Intermediate Care at Home

Wandsworth Maximising Independence Team

Central London Community Healthcare (CLCH) NHS Trust

October - December 2019

Acknowledgement

Healthwatch Wandsworth would like to thank the management, staff, patients and relatives who assisted us with carrying out this project.

The Project Team

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Intermediate Care at Home

Executive Summary

Section 1. Introduction

Healthwatch Wandsworth (HWW) is the patient and public champion for the community in the areas of health and social care. Healthwatch Wandsworth has been looking at different services that provide Intermediate Care (IC) in Wandsworth. Intermediate Care can be provided in hospitals, care homes, day centres or a person's own home. Previous HWW reports have looked at bed based IC and day centre IC. This report looks at IC in the home setting, specifically the Maximising Independence Team. The project explored the views of people using the service to understand their experiences.

Section 2. Background information

Intermediate Care was developed in the late 1990s and defined in the 2001 National Service Framework for Older People (NSF-OP) with the aim of:

"Providing integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living".

In Wandsworth bed-based Intermediate care is available at Ronald Gibson House and at Queen Mary's Hospital Mary Seacole Ward. Intermediate care in a day centre setting is available at St John's Hill and Brysson White centres. Home based Intermediate Care in Wandsworth is provided by Central London Community Healthcare Trust (CLCH) Maximising Independence Team and it is this service that is the subject of this report.

The Maximsing Independence Team is a multi-disciplinary service made up of physiotherapists, occupational therapists, speech and language therapists, rehabilitation assistants and support workers and an operational manager.

Section 3. Methodology

To explore patients experiences of using the service we devised a survey that was delivered to patients via their therapist along with a pre-paid envelope so that patients could return the survey back to us. We also accompanied members of the team on their visits to patients to gain a better understanding of how the service operates and meets needs of patients. In total we saw 14 patients on the visits and we had 12 responses to our paper survey.

Section 4. Findings from observations and surveys

Patients were highly complementary about the service. They all wanted to receive care at home, they felt the therapists were kind and were grateful for the support.

- On the most part they felt they were progressing and getting better.
- Some patients reported long waiting times and this was the most significant negative theme that arose.
- More patients reported not having had a discussion about what happens when they are no longer accessing the service than patients who did have this discussion. Only one of these, though, reported this as a problem.
- A third of patients didn't know who they would contact if they had a similar problem in the future.
- All patients understood their goals and most were involved in goal setting. Some patients reported that there was a lack of communication amongst the different services involved in their care.

Section 5. Our Conclusions and Recommendations

Overall the Maximising Independence service appears to be highly regarded by patients. Therapists were observed to have a good rapport with their patients and took the patients' holistic needs into account. Patients tended to feel that they were progressing and were mostly confident that they were getting better and more independent. Where they felt they were not progressing this appeared to be to do with patient's perceptions of their own ability and confidence.

The main concerns amongst patients related to long waiting times to be seen by the service and not being seen as often as they would like. Patients also reported some issues around poor communication between services. Although on observation visits good communication between services was witnessed. This would seem a well-regarded service. However, it could potentially benefit from a review of staffing levels and this might help address the recommendations that follow for consideration:

- To ensure patients know what to expect from the service beforehand.
- To have a clear named key person for patients to contact.
- To continue to work on increasing patients' confidence in their own ability.
- To ensure a discussion is held with patient/family members/carers on what happens once they are discharged from the service including how to keep well and who to go to help should they need help for a similar problem.
- To improve communications and co-ordination with and between other agencies involved in a patient's care.
- To ensure that all patients/family members/carers are involved in setting their own goals and that this is regularly reviewed.
- To refer patients to a signposting service like social prescribing and mental wellbeing support.

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 a 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 Purpose of Visit

Healthwatch Wandsworth has been looking at the different services that provide Intermediate Care (IC) in Wandsworth. Intermediate Care services can be provided in different settings including hospitals, care homes, or at a person's home, and may involve co-ordinated support from doctors, physiotherapists, occupational therapists and others.

Healthwatch Wandsworth have written reports on the following Intermediate Care services in Wandsworth:

- Ronald Gibson House – Bed based intermediate care (Report based on an Enter and View visit on 21st May 2018)
- Mary Seacole Ward at Queen Mary's Hospital, Roehampton – Bed based intermediate care (Report based on an Enter and View visit 13th November 2018)
- St John's Hill and Brysson Whyte centres – Intermediate care in a day centre setting (Report based on three outreach visits between December 2018 and January 2019).

