health-social-services-professionals-Jan-Stevenson-Linda-Spencer-The-Kings-Fund-July-2009.pdf

[3] Intermediate Care including reablement. https://www.nice.org.uk/guidance/ng74

promote faster recovery from illness; prevent unnecessary acute hospital admissions and premature admissions to long-term care; support timely discharge from hospital; and maximise independent living. Intermediate care services are usually delivered for no longer than 6 weeks and often for as little as 1 to 2 weeks. Four service models of intermediate care are available: bed-based intermediate care, crisis response, home-based intermediate care, and reablement.

2.2 Development of local Intermediate care services

A number of services have been developed in Wandsworth which fulfil the stated aims and standards of intermediate care but they are not currently integrated in any organisational sense and for the most part are embedded in wider services which also serve other functions. For example, home-based care meeting the aims of intermediate care is currently provided through the Maximising Independence function of Community Adult Health Services (CAHS) which is commissioned through Battersea Healthcare, a GP practice-owned Community Interest Company, and provided by Central London Community Healthcare NHS Trust (CLCH).

Bed-based care is available both from the Bed-Based Intermediate Care Unit (BBIC) at Ronald Gibson House, provided jointly by Brendoncare and St George's Hospital Foundation Trust (SGH) and by the In-patient Elderly Rehabilitation Service (IERS), Mary Seacole Ward at Queen Mary's Hospital, which is part of SGH. As our report explained the BBIC at Ronald Gibson House provides bed-based intermediate care in a care home setting to patients who are assessed as capable of engaging with and benefitting from rehabilitative therapy to restore mobility, confidence or daily living skills within a limited period and have signed a statement of intent to do so. The IERS at Mary Seacole Ward is structured as a traditional hospital ward and is available to a less narrowly-defined category of patients.

2.3 Our interest in visiting Mary Seacole Ward

As the report of our visit to the BBIC at Ronald Gibson House makes clear, we were in general favourably impressed by the way it performed its allotted role but were interested to visit Mary Seacole as a point of comparison. We have also been aware that Ronald Gibson House is likely to be rebuilt in the next few years as part of the redevelopment planned at the Springfield Hospital site. We accordingly felt that our study of intermediate care would be incomplete without a visit to Mary Seacole Ward. We were however aware that Mary Seacole had been the subject of a number of recent inspections by the Care Quality Commission and Enter and View visits by Richmond Healthwatch. We therefore felt we could confine our enquiries so far as possible to the question of the contribution which Mary Seacole Ward makes to the provision of intermediate care.

3.0 Preparing for our visits

3.1 Meeting with Commissioners, 17 July 2018

On 17 July 2018 four members of the Enter and View Team met with Sandy Keen, Commissioning Manager for Integrated Care and Older People, Rachel Oostra, Project Manager, IC, both of Wandsworth CCG, and Amanda Mayo, Head of Quality and Nursing, Battersea Healthcare. We discussed the report, which they had seen in draft, of our visit to Ronald Gibson House and the CCG's intentions on future commissioning.

We explained our interest in visiting Mary Seacole Ward with a view to comparing the provision of IC there with what is provided in Ronald Gibson House. The commissioners were happy with this proposal but explained that a lot of work had been going on at Mary Seacole (MS) reviewing procedures to improve the flow of patients through the ward and to monitor the use of MS beds to see how many are being used for active rehabilitation and how many for other patients. An E&V visit would best wait until this work had been taken further. We accordingly suggested a preliminary visit to MS at the end of August to meet one or both Consultants, the Ward Manager and the Therapies Lead and to discuss the model of care and when an E&V visit might best be scheduled. The commissioners agreed to make initial contact for us.

3.2 Meeting with consultants and managers at Mary Seacole Ward, 28 August 2018

On 28 August five members of the Enter and View Team met with Rachel Oostra, Interim Integrated Project Manager for Wandsworth CCG, Dr Samantha Keeling, one of the two consultants responsible for Mary Seacole Ward, Goretti Doolan, Matron, and Louise Paterson, Clinical Team leader for Therapies. We were given a great deal of information in response to our questions about the role and functioning of the ward. We were also given a brief tour (during which we met Dr Duncan Gerry, the other responsible consultant).

As the ward was currently focussing on a number of organisational and other changes, it was agreed that an Enter and View visit would better wait until, say November. We explained that we would want to provide a poster to alert relatives to our impending visit. We would also want the ward to obtain some patients' prior consent to our seeing their therapy goals.

3.3 What we learned about the service

3.3.1 Ward layout and facilities

Mary Seacole Ward is a mixed ward providing nursing and rehabilitation for older adults. There are 42 beds and the ward is managed as two 21-bedded units referred to as “A” and “B”. Each of the units has 3 six-bedded bays and three single rooms, which are mainly allocated on infection control grounds. The bays offer a good amount of space for bedside working. Each side of the ward has a large day room, one of which has an area equipped as a sensory room with music, light projection etc.

The large and well-equipped gym near the ward entrance is shared with other Queen Mary's Hospital (QMH) services. There is a bedroom, a bathroom and two kitchens in the corridor adjoining the gym all set up to enable patients to practice activities of daily living in an environment more closely resembling one at home.

There is a central courtyard with some railings and a garden.

