Healthwatch Southwark

Enhanced Rapid Response (ERR), Supported Discharge and Reablement Services - what are people's experiences of these services?

March 2018

Public version of the report without individuals' stories

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Introduction

What is Healthwatch?

Healthwatch is an independent organisation positioned in every local authority area across England and supported by Healthwatch England. Healthwatch Southwark (HWS) exists to ensure local people have a voice when it comes to shaping health and social care services. Our role is to:

- ✓ Gather the views of local people about access to and the use of health and social care services.
- ✓ Share what we hear with the people who design, fund, provide and monitor services.
- ✓ Act on concerns when things go wrong.
- ✓ Provide information and signposting on local health and care services.

Find out more by visiting our website.

Purpose of this project

In August 2017, we were approached by Southwark Adult Social Care (ASC) and Guy's and St Thomas' NHS Foundation Trust (GSTT) to gain feedback from people with lived experience of Enhanced Rapid Response (ERR), Supported Discharge and Reablement services.

These services are for people who need urgent and short-term support to recover from illness, injury or crisis at home and support them to remain independent, safe and well in their community i.e. preventing them from going into hospital, or preventing them from being readmitted into hospital, or enabling them to leave hospital earlier.

The services support the following people:

- Predominantly older adults with a physical disability / frailty.
- Those recovering from a short-term illness or impairment or crisis.
- Those that are housebound.
- High level of dependency / complex needs.
- Needing intensive (once a day or more) interventions to improve functional independence, and
- Health and/or social care professional skills required.

From April 2018, these services will be redesigned so that they are more integrated - this will mean that they will work together as one service to:

- Reduce any duplication or fragmentation.
- Ensure that the system is using resources in the best way.
- Reduce or contain spend on A&E admissions, hospital beds and longer-term care, and
- Provide more holistic care for Southwark residents.

HWS were asked to meet with people who have experience of being supported by the services as they are now, to inform the new integrated service.

What happens when a referral is made?

Enhanced Rapid Response (ERR)

A person may be referred to the **Enhanced Rapid Response (ERR) team** if a health or care professional has identified that they may need extra support to prevent an admission into hospital, or to help settle in when returning home from hospital after e.g. a fall or short-term illness.

The team quickly arrange for a senior practitioner to visit the person, so they identify what sort of help is needed, and together with the person, develop a plan of care.

The time a person will receive support from the ERR team will vary - this support could last a few days or for a few weeks.

Supported Discharge

A person may be referred to the **Supported Discharge team** if a health or care professional has identified that they may need support on their return home from hospital.

The service will enable the person to leave hospital as early as possible and provide them with rehabilitation at home. This could involve getting in/out of bed, washing, dressing, or managing medications. A social worker will visit the person in hospital to identify what they need support with and together develop a plan of care.

The time a person will receive support from the supported discharge team will vary, although it is designed to provide short-term care, i.e. a maximum of six weeks.

Reablement

A person may be referred to the **Reablement service** if a health or care professional has identified that they may need support, following a period of poor health or after a stay in hospital.

During a period of Reablement a person will receive one or more temporary services that help to prevent a person’s situation from getting worse and enable them to cope better with everyday tasks, such as getting dressed, washing, preparing food, walking and mobility.

Reablement services typically last for up to six weeks, but this will vary depending on the support a person needs.

Methodology

Who did we speak to?

We decided to interview five people, capturing experiences of each of the different referral routes:

1. Referred to the ERR service by a hospital's emergency department.
2. Referred to the Reablement service by social care.
3. Referred to the ERR service by a GP.
4. Referred to the Supported Discharge team by hospital.
5. Referred to the Reablement service by hospital.

How were these people identified?

The staff teams responsible for ERR, Supported Discharge and Reablement approached people who were able to take part in this project i.e. who were from one of the referral routes above, and who have the capacity to consent to the project, recall the care they receive, and feedback to HWS.