At the request of Wandsworth and Merton Clinical Commissioning Group (CCG) we agreed to look into home based Intermediate Care services in Wandsworth in order to provide a fuller picture of all IC services in the borough and to provide comparisons with bed based and day centre based services. The CCG provided additional funding resources to ensure that we could undertake this visit in addition to the other priority work we had planned for the year.

1.3 Project objectives

This project sought to explore the views of service users/patients to understand their experiences of the Maximising Independence service and specifically:

- How far it helps meet the needs of service users and carers in terms of rehabilitation and increasing independence after being unwell.
- How far it helps people keep well so that the problem doesn't get worse.
- How well the service works with other services.
- How well patients understand their needs and help set goals so they can achieve what they want to achieve.
- Explore the experiences of receiving care in the home environment.

2.0 Background

2.1 Intermediate Care: National guidance

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:

- 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 multidisciplinary rehabilitation services, free at the point of delivery remain. The National Institute for Health and Care Excellence (NICE) recently published guidance and information which defines intermediate care as a range of integrated services that: 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, homebased intermediate care, and reablement.

2.2 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.

2.2.1 Home based intermediate care in Wandsworth

The Maximising Independence Team, which is the focus of this report, is a multi-disciplinary service to reduce readmission into hospital and to increase a patient’s quality of life. The team is made up of physiotherapists, occupational therapists, speech and language therapists, rehabilitation assistants and support workers and an operational manager. Before our visits we were told that the service is goal focused rehabilitation service for:

Adults (over 16) registered with a Wandsworth GP:

- Who are house bound or require rehabilitation within the community setting
- Who have rehabilitation goals to improve their independence/function with daily activities following illness, injury or change in long term condition.

There are two pathways for patients to access the service: an urgent pathway (which should take 72 hours) and routine pathway (which should take 3 weeks). Referrals for patients to the service are all sent to a Single Point of Access (SPA) and can be from various sources such as GPs, acute hospitals or community nurses. Patients can also self-refer.

The patient receives an initial assessment and from that referrals can be made to other members of the team or to other services. They will then create goals for rehabilitation or supply of equipment. The therapist and patients work together to achieve this goal. Therapy programs are given to patients to practice.

The length of stay with the service will vary depending on the patient's needs and time it takes to achieve their goal. The patient's goals are reviewed to ensure the goal remains appropriate throughout the intervention. If these need to be changed or discharge needs to happen these discussions are discussed with patients.

The service has links with various other services including both primary and more specialist secondary care, mental and physical health services as well as voluntary sector services and social care. If the patient has a formal package of care then they will liaise with the carers to inform them of interventions or recommendations. The service also works closely with Quickstart who provide short term bridging packages of care.

The main office for the Maximising Independence Team is Battersea studios, but all patients are seen in their home. The service covers a large area so the team are split into localities; north, west, south, and east Wandsworth. The team travel around by various modes, driving, cycling or public transport.

Patient feedback

The service collect feedback using the Friends and Family Test. Feedback about the service using the Friends and Family Test was shared with us. We looked at the responses relating to patient feedback gathered in May 2019 (15 responses), August 2019 (11 responses) and September 2019 (10 responses). The feedback was very positive. Out of 36 responses, 26 (72%) answered Extremely Likely to the question "How likely are you to recommend our services to friends and family if they needed similar care or treatment?" and a further 9 (25%) answered Likely with 1 (3%) Don't Know.

2.3 Preparing for the project

2.3.1 Planning the project

Conversations between Healthwatch Wandsworth and Wandsworth CCG began in 2018. It was decided that the methodology for the project would be that Healthwatch Wandsworth would:

- Write and create an online and paper survey, aiming for 50 responses.
- Attend a staff briefing session with the Maximising Independence team introducing ourselves, the project and asking for their assistance in circulating the survey.
- Visit 10 people alongside CLCH staff in patients homes over 2 days (based on assumption of 5 patients a day) to observe the service, explain our work and ask if they want to take part in the telephone surveys. This required a CLCH staff member for any care or assistance the patient might need during the visit.
- Complete the survey with 30 respondents over the phone.

2.3.2 Known limitations of the project and how delivery differed from the planning

Before we began the project, there were conversations with the CCG and CLCH about the practicalities of undertaking the work given the high level of needs of the patients. Healthwatch Wandsworth stipulated that therapy or other appropriate staff would need to be present when interviewing patients in their own homes due to the level of needs and risks associated with patients who may request assistance. This then limited the time we had available to speak to patients as staff would be busy providing care to the patients. We had planned to try and visit five patients in a day but in practice it was usually three per day.