3.3.2 Source and type of referrals

According to the 2011 service specification for the IERS, the ward serves patients who have a Wandsworth or Richmond GP (although some Merton residents now seem to be admitted with costs charged to their CCG). Patients referred from St George's (mainly the orthopaedic and senior health wards), Kingston Hospital and some other hospitals on a "step-down" basis (i.e. after a period of hospital treatment and in preparation for return to residence in the community). A minority of referrals are also accepted on a "step-up" basis from the out-patient Brysson Whyte Unit or from the Senior Health Rapid Access Clinic (RAC) at QMH (e.g. if a patient receiving care at home deteriorates and is becoming unable to cope). Patients can also be referred on a "step-up" basis from the Ambulatory Assessment Area (AAA) in Richmond Ward or the Clinical Decisions Unit (CDU) in the Emergency Department at St George's.

We were told that patients usually have specific rehabilitation goals which are set as part of a multidisciplinary geriatric assessment carried out after their arrival on the ward. They arrive with a discharge summary (including when coming from St George's, as this is regarded as a separate in-patient stay). Patients who arrive from St George's should also arrive with their in-patient notes.

While, we were told, most patients are referred on the basis of confidence that they will be able to engage beneficially in rehab therapy, some are referred in the hope that they will be able to do so once they have recovered further, or to give them a chance to try (we suggested that these patients might be described as being in a "pre-rehab" stage). Although some rehab therapy is offered on the acute wards, it is considered better for people who require a period of rehab to be moved out of the acute care environment when possible and the environment at MS is more conducive to recovery.

It was also acknowledged that (as noted in the Richmond Healthwatch report of a visit in November 2016) when St George's acute wards are under pressure some patients not in need of rehab but with complex discharge arrangements to be completed (e.g. adaptations at home) are transferred to MS pre-discharge. The frequency of this type of referral fluctuates with the level of pressure on acute beds.

Although there can thus in effect be some stratification of patients in terms of their ability to engage in rehabilitative therapy, patients at different levels are not separated on the ward and the basic routine is the same for all.

3.3.3 Management of referrals

The ward's Discharge Co-ordinator, Magda Cooper acts as patient flow co-ordinator, dealing with admissions as well as discharges. The suitability of referrals is assessed by the medical team, normally on the telephone with the referrer using a triage form. The therapists will sometimes also liaise with the referring therapist.

From time to time there has been a waiting list for beds, usually only for a few days. Patients are normally admitted in order of referral but we were told that, when Opel (Operational Escalation Pressures Levels) 2 and 3 are in operation at St George's, priority may go to the St George's patients. Priority would also normally be given to any referrals from the community to prevent admissions to acute wards.

There were apparently two admission leaflets, one short and another more detailed, but we saw no sign of these in current use and understand these are being reviewed and updated for use again in future.

3.3.4 Therapy goals

On arrival patients receive a comprehensive geriatric assessment including assessment by a physiotherapist and an Occupational Therapist (OT). We were told that what patients want to achieve in rehab is discussed with them and this is then worked up into therapy goals which are included in the geriatric assessment documentation. These are meant to be “SMART”: Specific, Measurable, Achievable, Relevant and Timed.

Some patients have memory problems or are otherwise unable to identify what they want to achieve and in these cases the therapists work with the patients' families to set goals. It is not always clear on arrival whether patients are able to return home or will need to be placed in care. This may take a period of rehab to determine, during which definitive goals cannot be set.

Patients are given exercise sheets when appropriate but are not routinely given copies of their therapy goals. This had apparently been tried in the past, but the document often got lost or muddled. The question of giving patients copies of their goals is apparently being looked at again.

3.3.5 Length of stay and discharge

The average length of stay from April 2017 to September 2018 was 29 days, with monthly figures ranging from 21 days in September 2018 to 35 days in August 2017.

Over the same period 725 patients passed through the ward. Nearly three-quarters (74%) returned home, while 10% were discharged to nursing homes and 12% to St George's or other hospitals.

There used to be a leaflet to help patients prepare for discharge, but again, we saw no sign of current use. We understand It is being updated and a pictorial version is being developed for non-readers.

Interpreters are used for a few patients in connection with discharge or other important decisions/news. Communication is also a problem for a number of other patients e.g. hard of hearing. Mental capacity issues are common.

On discharge patients are often referred for further therapy at Brysson Whyte, St John's Day Hospital or through the Maximising Independence function of CAHS.

3.3.6 Staffing and organisation

The therapy team consists of 4 physios (3.5 whole time equivalent), 4 OTs, 1.6 speech and language therapists and 3.5 rehab assistants: at the time of our visit one physio post and one OT post were vacant and not all the team were permanent. Louise Paterson who is therapy team leader is non-clinical. The team works 5 days which means that there is no therapy at weekends - but it was pointed out that there is no discharge activity at weekends as Social Services work only 5 days. Patients can continue to mobilise with the help of nursing staff at weekends.

Current resources do not allow intensive therapy. Patients do not receive a session every day but may receive up to 3 a week. Nursing staff are part of the MDT and can help patients who are motivated to work on their own. OTs carry out home visits (sometimes with the patient) for assessment purposes when necessary.

The nursing team is overseen by Goretti Doolan, the Matron. A ward sister covers the whole ward and a junior sister each of the two "sides". At the time of our preliminary visit there was a 47% vacancy rate for qualified nursing staff, meaning heavy reliance on bank or agency staff. At the time of our actual visit this had increased to 65%. Each of the ward's two sides has 4 qualified nurses and 3 healthcare assistants on duty for 21 beds. There is supposed always to be a member of staff on hand in each bay to respond quickly to patients' needs. Each patient is supposed to have a named nurse responsible for them each shift but the ward does not currently operate a keyworker system (although this is mentioned in the 2011 service specification) because of the scarcity of permanent Band 5 nurses.