We provided frontline professionals with:

- **An information sheet for staff.** This gave details about the project, including - what it would involve, who would be eligible to take part, and what information they needed to gather.
- **An information sheet and *'I'm interested!'* form.** This was for staff to give to people they approached about the project. It explained what the project would involve. If they were interested, the staff teams would support the person to fill in their contact details.

Once this form was completed, the staff would phone the HWS team to pass on the person's contact details. We then phoned the person, or their carer, to tell them more about the project and to arrange the first interview.

What did taking part involve?

As these services are intended to provide short-term care, we adopted the 'Going Home' methodology (developed jointly by Healthwatch Southwark and Healthwatch Lambeth), which involves building a picture of people's experiences of health and social care services by meeting them regularly over a certain period of time. For this project, we chose to meet people four times over a six-week period. This would allow us to capture the full journey of the patients. There would also be a follow-up call after discharge from the service, after the Christmas break.

Methodology

The interview guides were developed by HWS, with input from ASC and GSTT colleagues. Each interview was guided by the topic guide and by the topics important to the person.

All interviews except the last phonecall were conducted in people's homes by two DBS-checked staff members. We encouraged carers or family members to participate. Interviews lasted one to two hours each time we visited.

On the last visit, we asked if we could take some photos in people's homes, to help those reading this report to get a broader picture of the people we spoke to. These images were directed by the person and give a flavour of the home environment.

What we discussed at each interview

Interview 1:

- Getting to know the person - their background, home life, what they enjoy doing, who is important to them, their living situation, their health and wellbeing, whether they receive any help with day-to-day living (e.g. paid carers).
- How they ended up being referred to the service - what happened, whether they felt this was coordinated, what they have been told about the service (e.g. what should be happening and when)
- Their experience so far - if it has been explained clearly, if they have had the opportunity to ask questions, if they feel they have been listened to.
- For how long they expect to receive help from this service.
- Whether someone has spoken to them about 'goal-setting', what they want to achieve and by when, whether they have a written record of what has been discussed and agreed (e.g. a care plan).
- Whether they know who to contact if they want to ask questions/if there is a problem.

Interview 2 and 3 (we ask the same questions at both these interviews as they may still be receiving care from the services):

- Recap of what has happened since the last interview.
- Their experience so far and their progress.
- Whether it is helping them to reach their goals.
- Whether they know what the next steps should be.

Interview 4:

- Recap of what has happened since the last interview.
- Their experience so far and their progress.
- Whether their progress has been reviewed and whether this is an accurate reflection of how they feel.

Methodology

- How they feel about leaving the service - if they feel safe, ready.
- Overall, their experience of the service - anything good or anything they feel needs to be improved.
- If they feel the service has/will help them to get/stay fit and healthy.
- If they feel the service has/will help them to increase their independence.

Interview 5 (a more informal phone call after Christmas):

- Catch up on their progress
- How they are feeling now that the above services have stopped supporting them
- What they feel has worked particularly well
- What they feel could have been improved.

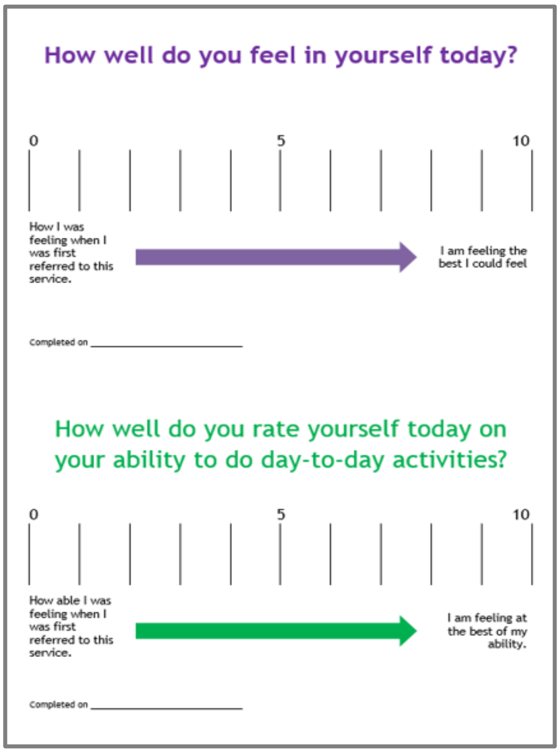
ERR, Supported Discharge and Reablement are short-term services, designed to last for up to six weeks. However, the services are flexible and tailored to a person's needs so this may vary. People may also move from one service to another. We monitored this as we carried out interviews.