Limitations on the sharing of patient information restricted our options in contacting patients. We were not able to access patient addresses or phone numbers directly so we relied on staff handing out information and patients contacting us if they were interested to take part. The service paused its usual processes of calling patients for feedback to avoid duplication but we were not able to find a way of using this process to gain more responses. Access to data and contacting patients is something that we and the CCG may need to consider more carefully when designing our work in future to find opportunities to reach more people. Moreover, we wonder if the fact that we were attempting to gain feedback from current clients may have affected participation and, if they were less well at this point in their care, they were less inclined to take part. Perhaps it would have been better to target patients after discharge.

Healthwatch Sutton has done a piece of work on a similar topic, whereby letters and surveys are circulated by staff and a small number of telephone interviews had been possible. The work appeared to need continue support from service managers and staff to ensure participants are recruited. Therefore, we decided to make sure that we had a blended approach to try and complete surveys either by circulating paper copies, by inviting patients to telephone interviews and completing some observations and gaining some feedback during face to face visits. We presented at a staff meeting and worked closely with the service manager to ensure information was circulated to as many patients as possible.

We initially intended to observe patients on two separate days alongside therapy staff and complete a number of surveys over the telephone. However, it became apparent early on that we would have difficulty recruiting people to take part in telephone interviews. Patients weren’t keen on speaking on the phone for a number of reasons including radiation fears from mobile phones, communication problems meaning the partners/spouses wanted to complete the survey in person with the patient, not liking talking on the phone. Therefore, we arranged to visit more patients to increase our observation and feedback data.

Many patients that are seen by the service receive care from a number of different agencies. Whilst we tried where possible to make it clear that we were referring to the Maximising Independence service, it is possible that when answering the survey patients may have been talking about another service.

3.0 Methodology

3.1 Our observation visits

The surveys were developed by HWW and shared with Wandsworth CCG. As well as the surveys other documents were created – a participant information leaflet explaining the project, a telephone consent form asking patients to consent to us contacting them by phone and providing us with a telephone number and a staff guidance sheet describing the project to the MI team. The Information Governance team at CLCH made comments and approved the participation information leaflet and telephone consent form.

HWW then attended a Maximising Independence team meeting at Battersea Studios on October 31st 2019 where we gave a presentation on the project, answered questions and gave staff members copies of all documents and pre-paid envelopes to hand out to their patients when they visited them over the coming weeks.

The manager of the Maximising Independence team arranged for 2 days of observation visits for HWW in the first week of November. As explained above it became apparent early on that we would have difficulty recruiting people to take part in telephone interviews. Therefore, we asked the manager of the team if we were able to do more visits than originally planned for, given the lack of take up of telephone interviews. The team were happy to assist with this. Five days of observation visits took place during November and early December.

HWW spent 5 days on observation visits with Maximising Independence staff seeing 14 patients over the 5 days. We accompanied a range of people from the team including 5 physiotherapists, a speech and language therapist and a senior rehabilitation assistant. The purpose of the visits were to observe the service, and to ask the patient to complete a survey – either on the phone or if they were not wanting to do this then to complete a paper version and post it back in a reply paid envelope. It was important that we didn’t impede the service being provided but where appropriate we gathered feedback from patients about the service they were receiving.

The patients seen on the observation visits ranged in age from mid 20s to mid 90s. It appeared that all but two were over 65. Nine were White British with the others Asian, African and Black Caribbean. Ten were female and four were male. Two spoke little English and had a family member interpreting. Eight lived with a spouse/partner who took on a carer role and provided much of the day to day care. Two of the single patients lived with grown up children although the children were often at work in the day. Three lived alone one was in a care home.

We completed two surveys with patients on the observation visits. These were the exception and it wasn’t planned to do due to time constraints and not wanting to impede the work of the therapists. But, in a couple of situations it was possible to do this. We left 10 surveys for patients to self-complete. Most of these did not want to have a telephone interview out of preference. Because of communication difficulties the spouses of two people said they would complete the survey with the patients. One person did not want to be left a survey to complete and in one case it was inappropriate to do so (the patient was in a care home and was confused and had communication difficulties).

Four of the visits we observed were initial assessments. This appeared to be a thorough process that firstly goes through medical background and then the second part is a physical assessment. Sometimes the second part is done on a different day if the first part has taken a long time or the patient is particularly tired.