In addition to these nursing staff there is a "practice education" adviser who works full time solely on the ward and provides induction, training, supervision and appraisal for nursing staff, as well as standing in for the ward sister and carrying out some specific expert clinical functions commensurate with her grade and experience. Medical supervision is provided by 2 consultants who cover 21 patients each across both sides of the ward and 5 junior doctors. There are 4 consultant ward rounds a week.

In addition to the above, the ward has the services of a dietician and a pharmacist (0.5 wte each).

3.3.7 Ward routine and activities

We were told that although it was the aim for patients where possible to get up in the daytime and wear their own clothes in practice this does not happen very much either because there is nobody to bring clothes in or because people did not want to. Staff could only try to encourage patients. The laundry service is only for hospital clothing.

We were told that the therapy team did try to do some group work but patients seemed less inclined over the last couple of years to join in and were reluctant to move away from their bay. Advantage is taken of times when patients have to go to the day room to allow weekly deep cleaning of their bay. Sometimes singing is organised in the sensory room. One rehabilitation assistant sings and plays the guitar with patients.

The hospital has a daily sheet of facts, puzzles etc., called The Daily Sparkle, funded by the Friends. TV and radio are provided in the dayrooms.

Meals are normally delivered individually to the bedside. We were told that sometimes the attempt is made to get patients to eat together at a table set up in their bay but this rarely succeeds for more than a few days at a time.

Meals, cleaning etc. at Queen Mary's Hospital are provided by Sodexo, a commercial company, under a facilities management contract.

3.3.8 Comparison with Ronald Gibson House

Obvious differences between Mary Seacole Ward and the intermediate care unit at Ronald Gibson House were apparent before our visit. MS can accommodate more than twice the number of patients as RGH and is organised as a traditional hospital ward with beds in bays, rather than individual rooms as at RGH. MS also has access to a wider range of therapies (e.g. speech and language therapy) and to wider medical backup. Partly as a result, MS can and has admitted patients with a wider range of needs, including patients who are frailer, more dependent or with more complex medical problems including delirium.

On the other hand, RGH has been required to apply more IC-focussed admission criteria, including the patient's agreement to the use of goal oriented therapeutic care: these are not applied for admissions to MS nor, we were told, would some patients be capable of giving such agreement.

We identified some other points of comparison before our visit: in various respects rehabilitation facilities are better at MS, but the therapy regime appears to be no more intensive, and possibly less so, than at RGH. At RGH most patients receive a therapy session every day and the therapy team continues some work at weekends, whereas at MS therapy sessions are about three times per week and therapy staff only work Monday to Friday. The average length of stay however seems to be very similar at the two units.

3.4 Identification of objectives for our visit

In the light of the information obtained about the ward and with a view to focussing our approach to the eventual Enter and View visit, we gave some thought to identifying specific objectives for our visit.

We decided that we needed in particular to:

1. Explore how far MS was being used for intermediate care, including identify the numbers of patients on the ward actively engaged in rehabilitative therapy designed to recover independence as opposed to other categories.

2. Explore how well the IC pathway to MS was working including discharge planning.

3. Explore the experience of patients actively engaged in rehab therapy and, where possible, compare with experience at Ronald Gibson House, particularly in relation to the quality of therapy goals and of the help which the ward provides towards achieving them.

4. Explore how nursing and therapy resources are deployed to achieve patients' goals.

5. Explore how the overall ward environment and practices contribute to patients' recovery of independence.

6. Obtain the views of families and carers about IC at MS including therapy and discharge planning.

4.0 Our Visit

Two members of our team arrived at 9 am and were greeted by Elera McIntosh, the Practice Educator, and were shown to the dayroom where Louise Paterson (therapy team leader) and Goretti Doolan (Matron) joined us. They told us that the ward was nearly full: the figure was later confirmed as 40 patients at the start of the day and 38 by the end. They kindly provided details of 19 patients, 11 on side A and 8 on side B, whom the ward team had identified the previous day as being actively engaged in rehab therapy and likely to be able to provide interviews. We were subsequently told that there were 11 other patients who were having rehabilitation but had marked cognitive issues with either severe dementia and/or delirium and would not have been able to communicate with Healthwatch members. The 19 had all been asked and given consent to participate, including to us seeing their care plans. We were offered use of the dayroom as our team base.

We were told that our letter had been distributed to patients and we later found that many of the patients we spoke to were aware of our visit. We saw our poster displayed in more than one location.

We discussed how best to structure the visit: we were told that side A would be having a ward round before lunch, so it would be better to start with Side B and the managers gave us additional information in answer to questions we had (which we have incorporated in our report as appropriate).

The remainder of our team joined at 9.45 am. We began by looking at a selection of patient notes from Side B to see how the therapy goals were identified and recorded. We then proceeded to conduct interviews on Side B up to lunchtime and later switching to Side A. Our team of six divided initially into three pairs (one interviewer and one note-taker) and later some interviews were conducted by one person alone. In addition to patients, the team spoke to the Practice Educator, the Discharge Coordinator, an OT, a

Physio and two nurses (both permanent members of staff) as well as a visiting relative. The anonymised findings of our interviews together with the results of our observations are set out below under a series of general headings. Gender-neutral pronouns are used throughout.