At the end of each of each interview (apart from the follow-up call), we asked respondents to answer two questions put against a scale. This is so we could monitor whether they were starting to feel better and more independent as they received care from the services.

The first question: 'How well do you feel in yourself today?' was set against a scale where 0 represented how they were feeling when they were first referred to the service, and 10 represented the best they could feel.

The second question: 'How well do you rate yourself today on your ability to do-to-day activities' was set again a scale where 0 represented how able they were feeling when they were first referred to the service, and 10 represented being at the best of their ability.

The below image shows the scales used in the interviews. These were printed on A3 paper to help people to actively plot how they were feeling.



How well do you feel in yourself today?

Completed on ______________________

How well do you rate yourself today on your ability to do day-to-day activities?

Completed on ______________________

People that participated in the interviews

We were successful in hearing from people from each of the referral routes identified. In total, we received eight referrals. Three were fully completed (with four interviews in their homes and a phone call in the new year). One had all four interviews in their home, but we were not able to contact them for the follow up phone call. Two had one interview only (reasons described below). Two declined to participate when HWS contacted them to arrange the first interview.

The names of the people in this report have been changed to protect their anonymity.

Service (referring service)	Name	Interview 1	Interview 2	Interview 3	Interview 4	Interview 5
1. ERR (from A&E)	Beth *	2 Nov	-	-	-	-
2. Reablement (from social care)	Patricia	30 Oct	13 Nov	28 Nov	11 Dec	18 Jan
3. ERR (from GP)	Donna	9 Nov	21 Nov	1 Dec	12 Dec	18 Jan
4. Supported Discharge (from hospital)	Audrey **	30 Oct	-	-	-	-
	Sam ***	-	-	-	-	-
	Hannah	8 Nov	22 Nov	6 Dec	12 Dec	16 Jan
5. Reablement (from hospital)	Parminder ****	-	-	-	-	-
	Phil *****	2 Nov	13 Nov	30 Nov	15 Dec	-

Find below more information about why these referrals were not fully completed:

- ***Beth:** A person referred to ERR: After interview 1 Beth withdrew from the project due to ill health.
- ****Audrey:** A person referred to Supported Discharge from hospital – after we conducted one visit with supportive family members, Audrey withdrew from the project due to ill health.
- *****Sam:** A person referred to Supported Discharge from hospital – we phoned Sam on several occasions to explain the project, but she was not able to fully understand what would be involved - we decided that it was not appropriate to continue the project with Sam.

- ****Parminder:** A person referred to Reablement from hospital – we contacted Parminder to explain the project; he refused due to ill health.
- *****Phil:** A person that fully participated in the interviews apart from the final call.

We shared anonymised case studies in our report to the services. These have been removed from the public report.

We do not claim that this report fully represents the views and experiences of all people who use these services. However, through this work we have spent many hours with respondents and have heard their experiences in-depth and over a period of time while they are receiving support. This has allowed us to gather rich information at the point of delivery when issues are fresh in people's minds.

Every voice counts and even if only a small number of people (or a particular group of people) report a problem in the health and social care system, we believe this should be addressed wherever possible.

Joint workshop

A two-hour workshop was convened, with representatives from each of the referral pathways, together with senior managers from both GSTT, Southward Council Adult Social care and the HWS team. We discussed the draft recommendations that had been proposed by HWS following the conclusion of the interviews.