3.2 Paper surveys

Surveys were delivered to patients by therapists in the team along with patient information and a return pre-paid envelope. 250 surveys were delivered. There were 12 responses to the survey in total – two completed in patients' home whilst on observation visits, one was a telephone interview, and nine were returned by post (four completed by patients themselves and five by family or carers).

Nine of the survey respondents were female. They ranged in age from 35 to 92 with all but two being late 70's and over. Seven of the 12 were White British; the remaining 5 reported a range of different ethnic origins.

4.0 Findings from observations and surveys

In this section the findings of both the observation visits and surveys will be presented in relation to the original project objectives which were:

- How far it helps meet the needs of service users and carers in terms of rehabilitation and increasing independence after being unwell.
- How far it helps people keep well so that the problem doesn't get worse.
- How well the service works with other services.
- How well patients understand their needs and help set goals so they can achieve what they want to achieve.
- Explore the experiences of receiving care in the home environment.

4.1 Meeting the needs of patients and carers

4.1.1 Where patients want to receive intermediate care

One of the objectives of this report was to see how far the service meets the needs of service users and carers. In terms of where patients wanted to receive rehabilitation, home was the preferred choice of all those answering the survey. This view was echoed by patients seen on the observation visits with nobody stating they wished to have care elsewhere. They liked being able to receive care in familiar surroundings, they reported the difficulties in accessing a day centre, and one patient we visited mentioned how much he missed his cat when on an in-patient ward. His cat provided him great comfort and was important to his emotional well-being. Two patients mentioned receiving care at Ronald Gibson House in the past and were both complimentary of the care they received there but at this time home was the place they wanted to receive care. The only divergence from this view came from a daughter of a lady receiving care who, whilst highly complementary of the service received, wondered if her mother would have progressed more quickly in an in-patient setting.

4.1.2 Patient’s needs

All patients were overwhelmingly positive about the service. They commented on the care and kindness shown by the therapists and this was witnessed on the visits – the rapport between therapists and patients was apparent with therapists taking into account patients’ preferences and needs. For example, one patient who did not want to attend group physiotherapy classes, despite the therapist stating that this might have the dual goal of helping the patient with physical needs whilst also potentially helping this recently widowed person to feel less socially isolated. However, the patient was not keen and the therapist did not push this. Another example was a patient with very limited preferences in terms of food. The therapist accepted that as this patient was terminally ill and trying to persuade them to try other foods would have a detrimental effect on their emotional state whilst having limited benefit to their physical health.

Whilst most comments about the service were very positive there were a couple of negative comments, for which we can’t be certain are relating to the Maximising Independence team or other professionals who assist them from different organisations.

“Generally the care for my mum has been good but sometimes the arrival times have been an issue. 1 or 2 carers have been rude and had to be replaced”

“Office back room staff to not communicate important messages for the patient to the carers”

4.1.3 Referral process

Most patients answering the survey (10 out of 12) stated that there had been no difficulties in the referral or admission process. The two who said they had experienced difficulties both cited the long wait to be seen by the service. This frustration with waiting was also mentioned by two people on observation visits. In fact, this was the main complaint amongst patients who were quick to state how happy they were with the service but would have liked to have been seen sooner and more frequently.

Most people answering the survey (9 out of 12) said they were given enough information about what to expect from the service. The comments of those answering “No” are presented below.

“Doctor told me they would be referring and didn’t expect the wait.”

“Myself and my brother were not always kept informed of the help mum received and we had to contact various agencies in order to find out plus agencies didn’t seem to communicate between each other”

“What are the services available?”

4.1.4 Family members and carers

Most of the patients visited on home visits lived with partners/spouses or children who were all involved in the care of the patients. On the visits the therapists communicated with the carers as well as the patients involving them in the discussions about the care. Of those who answered the survey eight stated that family/carers were involved and supported to help provide care and rehabilitation. Of the four that responded "No" to this question it is not clear if they answered "No" because there was no one relevant around to help with the care.

"My wife is involved in discussions about my treatment."

"Family - children are involved in doing exercises at home."

"My husband helps me with exercises."

"Sons help with general day to day needs in between carer time hours"

"Sons don't live nearby."

4.1.5 Named key person

When asked if there was a named key person in the service that patients could talk to about their care seven responded "Yes", two "No" and three "Don't know".