We gave some initial feedback to Louise and left the ward about 5pm.

5.0 Our Findings

We interviewed a total of 15 patients and the relative of another. Of these, 11 were female and five male (roughly corresponding to the overall gender balance on the ward). Altogether 11 were White British, one White Irish, three of Black African or Caribbean ethnicity and one of Middle Eastern origin. The ages we recorded (not in every case) ranged from the mid-50s to 93, with more than half over 85. In the sections which follow the reader should note that not every patient gave a response to each aspect of care so the number of responses should not be considered as a proportion of 15.

5.1 Pathway

Of the patients we spoke to or about, 13 had been transferred from St George's Hospital and three from Kingston Hospital, a few after quite short stays. At least three patients had been in Mary Seacole before. Three patients had been on the ward for a week or less, a further five up to 2 weeks, six up to 4 weeks and two for longer (the longest nearly two months). All expected to be able to return home in due course and were working to that end. One patient would have preferred a referral for neurological rehabilitation with their existing clinical support team but was admitted to Mary Seacole instead because they were told that there is a long waiting list for this. (We have subsequently been told that this patient has now been referred for neurological rehabilitation.) A few others were awaiting surgery or a specialist appointment after completing rehabilitation.

Falls were mentioned in the case of five of the patients we spoke to or about, a further three had broken a hip or ankle, two more spoke of a collapse or seizure, one said their knees had given up on them, a further three had become otherwise unwell or unable to cope at home (leaving two who gave us no specific information on the cause of their admission). In addition Alzheimer's, MS, osteoporosis, heart failure, pneumonia and fluid on the lungs were mentioned as contributing to the condition of some of the patients.

For the most part the transfer process had gone smoothly enough but problems were reported in four instances: one patient was sent over from St George's too late in the day to be booked in and had to be returned there for the night; another had an uncomfortable and unexpectedly long ambulance ride, taking another patient home on the way; another lost some property including their reading glasses in the transfer; a fourth patient caught pneumonia which they seemed to attribute to the transfer.

In a few instances patients felt that they had not been involved in the referral to Mary Seacole but were merely told they were going and in at least six cases, patients told us, they were given insufficient or very little information and did not know what to expect. No-one mentioned receiving any written information and one patient told us they would

have liked a booklet with information about the ward, including the different staff uniforms.

5.2 Care

Having got to Mary Seacole, did they like it? Ten patients gave positive comments, ranging from "fantastic" through "quiet, nicer than Kingston", "less crowded than St George's" to "OK". Two patients were more negative; "I can't say I like it but I know I've got to be here" and "I liked St George's as they do more with patients". Three did not express a clear opinion.

Generally patients were positive about nurses' attitude and the way they treated patients; one said the nurses work hard and are "a marvellous help". But one patient felt the handling was "sometimes very rough" and another said "you can get some awkward ones". We observed nurses preserving patients' privacy by drawing curtains round and by talking quietly with them.

On the question whether staff were available when needed, the patients we spoke to were pretty evenly divided: seven patients were satisfied with staff's response to their calls, but eight were not or felt that staff were overworked - some of these mentioned uncomfortably long waits for assistance e.g. to get out of bed and go to the toilet or bays being left unattended during staff breaks. Four patients mentioned staff not having time to listen or chat, although another said that even when busy staff made time to talk and listen. In addition two of the staff members we spoke to felt that the nursing team were "noticeably understaffed", "overstretched" or "struggling".

We did on occasion as expected observe nurses stationed at the entrance to bays but they seemed to be more often on the move, attending to patients' needs, than when we visited the ward in August. We also observed one example of the pressures on staff: while we were conducting an interview, a patient across the bay fell onto the floor from their bed or chair; the nurse who was helping another patient out of bed at the end of the bay did not notice this until alerted to it. She had to make the patient she was with safe before she could attend to the fallen one; she then went for help to lift the fallen patient but the first potential helper she found did not feel able to assist so she had to go and find another.

Eight patients we spoke to felt involved in decisions about their care and treatment while one did not. Four patients seemed satisfied with the frequency with which they saw a doctor while three were less satisfied and a relative told us that their relative had been seen by the consultant the day before for the first time in 12 days. (We were subsequently told by ward management that patients are normally seen by a consultant once a week and that patients newly admitted to the ward should be seen at the next consultant ward round which in practice means that they should not be waiting longer than 4 days.)

We were told that the ward does not currently operate a keyworker system because of the scarcity of permanent Band 5 nurses but that each patient should have the name of the nurse in charge of them each day written above their bed. We did not observe this in practice. We asked patients about raising any concerns. Five patients were confident they

would be able to raise concerns, although mostly without knowing specifically whom they would approach, while four were less confident about this, including one patient who felt that little had been done when they had persisted in raising a concern.

A few patients and a relative mentioned specific issues about care. One patient would have liked staff to be more proactive about constipation (which can be an issue for bedbound or inactive patients). Another felt that not enough attention was being paid to the essential tremor (a neurological disorder) which they suffered and that they had been left short of prescribed medication to control it. The relative we spoke to was unhappy about the management of the pain relief their relative was receiving and felt that not enough was being done to treat the underlying causes - we passed this concern on to ward management with their agreement. This relative also thought that St George's was much more organised in its approach, especially to record-keeping, and said that there had been an instance when the wrong meal was given and another where the wrong person's medication was almost given. Another patient mentioned that the bay nearest the nursing station (in the corridor outside) suffered from the associated noise and light at night. Another patient was irritated by the noise of banging locker doors and popping blister packs associated with the current arrangements for delivery of medication which he felt could be quieter and more efficient. Another patient was unhappy that their request to be moved to a bed near the door, which was becoming free, was refused.