To ensure that feedback was as comprehensive and realistic as possible, participants were selected from a variety of front line roles and grades. On the day of the workshop, there was a higher than usual demand on staff due to unexpected weather conditions. Some of the ERR team invitees were unable to attend.

Attendees were given documents to review:

- Interviewees' stories (shorter poster versions were visible on the wall)
- A list of 'what worked well' and 'what could have been better' for each interviewee

The themes for group discussion (issues emerging from engagement) were:

- **Communication**
- **Goal Setting & Care**
- **Leaving the Service**

Under each of these themes, attendees were asked to consider solutions at three levels:

- **Service-specific**
- **Health and social care system**
- **Wider system change**

Each group included a range of staff, such as physiotherapists, RSW staff and service delivery managers. Each table was joined by a HWS representative to respond to any questions about the engagement work. This allowed us to reflect on the findings, share staff experiences and coproduce recommendations for the integrated services from 1st April 2018.

Reflections on methodology

Interviews

- Interviewing people as they are experiencing care gives us rich information about what it is like from a patient's perspective and helps people to recall recent experience. It also allows the interview team to build a relationship with the respondents so that they can talk more openly.
- Interviewing people at home allowed us to visit the person in a safe and familiar environment where they could talk openly about their experience and show us some of the challenges and adaptations they have had e.g. physiotherapy bands, commodes, Zimmer frames.
- Having two people present to ask questions and take notes worked well.
- The topic guide worked well to capture experiences, though more care could have been taken to reduce duplication of questions by us.
- A lot of the interview time was spent getting to know and understanding the person. This is not captured in this report but was essential in supporting the relationship between the HWS team and the respondent.
- We observed that the first interview was a useful testing time for participants to decide if they wanted to consent to future visits from the team.
- Being flexible with interview dates and times helped to capture full experiences - some interviews were conducted first thing in the morning and others took place in the late afternoon.
- There were two occasions where the person could not hear the doorbell, on another few occasions the person was unwell or had forgotten that HWS were due to visit. It worked well to phone the person well before the interview to remind them to expect us at a certain time.
- People were generally happy to share their stories with us, providing they were anonymised. People tended to be happy to allow us to take photos in their homes to give life to their anonymous story - our approach was to ask them what they wanted us to take photos of and allow them to delete the photos they were not happy with, so they had control of the images.
- At times carers and family members were present during the interviews. We observed

that some family members would seek to encourage the person to share their story and prompt issues they had overlooked. However, at times family members would talk over the person, undermining what the person was trying to express.

Rating scales

- It was helpful to have a visual tool to mark the end of the interview.
- Explaining the two questions to each person required a different approach each time, for example, reminding the person how they might have felt when they were first referred to the service, which could have been traumatic or hazy.
- The question about ability to do day to day activities was at times difficult for people to answer because thinking back to what they could do before being referred to the service was difficult.
- If this approach is used again, we suggest scales from 10, 'the best you could be feeling', to 0, 'the worst' as it was hard for people to remember who they felt when first referred to the service.

Joint workshop

- HWS asked Community Southwark to facilitate this session using findings from HWS's engagement. Having an external representative to lead discussion provided an element of overview and detachment.
- This is a new way for HWS to coproduce recommendations. We found the process useful and it was important to hear a staff perspective, discuss issues and create solutions together.
- It worked well for our partners to select the right attendees to take part in the session. This meant that we had a good mix of frontline staff and senior management, and thus varied perspectives in the discussions.
- Having a HWS representative on each discussion table worked well for the group to gain clarity on engagement.
- Table discussions could have been better supported with tools to guide the conversation around the main areas of concerns.
- For future sessions like this, we will share write ups of the stories in good time to allow workshop attendees ample time to read the stories.