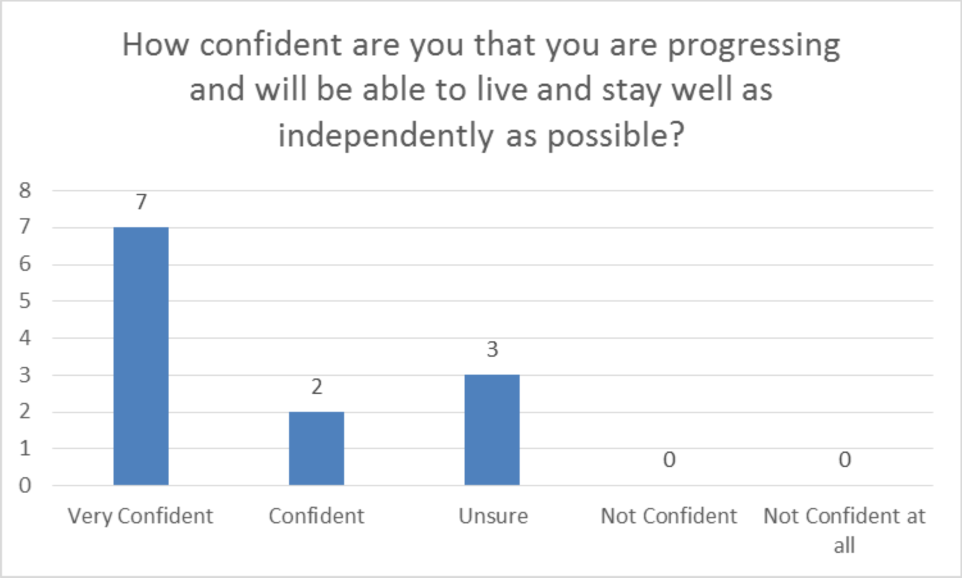
4.1.6 Recommendations - Meeting needs of patients

Based on the above we would recommend the following could be considered:

- To work toward lowering waiting times to be seen by the service.
- To ensure patients know what to expect from the service beforehand.
- To have a clear named key person for patients to contact.
- To improve communications and co-ordination with and between other agencies involved in patients care.

4.2 Keeping people well

Another objective was to explore how far the service kept people well, and increased their independence. Nine out of the twelve answering the survey reported they felt either very confident or confident that they were progressing and would be able to live and stay well. None reported not being confident with three saying they were unsure.



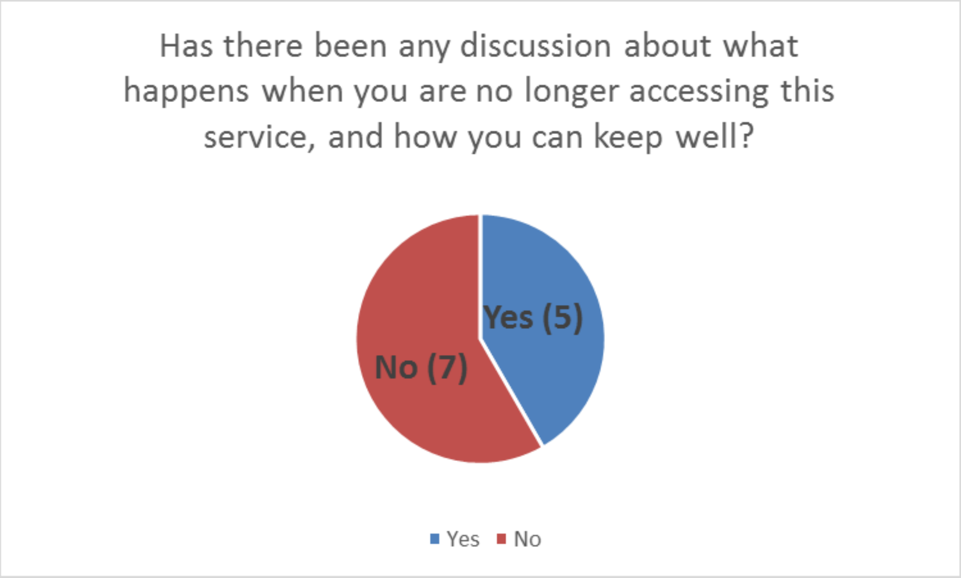
Patients who seemed to be unsure about this and those we visited who were hesitant about expressing confidence in their progress did not feel this was the fault of the service but either to do with their increasing age and frailty or their own ability to stick to the exercise.

"I am very confident about the first bit of question - that I am progressing but in terms of me living and staying well depends on me and how much I push myself. I need self-motivation which sometimes I have and sometimes I don't."

"Mum has now improved greatly but given her age and situation we cannot be confident that she will be independent much longer."