We did not ask specifically about the food on the ward, which is supplied by Sodexo, but received some conflicting comments on it. Four patients liked the food and one mentioned their halal diet was respected. Another said the food is "just about OK, but variable" while another patient said the food is "awful" and another thought the choice at breakfast was inadequate so brought their own muesli. We observed lunch being served. We noticed that in one bay four out of six patients were given red trays: we were told that these are used to identify patients in need of some supervision (e.g. in case of choking) as well as those needing help eating. We also asked a member of the Sodexo team clearing away about the large amount of food left on one particular red tray: we were impressed by the Sodexo staff member's apparent knowledge of the individual patient concerned.

5.3 Rehabilitation

As already explained, this crucial aspect of the ward's work was the main focus of our visit. It had already been suggested to us, and two members of staff confirmed this during our visit, that partly because of pressures elsewhere in the healthcare system the ward is receiving more patients than previously who are quite unwell and unable to engage in active rehabilitation. One staff member suggested that because of pressure on senior acute wards patients are being referred to Mary Seacole more quickly, before their potential for rehabilitation has been properly determined and it is being left to the ward to identify patients unsuited for rehabilitation and to transfer them on as necessary. Another staff member said that when St George's is on black alert the ward's admission standards "go out the window" and that they can receive end of life patients or those on palliative care and it can be a problem managing expectations. Ward management however queried whether palliative care or end of life patients had been received - we

are not in a position to resolve this point. Two other staff members felt that it was only occasionally the case that patients unable to benefit from rehabilitation were admitted.

We had made clear our intention to focus on patients who were actively engaged in rehabilitation and the ward kindly provided us on arrival with details of 19 such patients whom we should be able to interview. We were subsequently told that there were 11 other patients who were having rehabilitation therapy but who had marked cognitive impairment such as dementia or delirium and would not be able to assist us: these patients are not able to discuss and agree their aims or goals with therapists and so therapy is carried out in what is considered to be their best interests. One patient was in too much pain to engage in therapy and the remainder had been discharged from therapy and were likely to be discharged from the ward in the near future.

Before each interview we looked at some of the paperwork concerned with the setting and monitoring of rehabilitation goals for that patient. Although we found that there are physio and OT assessments and goal sheets as part of the CGA paperwork (Comprehensive Geriatric Assessment) these seem to be completed at the time of the initial assessment and do not seem to be used as the specific goals for returning home so much as a more general guide and they were often very incomplete: sometimes with no entry at all, or only one goal, and were often unsigned and undated. They do not generally appear to be used as "active documents". Both the assessments and goal sheets were written using abbreviations which nursing staff and the lay person would not be able to decipher (there is apparently a plan to make a dictionary of abbreviations and symbols and to standardise these). The physio section included a column for the patients' goals. Although there was some evidence that patients were asked about their goals, what was written was often limited to one goal (e.g. "To be able to walk again"). The second column was for the physio's formulation of SMART[4] goals. Similarly, OT goals were variable with few examples of what would be needed for a person to return home.

We had intended to assess how far the goals were SMART and appropriate for intermediate care but as so many of the sheets were so incomplete and there were other systems in place for physios and OTs to use, we could not do this systematically. We noted a few instances when patients had stated their own goals and these were written down. However patients do not receive copies of their goals or any ongoing written information about their progress.

One other specific observation that we made about the therapy goals we saw is that falls prevention was not explicitly mentioned - we found a similar lack of reference to this important concept in our visit to Ronald Gibson House and believe it should be addressed.

All individual therapy sessions are written up in the progress notes part of the patients' files. The therapists also use a shared computer drive (the O drive) for some therapy progress notes and they use this system informally to handover what they have been doing

[4] Specific, Measurable, Achievable, Relevant and Timed, as explained above.

with each patient. We learned that all staff make use of the handover sheets which are updated twice a day and printed off.

We asked patients about their goals as part of the interview process. The majority of the patients we spoke to had evidently set identifiable, if rather broadly defined, rehabilitation goals for themselves in consultation with the therapy team. But in a few instances what patients told us indicated that they did not have even this level of understanding with therapy staff (for example one patient had their goal recorded as "I want to go home", another said the same thing to us when we asked the question, a third similarly said "get stronger, do the physio and get home" and a fourth said "my goal is to be independent again" but that they had not set any goals with staff).

As regards goals and the course of rehabilitation therapy therefore our impression, in the light of the paperwork and what we were told, is that the therapy team largely proceed on the basis of their own professional judgement on what is achievable and will benefit the patient, in particular what will be needed to allow them to return home safely. There is minimal input from many patients especially from the significant proportion with marked cognitive issues such as dementia for whom they say they are acting in what they believe to be their best interests. Few of the patients we spoke to appeared to have much detailed knowledge of the specific course of therapy or milestones that their therapists were working to, although some of those closest to being discharged showed more understanding of the route they had travelled.