Acknowledgements

We would like to thank the respondents that were willing to take part in the interviews along with their family members and carers. We would like to thank staff who referred potential respondents to us and who took part in the joint workshop to produce recommendations.

Common themes and recommendations

From the engagement we identified common themes that came up in the experience of patients and staff. Following the patient interviews and joint staff workshop, we have now coproduced a set of recommendations to support the success of the new integrated service.

Some of these can be addressed within the service, but at times they go beyond its realm of influence to that of other providers and the wider health and social care system. We decided to focus recommendations around 3 broad areas for improvement:

Communication **Goal Setting** **Leaving the service**

Recommendations for the new integrated service ('Intermediate Care')

Communication		
#	**Recommendation**	**Reason**
1	**Intermediate Care should revisit and review its name before it is launched in April 2018.** The service should be named using words patients are familiar with and understand. It should encapsulate the purpose of the service which is to 'reable' people.	HWS interviews: Not all patients were clear that they had been referred to a distinct team or what it was meant to do. It has been commented that the word 'enhanced' isn't clear, and 'rehabilitation' is associated with drug and alcohol services, but 'reablement', 'rapid' and 'response' are familiar to patients. One person suggested 'Rapid Reablement.' Workshop discussion: The name 'Intermediate Care' had already been chosen by the time of the workshop. However, some of the staff present were unconvinced that the name was appropriate.
2	**Improve understanding of Intermediate Care before referral into service.**	HWS interviews: Not all the people HWS interviewed remembered the conversations they had had in

	Ensure that the professional first explaining the service to the patient gives written information to support this conversation. Copies of this information should also be carried by frontline community staff (such as physiotherapists, occupational therapists and social workers) in case the patient has misplaced the leaflet. Family members and carers should also be given this information where more vulnerable patients are being referred in to the service, where appropriate. However, if the patient has capacity this should be *in addition to* information being provided to them.	hospital or had written information explaining the service to hand. In one case, the patient's family were given more information than they were, despite them having mental capacity. Workshop discussion: Service leaflets already exist and should be given out to patients.
3	**Improve information in the patient-facing leaflet** to include: • Who the service is for. • Who the care coordinator/key worker is, with their contact details on the front page e.g. have boxes for different professionals to tick and add contact details. • Diagram to show which professionals are a part of the service and how the service is structured. • Pictures of the kinds of support that will be offered. • How to give feedback on the service, including complaints policy. • How long to expect support to last, including indications/reassurance of what to expect after discharge from the service.	HWS interviews: Some patients were unclear about what to expect as part of the service and what would happen after it finished. Workshop discussion: Participants mentioned the need to emphasise with the hospital social workers that they should tell patients the service is available for *up to* six weeks (rather than six weeks).
4	**Improve information in the Care Plan folder** to include: • Be rebranded as 'My Care Plan'.	HWS interviews: Patients were not always aware of having a care plan and goals, and

	• Key contact details should remain on the cover page • The goals section (see below) should be included prominently. • Streamline to make it easy for the patient to refer to e.g. timetable of visits, medication information, summary for each visiting professional of what they are to help the person to achieve. • Elements of the document could be duplicated/detached for display in the person's home (e.g. tear-off appointment details to put on the fridge, physiotherapy exercise reminders). • Use simple, jargon-free language suitable even for those with limited English literacy or cognitive ability. • Use an appropriate font size for people with limited vision. • Make it visually engaging and attractive for patients to interact with and take ownership of (explore colour coding folders/sections - include a key if used). • It should be agreed with the patient on where to keep the folder, so they and frontline community staff can access it.	some did not read or use the information in the care planning folder at all. Workshop discussion: Several participants at the workshop were enthusiastic about ideas for making the care plan more accessible and interactive for the patient.
5	**Improve patient understanding of who to contact, when, and what to do when the service or person is not available.** A key working system is in place but needs to be made clearer to patients, family members and carers. Clear communication is needed from	HWS interviews: Some patients were clearer than others about who their key contact in the new service was. Some preferred to see their GP as their key contact. At times patients found it difficult to contact services, particularly the care service at the weekend. Patients