Lack of confidence was a big issue for many patients. On the visits it was common to hear patients express their fear of falling. A big part of the physiotherapists' role appeared to be in building confidence in the patient. They had confidence in the patients' ability to do many of the exercises, but the patients often worried about their own ability and were scared of falling.

One of the questions in the survey asked about whether there had been any discussion about what happens when they are no longer accessing the service. Most patients (7) stated they hadn't had this discussion but most of the comments suggested that this was because this was a way off for the patients. One patient stated they would like more information about this.



When asked in the survey what skills or information patients thought they might need to continue their rehabilitation at home four responded that they had all the information they needed, two didn't know, one stated information on simple cooking, one stated exercise sheets, one mentioned following the exercises given and another mentioned the skills of a carer were needed. A further comment was about concentration and wanting to improve.

A third of people responding to the survey didn't know where they would go for help instead of the hospital for a similar problem. Two reported going to the hospital.

Where do you think you would go for help with a similar problem instead of hospital?

GP	4
Hospital	2
Maximising Independence Team	1
Don't know	4
No response	1

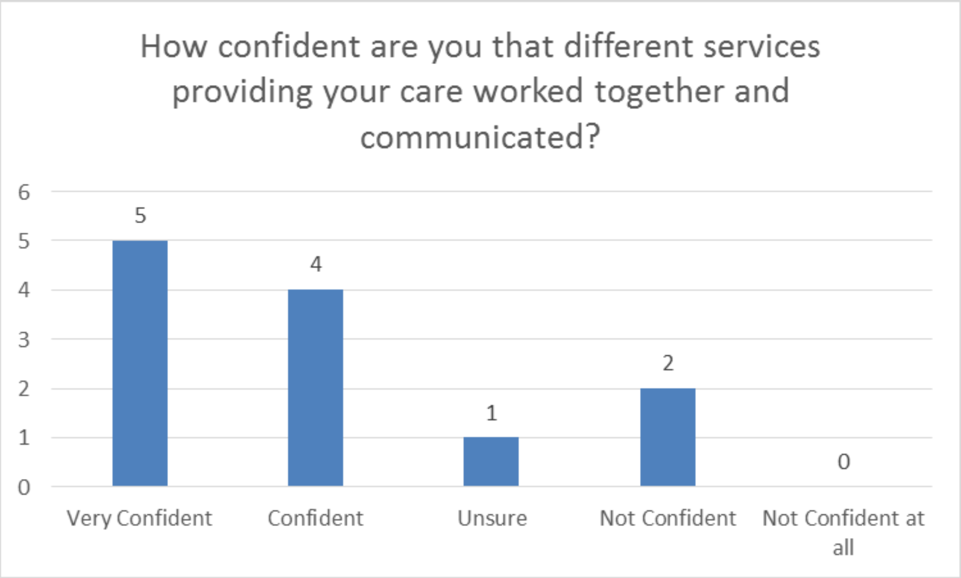
4.2.1 Recommendations – keeping people well

Based on the above we would recommend the following could be considered:

- To continue to work on increasing patients confidence in their own ability.
- To ensure a discussion is held with patient/family members/carers on what happens once they are discharged from the service including how to keep well and who to go to help should they need help for a similar problem.

4.3 Working with other services

Whilst most patients reported being happy that different services involved in their care worked together and communicated, there were some who did not feel this was the case.



Two patients answering the survey were not confident that this was working well.

“Have found that different care services have not always communicated information.”

“Certainly initially agencies involved did not seem to communicate.”

One patient on a visit mentioned the difficulty with living in a different borough to the service. This patient lived in Lambeth but was receiving care from this team because their GP was in Wandsworth. This caused problems in terms of being able to access equipment. They needed a bath lift but, as they didn’t live in Wandsworth, wasn’t eligible for funding for this so the patient bought one with birthday money from relatives.

One patient we visited was an elderly lady in a care home. There seemed to be an issue where the care home had not followed what had been on the patients discharge summary regarding her food and liquid needs. The speech and language therapist was unhappy about the organisation of the care for this patient as it appeared that no one understood the patients’ needs regarding her eating and drinking. The therapist made an effort to find someone in the home that could answer her concerns, but no one was able to help. She made a phone call to a care home staff member who was working at another site that day to arrange when she could come back and talk through the patient’s food and liquid needs.