We also asked patients whether they felt they were getting enough therapy and the right therapy to make the progress they wanted to. A few patients were not really in a position to answer: one had only been on the ward three days and did not seem to have started therapy yet, another who had been there longer needed to get over a chest infection before starting physiotherapy although they had done some walking with nurses' help. Nine (well over half) of the patients we spoke to commented positively on the therapy and/or the progress they were making, although one of these would have liked more physiotherapy than they were getting and felt there were not enough staff for all the patients, while another said more physiotherapists would be better but considering the small numbers the provision was excellent. More critical comments were made by three patients: one who had been on the ward a week said that they were not getting enough physiotherapy to make progress and had not yet seen an OT; another thought that shorter, daily sessions in the gym would be more useful than the one half-hour session a week they had been getting and mentioned that nurses were too busy to help with exercises or with walking; the third told us they had a weekly gym session, twice weekly sessions on an exercise bike and once weekly walking with a frame and considered that this was less than they had previously received at St John's Day Hospital in Battersea. (However ward management suggested that it was very unlikely they would have been receiving more therapy there.)

In our interviews with staff, the Discharge Coordinator thought that the nursing and therapy teams worked closely together and that therapy was provided about three times a week, with the nurses carrying out parts of the rehabilitation plan at other times. An occupational therapist however said they would like more therapy time and staff: current

staff shortage meant that they had cut back on some active rehabilitation and on activities such as music. A physiotherapist felt that therapy provision was not up to NICE or professional standards and to achieve these the complement would need to be increased; they also pointed to the fact that the therapy teams were currently below complement and the physiotherapy team in particular was only able to function at "between 25% and 75%" given absences for illness and leave.

We were told about the system of priorities which the therapy team use on a daily basis to prioritise their work: top priority is given to new patients and those who have not had a therapy session for two days; the second priority is for other patients actively engaged in therapy; while lowest priority is afforded to the category described as "maintenance". On the day of our visit, we have been told, there were 14 patients in priority 1, 15 in priority 2 and eight in priority 3. We were also told that the therapists aim to preserve a degree of continuity in their work with individual patients. The OTs were able to achieve this more than the physios. We asked patients about this aspect: most had seen a number of different therapists but were generally happy with this and two said that the therapists communicated well with each other and worked as a team.

Two of our team visited the gym along the corridor from the ward and were favourably impressed by the range of equipment available. We observed a physiotherapist working with a patient for about 20 minutes with the help of a physiotherapy assistant and a student physiotherapist. The task consisted of practising getting up from a wheelchair to a standing position at the parallel bars, walking three steps forward and back using the bars and finally transferring to a wheeled walking frame and walking about 10 metres across the gym. This was all done with great care, attention, encouragement and responsiveness to the patient. We also observed therapy assistants helping patients walk with the help of frames in the corridors and similar walking or standing practice, sometimes involving nurses, within the bays.

We asked patients whether their stay on the ward was helping them to be as independent as possible. Three said "yes" to this and there was a range of other comments, some inconclusive and others already reflected in comments on care and rehabilitation above. Some responses related to the issue of wearing one's own or hospital clothes. One patient said they wore hospital clothing because they were easier to put on and they needed help dressing: but they seemed to feel that given the right help they could become more independent and dress themselves. Another patient preferred wearing hospital clothing because their condition or the medication made them sweaty and they needed a change every day. On the other hand two patients took pride in always wearing their own clothes as a mark of independence while another had just started wearing their own clothes as they were feeling better and would soon be going home. A third was wearing a mixture of their own and hospital clothing, apparently because staff would not let them wear items that were stained. A number of patients who were in the dayroom, having been moved out of their bay while it was being deep-cleaned, were also wearing their own clothes. But more than half of the patients we spoke to were wearing hospital clothing. Almost all of the patients we spoke to were out of bed, either sitting by their bed or in the dayroom. One member of nursing staff said that wearing of own clothing was being encouraged to promote independence and that there were plans for a policy on this. However they

admitted that it is very difficult to do this without laundry facilities. Apparently these are available in the part of the hospital which serves amputees.

This may also be the place to mention the question of activity, about which we did not ask everybody. Some patients were content to sit and think, "listen to the world go by", listen to their own radio or recordings, read books (there is a visiting library service) or the occasional paper brought in. Several patients were unhappy about the lack of radio, TV wifi or newspapers and pointed out that they need help getting to the dayroom where TV is (not always) available. Apart from those patients in the day room during deep-cleaning, we did not see the day room used at all. Apparently they had had a tea for Armistice Day (on the preceding Friday) but there did not seem to be any regular activities or ways to keep occupied.

5.4 Carers and families

Without exception the patients we spoke to had people who visited them whether partner, children, siblings, friends, neighbours or in one case a cleaning lady. No difficulty was reported keeping them involved (in one reported instance the doctor rang the family from the patient's bedside). The only problem was the distance at which many children or siblings lived.

We only spoke to one visiting relative who asked to see us. They had no concerns about visiting arrangements or involvement but, as reported elsewhere, were concerned about the standard of care and anxious about discharge.

5.5 Discharge planning

The ward has a fulltime Discharge Coordinator who explained to us how the discharge planning system worked. An Expected Date of Discharge (EDD) is set for each patient on admission but after commencing therapy a more considered Provisional Date of Discharge (PDD) is agreed by the multi-disciplinary team and reviewed each day. We saw evidence of this on the daily handover sheet but patients themselves did not seem to have access to this information and we saw no sign of a discharge leaflet.