	frontline community staff around where to report any issues or get information about Intermediate Care. Patients should be told how often to expect contact from the key worker.	appreciate regular communication from the person who is coordinating their care and it is variable whether this happens. Workshop discussion: It is timely to discuss care provider issues as the new contract is currently being agreed. Patients should be provided with information on who to contact if they have been unable to get through. If they report not being able to get through to a professional, there should be a way for this to be escalated. A social worker might only visit at the start or end, unless there is a safeguarding concern or further assessment needed.
6	**Improve information and communication with patients about who is visiting them, to help with what, and when.** Patients should receive clear information and support to remember who will be visiting and when. This could be through a timetable in their care plan, updated as necessary. Patient-friendly language should be used, for example to explain unfamiliar terms such as 'occupational therapist'. Special consideration should be given to identification, particularly if the patient is vulnerable. If the patient finds it helpful, professionals should call shortly before they visit to remind	HWS interviews: Patients prefer to know who is visiting so they can prepare for the visit and conversation. Staff often visited patients soon after they were referred to the service, patients seemed surprised to see them - but grateful. Patients may be having visits from a wide range of professionals and find this overwhelming at times, with some people concerned about implications for safety. Workshop discussion: General discussion about issues patients find confusing.

	people and check access arrangements. Positive and consistent language needs to be used by staff, so the messaging is clear to patients, e.g. ‘we work as a team - you will see different members of staff in the time you are with Intermediate Care.’ Staff should not promise a visit/contact from another team unless certain. Providers should make patients aware of relevant policies, procedures and code of conduct for adoption by all staff, regardless of organisation - particularly around accessing a client’s property.	
7	**Maintain factors which enable rapid transfer of care/referral into the service, and rapid arrangement of equipment.**	HWS interviews: Several patients have been impressed with rapid transfer of care/referral including having people visit them as soon as they are discharged or on the day of referral. Arrangement of equipment also seems to have worked smoothly in several cases.

Goal setting		
#	**Recommendation**	**Reason**
1	**Demonstrate the goal setting process to be a joint conversation with the person and Intermediate Care from the outset.** Staff should consistently use person-centred, listening approaches to discuss goal-setting and care-planning, enabling patients to take joint ownership of a plan. (Some patients may benefit from physically writing in	HWS interviews: There seemed to be a mismatch of understanding between the patient and staff about goals, with the quality of the goal-setting conversation varying. Some patients did not have a sense of ownership of their goals and care plans. Workshop discussion:

	their own care plan or contributing in non-written ways, e.g. with pictures.) The service should ensure that all coordinating staff have had specific training in these skills. The service should also review workflow to ensure that sufficient time is allowed in early visits. The service user should be supported to check information in the care plan straight away, given the chance to ask questions and receive answers that satisfy them. Clients with capacity should be asked to sign to state that this has happened.	Current visit durations may not allow for enough staff time to sit, talk and listen as much as we would like. Discussion around goals at start will help to reinforce patient understanding for having support from Intermediate Care.
2	**Develop protocols for comprehensive goal setting and care planning.** The service should develop a thorough protocol for a goal-setting and care-planning conversation covering the wide range of topics which might impact on a person's reablement, including home safety, transport, social goals and (crucially) mental wellbeing as well as personal independence and physical rehabilitation. This should include both the condition which led to any recent episodes of acute care, and conditions which concern the person most.	HWS interviews: Some patients were supported well by the service to reach their goals but with others this was less comprehensive and purposeful with lack of clarity about actions and responsibilities. Workshop discussion: Parity of esteem for mental health should be an element of discussion when setting goals. 'Initial goals' are set by hospital/therapist - if it is decided reablement is not realistic at the start, the person is redirected straight to long term assessment.
3	**Create a goal-setting sheet to be included in the care plan patient folder, for staff to refer to at each patient visit.** The resulting care plan should make clear each goal, how far the patient can hope to improve during their time	HWS interviews: Not all patients had received enough information about how to reach their goals, e.g. using equipment. Workshop discussion:

<table>
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<td></td>
<td>with the service, what will be done to achieve it and by whom. This could include referrals outside the service, such as to the voluntary sector.