On one visit we made with a physiotherapist to a patient’s home the care agency involved in caring for the patient turned up whilst we were there. The physiotherapist explained to the carer the exercises that the patient should be practising each day and explained that the patient was lacking in confidence to do the exercises alone. The carer was happy to help the patient do the exercises when she visited the patient. They also swapped telephone numbers. This is a good example of services collaborating to support a patient's needs.

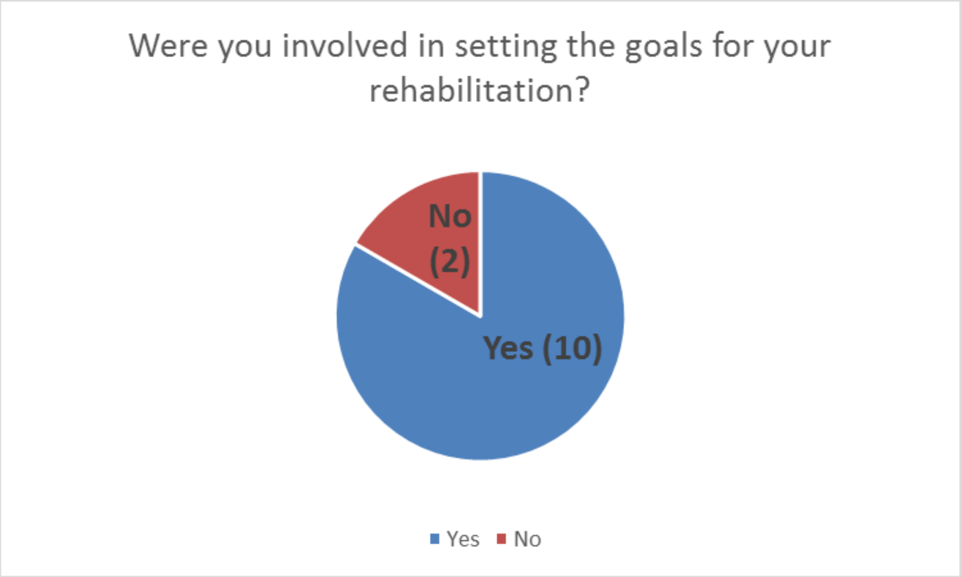
4.3.1 Recommendations – working with other services

Based on the above we would recommend the following could be considered:

- To improve communications and co-ordination with and between other agencies involved in patients care.

4.4 Understanding and involvement in goal setting

All twelve patients answering the survey understood their goals for rehabilitation and ten of them stated being involved in setting their goals. Two patients stated they weren't involved in goal setting.



"Mum was not initially involved but I did become more involved."

"Not really because now I am home I can see what more I need. I would really like a stairlift to have more access to the upper part of the house."

4.4.1 Recommendations - Understanding and involvement in goal setting

Based on the above we would recommend the following could be considered:

- To improve communications and co-ordination with and between other agencies involved in patients care.
- To ensure that all patients/family members/carers are involved in setting their own goals and that this is regularly reviewed.

4.5 Other findings - Emotional well-being

Four patients answering the survey reported that their physical health had had an impact on their mental health.

“I get fed up and down at times but not clinically depressed. I have things that help me like friends, my wife, church and family.”

“Low moods.”

“Get very annoyed with myself, not being able to do things. Worry a lot.”

"Frustration, anxiety, sadness”

The therapists took into account patient’s well-being in different ways from directly asking about their mental health in the assessment questionnaire to looking for solutions that might help enhance their well-being. As mentioned earlier one physiotherapist suggested a group exercise class for a patient as a way to help her mental well-being as well as her physical needs.

4.5.1 Recommendations – other findings

Based on the above we would recommend the following could be considered:

- To refer patients to a signposting service like social prescribing and mental wellbeing support.

4.6 Further comments about the service

“I have found the care very helpful and would not have managed in the early stages without it.”

“I am generally happy. They let me progress at my own pace but push me when needed.”

“It is a good service. They are very helpful”

“It's so pleasant meeting all the physiotherapists. They help an awful lot. Always so pleasant.”

"They put me in a rehabilitation home for 2-3 weeks then home. Much better at home.”

“Mum was very grateful for the help she received and we did find it useful.”

"The rehabilitation and care at home service have been amazing and really kind with my mum. They have encouraged my mum to keep up with her exercises. Although I feel a rehabilitation inpatient centre would help my mother more as she has been unable to walk for more than a year now."

5.0 Our Conclusions and Recommendations

Overall the Maximising Independence service is highly regarded by patients. We observed therapists having a good rapport with their patients and taking the patients' holistic needs into account. Patients tended to feel that they were progressing and were mostly confident that they were getting better and more independent. Where they felt they were not progressing, this appeared to be to do with the patient's perceptions of their own ability and confidence.