The Discharge Coordinator's task seems to be mainly to ensure that any potential obstacles to safe discharge are dealt with within the timescale identified by the rehab team. She has a discharge checklist to help her track this. We heard from a number of patients reaching the end of their therapy about home visits carried out with or by therapists to assess the potential need for adaptations at home and/or to verify the patient's ability to carry out basic living tasks in the home setting. The Discharge Coordinator told us that she often attends family meetings where plans for discharge are made but that she does not liaise actively with relatives until very close to the time of discharge.

Our interviews with patients gave us no indication that these arrangements are not generally working well. For some patients talk of discharge was clearly premature, while others were expecting to go home soon. Several patients were clearly relying on a relative to deal with any issues relating to discharge. Local Councils were mentioned as being involved in two cases.

We asked about adaptations at home. In several cases these had already been carried out at an earlier stage but three patients mentioned that stairlifts needed or might need to be fitted. A few spoke of new beds or beds needing to be moved downstairs.

We also asked about provision of carers. Again one or two had carers coming in already. Two knew carers were being arranged, in one case with as many as four visits per day, while another thought they were likely to need carers. Another two who were some way off discharge were uncertain. We encountered only one case in which a patient's discharge seemed to be being delayed and this was because Wandsworth Council's KITE (Keep Independent Through Enablement) scheme had a waiting list so the possibility of interim care had to be explored.

A relative we spoke to was very anxious that their relative might be discharged too soon without making progress and would risk further falls. With their agreement we passed on this concern to ward management but it was not clear to us that imminent discharge was likely: possibly there had been some miscommunication with the patient or the relative.

6.0 Overall Conclusions

Picking up the objectives we set ourselves at 3.4 above (but not in quite the same order), we have come to the following overall conclusions in the light of our visit to Mary Seacole ward and looking back at our visit to Ronald Gibson House. We set out some specific recommendations for improvement at 7.0 below.

6.1 Patient and carer experience of care

The majority of patients we spoke to were generally positive about the standard of nursing care they were receiving and the attitude of nursing staff. The one relative we spoke to was more critical. A number of patients and the relative mentioned specific issues or concerns which we have recorded under 5.2 above. On general grounds we feel that patients and their families should have clearer information on who best to approach with concerns that go beyond the responsibility of the nurse (usually unqualified) on station in the bay.

But more significant in our view is the question of staffing levels, particularly on the nursing side. While nearly half of the patients we spoke to were apparently satisfied with the responsiveness of the nursing team, a larger number and several of the staff we spoke to thought the nursing team was understaffed, overworked and struggling. To some extent this was borne out by the impression we received on the day of our visit: in particular we did not observe as much relaxed interaction between nurses and patients as we would have hoped. The excessively high proportion of temporary staff may partly be responsible for this along with the overall numbers.

6.2 How patients' rehab goals are achieved

The 2011 service specification for the IERS (Mary Seacole Ward) and the more recent one for the BBIC at Ronald Gibson House both highlight the need for a personalised, goal-oriented and multi-disciplinary approach to rehabilitation in intermediate care. From what we saw and heard, the therapy team at Mary Seacole Ward are committed to and practice

such an approach effectively within the constraints of their resources and client profile. But as we found (also to some extent at RGH) the therapists seem more often inclined to rely on their own professional judgement rather than involving patients, some of whom struck us as fully capable of a greater understanding of and engagement with the therapy process. The documentation in patients' folders of patients' involvement in setting goals and of their progress towards those goals was, as at RGH, deficient in a number of respects. Therapists seemed to rely heavily on a computer drive accessible only to them as a group for the exchange of information on progress. In view of our more detailed findings in Section 5.3 above we feel that a thorough review is needed of arrangements for involving patients to the maximum extent possible in goal-setting and progress-monitoring as well as for documenting their involvement and progress.

One of the constraints within which the therapy team works is of course the available resources. Particularly given the current vacancies, the therapy staff-patient ratio at Mary Seacole appears to be significantly tighter than at RGH and the intensity of the therapy regime on offer correspondingly lower. While more than half of the patients we spoke to were positive about their therapy and their progress, a significant minority of the patients and all of the therapy staff we spoke to felt that to deliver a high-quality service more resources were needed. Although the ward continues to be notably successful in achieving a short length of stay in the majority of cases, we feel that consideration should be given to the case for increasing therapy staff resources. The lack of therapy staff at weekends, unlike at RGH, also leads to breaks in therapy.

6.3 Ward environment and routine

Although in the various guidance literature intermediate care is presented as an alternative to hospitalisation, we found that - in contrast to Ronald Gibson House - Mary Seacole is very much a hospital ward both in layout and in routine. Patients seem to spend most of their time and take their meals in or beside their beds. The large dayrooms are little used except when patients have to be decanted from their bays to allow deep-cleaning. Despite a declared policy of encouraging people to wear their own clothes, in practice, in the absence of a laundry service, most patients find it easier to wear hospital clothing although there are some determined exceptions and people sometimes start to wear their own clothing again as discharge approaches. There is also a distinct lack of activity with only some provision of newspapers and no formal access to radio, TV, and the internet. Patients in side rooms fare slightly better with TVs provided. The lack of TV, radio and internet is in contrast with the rest of St George’s where these can be paid for and charging is, we understand, under review. We wonder whether a more homely, “normal” environment might contribute positively to a frail older person’s efforts to recover independence and in any case feel that efforts to enrich the experience and particularly to increase patients’ sense of autonomy would be worthwhile.

6.4 Admission pathway and discharge planning

On the whole, the arrangements for admission to and discharge from Mary Seacole Ward seem to work pretty smoothly although we heard few concerns from patients. But we noted a distinct lack of information for patients and their families prior to admission about

the ward and the rehab regime as well as a prevailing uncertainty among patients and their families, sometimes leading to anxiety, about the timing of discharge as they were not updated about a probable date of discharge and some had only an estimate of two or three weeks which seemed to be norm of what patients are told on admission. In the absence of a keyworker system we consider it important for these information deficits to be filled.

6.5 How far the ward is being used for intermediate care

From what we have seen and heard we are clear that the primary function of Mary Seacole Ward continues to be the provision of nursing care and rehabilitation therapy for a limited period to enable older people to return to more or less independent living in the community, and for the most part at home, after hospitalisation following a fall, injury or acute illness. This function is clearly being delivered with commendable success. To that extent the ward can be seen as falling within the broad definition of intermediate care. In particular, it seems very largely to avoid the dangers mentioned in the 2002 Kings Fund Guide (see 2.1 above) of becoming a "ghetto", a "dumping ground", a "dustbin" or a "hotel".

But it does seem clear from all that we have been told that the ward continues, as was noted in the Richmond Healthwatch report of a visit in November 2016, to be driven at times by pressures elsewhere in the system. At such times the ward admits a variable number of patients who have little or no realistic potential to benefit from rehabilitation therapy and cannot therefore be considered to be receiving intermediate care as such. We received conflicting accounts on this point and are not in a position to form a definitive view of the extent and frequency of such admissions but on the day of our visit there seemed to be as many as 20 to 25% of patients who might not be considered as receiving intermediate care.

From the point of view of patients and their families this flexibility in the ward's admission policy may not make much difference, although as we have noted above we do feel that patients and their families deserve fuller and clearer information on various aspects of the functioning of the ward. But it does seem of concern to some therapy staff and it could, we imagine, cause potential problems from the point of view of health service commissioners, if they wanted to create a range of more integrated intermediate care services in line with the NICE guidelines.

Finally, looking back at our visit to Ronald Gibson House we recall that some of the patients we talked to there were a little younger and (but for their current temporary injuries) significantly more mobile and independent than many we saw at Mary Seacole. They liked the degree of independence which the care home layout and regime at RGH allowed. We wonder how comfortable some of these patients would have been, and whether they would have made the same progress, in the hospital setting at Mary Seacole. In any case following our two visits we incline to the view that the right provision for intermediate care in Wandsworth would continue to comprise elements of bed-based care in both hospital-type and nursing home-type settings.

7.0 Our Recommendations

- To QMH /St George's University Hospital Foundation Trust as service provider

1.To provide an information leaflet for patients and their families before or on admission to the In-Patient Elderly Rehabilitation Service on Mary Seacole Ward explaining what to expect from their stay, including:

- general information on personalised, goal-oriented and multidisciplinary rehabilitation therapy;
- the range of different staff likely to be encountered and their uniforms;
- who to approach if patients or their families have any concerns likely to be outside the responsibility of the nurse on duty in the bay; and
- the discharge planning process.

2. To review arrangements for rehabilitation goal-setting, progress monitoring and involvement of patients and their families so as to ensure that the following standards are applied as the norm:

- individual patients are involved in setting clear and realistic overall goals designed to maximise their independence in line with their individual circumstances and wishes;
- specific rehabilitation therapy "stepping stones" towards those goals are set, meeting the SMART criteria, and kept under review;
- the goals, "stepping stones" and patients' progress towards them are recorded and accessible to the whole multi-disciplinary team in clear language;
- a copy of the goals and "stepping stones" and of any subsequent changes to them is given to the patient and/or their family;
- patients are kept informed about their progress in rehabilitation therapy.

Where in the patient's interest it is not considered appropriate for one or more of these standards to be applied, e.g. for reasons of mental incapacity, this should be clearly recorded in the patient's records. These arrangements should be subject to regular management audit until they have become securely embedded.

3. To explore ways of improving arrangements for informing and updating patients and their families on the discharge timetable, e.g. by displaying the Provisional Date of Discharge (PDD) on the whiteboards above patients' beds or writing it in to their copy of their therapy goals and "stepping stones".

4. To review staffing levels for the nursing team on Mary Seacole Ward in view of the pressure which they currently seem to be under.

5. To consider the case for an increase in rehabilitation therapy staff resources available to Mary Seacole ward to increase the intensity and/or quality of rehabilitation therapy for those patients who might benefit, including the possibility of extending therapy cover to weekends.

6.To seek means of providing individual access to radio channels, TV and the internet for patients on Mary Seacole Ward, ideally without a fee.

7. To explore other possibilities for increasing levels of both activity and autonomy for patients on Mary Seacole Ward and enriching their experience during their stay.

8. To ensure that a laundry service is made available for patients' own clothing on Mary Seacole Ward.

- To Wandsworth CCG as commissioner for intermediate care

9. To support QMH to the extent possible in carrying out the above recommendations.

10. To take note of our view, following our visits to Ronald Gibson House and Mary Seacole Ward, that the right provision for intermediate care in Wandsworth would continue to comprise elements of bed-based care in both hospital-type and nursing home-type settings.

Revised 6 January 2019

Disclaimer

Please note that our findings in this report relate to observations and interviews on particular days. It should not be taken as a representative portrayal of the experiences of all service users and staff associated with the In-Patient Elderly Rehabilitation Service over time.