The main concerns amongst patients were to do with long waiting times to be seen by the service and not being seen as often as they would like. Patients also reported some issues around poor communication between services. Although on observation visits good communication between services was witnessed.

Whilst most people felt they did know what to expect from the service beforehand, a few did not. Furthermore only 7 of the 12 said there was a named key person to talk about their care.

A number of patients reported they hadn't had a discussion about what happens when they are not accessing the service and a few were unsure of where to go should a similar problem arise.

On the whole this appears to be a well-regarded service with therapists that are kind, compassionate and encouraging of their patients and patients report being happy with the service. However, the service could potentially benefit from a review of staffing levels and this might help address the recommendations that follow for consideration:

- To ensure patients know what to expect from the service beforehand.
- To have a clear named key person for patients to contact.
- To continue to work on increasing patients' confidence in their own ability.
- To ensure a discussion is held with patient/family members/carers on what happens once they are discharged from the service including how to keep well and who to go to help should they need help for a similar problem.
- To improve communications and co-ordination with and between other agencies involved in the patient's care.
- To ensure that all patients/family members/carers are involved in setting their own goals and that this is regularly reviewed.
- To refer patients to a signposting service like social prescribing and mental wellbeing support.

Revised 31.01.2019

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, carers and staff associated

6.0 Appendix

6.1 Appendix 1 - Intermediate Care Survey

Intermediate Care at Home Survey

Healthwatch Wandsworth (HWW) is the patient and public champion for people in Wandsworth who use local health and social care services. We listen to patients, their relatives or carers, and senior staff responsible for managing health and social care services, who tell us what areas of these services are working well, and what could be made better.

Intermediate care services are currently provided in different settings including hospitals, care homes, or at a person's home, and may involve co-ordinated support from doctors, physiotherapists, occupational therapists and more. Intermediate care services;

- Help people **rehabilitate** to recover and **increase independence** as far as possible after being unwell, or
- Help people keep well so that a problem doesn't get worse and lead to the need for more serious help and care.

We are interested in finding out about the **care you have received at home**.

Your responses to this survey will be anonymised and written up into a report that will be available on our website.

1. Are you currently receiving **short-term rehabilitation care and support at home?**

   ☐ Yes ☐ No

   If you are completing this on behalf of a patient please tell us who you are

   ☐ A carer
   ☐ A family member or friend
   ☐ Other, please state
   ____

2. Why are you receiving **this type of rehabilitation?**

   ____

3. Was receiving this type of rehabilitation at **home** your preferred choice of **where** to receive this care?

☐ Yes ☐ No ☐ Not sure

Please comment further

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4. Were there any **difficulties in getting this type of rehabilitation** (the referral or admission process)?

   ☐ Yes ☐ No If yes, please comment?

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5. Were you given **enough information about what to expect** from the service?

   ☐ Yes ☐ No If no, please tell us more about what you would have liked to received?

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6. Were you **involved in setting the goals** for your rehabilitation?

   ☐ Yes ☐ No If no, please comment

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7. Did you **understand your goals** for rehabilitation?

   ☐ Yes ☐ No If no, please comment

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8. Is there a **named key person** in the service you can talk to about your care?

   ☐ Yes ☐ No ☐ Don't know

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9. Are your **family/carers involved and supported** to help provide your care and rehabilitation?

   ☐ Yes ☐ No If yes, how are they involved?

---

10. How confident are you that different services providing your care **worked together and communicated?**

☐ Very Confident
☐ Confident
☐ Unsure
☐ Not confident
☐ Not confident at all

Please comment further

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11. How **confident are you** that you are progressing and will be able to **live and stay well as independently as possible?**

☐ Very Confident
☐ Confident
☐ Unsure
☐ Not confident
☐ Not confident at all

Please comment further

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12. Has there been any discussion about **what happens when you are no longer accessing this service**, and how you can keep well?

☐ Yes ☐ No Please comment

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13. **What skills or information do you think you will need** to continue your rehabilitation at home?

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14. Where do you think you would you go for **help with a similar problem instead of** hospital?

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15. Has your physical health had an impact on your **mental health**?

☐ Yes ☐ No If yes, please say how?

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16. Is there **anything else** you would like to tell us about receiving this type of **care at home?**

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17. If you are a **carer or family member** filling this in on behalf of a patient do you have any comments from **your perspective** about the rehabilitation and care at home service?