Where service users need to undertake activities (e.g. physiotherapy exercises) themselves or with the support of carers, they should be offered written/visual information on how best to do this and workers should ensure they and their carers feel confident.

Goals should be explicitly referred to during each visit to allow patients and staff to tick off, adapt or amend goals as they progress through the service.</td>
<td>An example of a possible template was discussed and is illustrated below.
<table>
<tr><th>Goal</th><th>Outcome</th></tr>
<tr><td>To be able to make my own meals within 6 weeks</td><td>I am now independent making meals, therefore do not need carers for this</td></tr>
<tr><td>To be able to walk to Sainsbury’s to do my shopping within 6 weeks</td><td>Not yet achieved, therefore referred to community physio</td></tr>
</table>
This could potentially include further detail, such as ‘Who is responsible for helping me meet this goal?’ and ‘What do I need to do myself to meet this goal?’
A CM2000 form [electronic home care monitoring] is already in use - the therapist writes a target (to include identifying any triggers), and worker has to fill in whether this has been achieved.
Ongoing goal review should also be happening, including a discharge review.</td>
</tr>
<tr>
<td>4</td>
<td>**Staff should undertake real-world activities with patients that demonstrate moving towards their goals.**

For example, a physiotherapist working with the person to identify going to the shops as a goal and walking to the shops together to assess ability, this</td>
<td>HWS interviews:
This was an area of good practice identified among some professionals and could be replicated.

Workshop discussion:
The person’s own goals may not be realistic; the “key worker” then</td>
</tr>
</table>

	would give a sense of purpose and build confidence.	needs to be able to manage those goals. Discussion around patients that might ‘go along with it’ or seek to please the staff supporting them as they want to receive help and as there might not be an alternative service for them at that time of need.

Leaving the service		
#	**Recommendation**	**Reason**
1	**Staff should discuss plans around leaving the service with the patient from the start, as part of the broader goal-setting process above.** As above, there is potential for further staff training in this area.	HWS interviews: Patients were mostly told they would receive support for six weeks rather than *up to* six weeks. Not all were clear/confident about what would happen after that. Workshop discussion: Discharge should already be discussed from the start. Deal with anxiety by better communication around what expectations should be. Staff should encourage person with motivational (even scripted) language: 'Well done, you're doing so well, you don't need us.' 'We are a team with you and your family.' ‘You are receiving this because we think/hope you won’t need all this after your service package has finished.’ Staff to take notice of higher levels of anxiety, including among family and carers.

2	**Ensure a standardised, thorough pre-discharge assessment process, and communicate this to patients.** The patient must be supported to prepare for this assessment (with the help of family members or carers where appropriate) to give their genuine views and express any concerns, perhaps including a formal scoring system. Enough time must be allowed to discuss progress towards goals and take into account mental wellbeing. Any goals which have not been met when leaving the service should be discussed and a plan developed for further support or onward referrals. This should be signed off by the patient and the service together and documented in the patient's care plan. Where assessment is made of people's physical capabilities they should be ask whether they feel their 'performance' on that day reflects their usual ability, and repeat assessments conducted if appropriate.	HWS interviews: Some respondents felt their discharge from the service was abrupt and did not feel ready. One felt the assessment did not reflect their usual abilities. Workshop discussion: Support might currently increase to 7 weeks with some patients, if assessment says that they are nearly ready to do without the care package. Service users should already be being assessed more than once to ensure that any improvements/abilities are consistent. Discussion around how much time is allocated to a pre-discharge assessment, physical and psychological assessment, planning and documentation, particularly if the patient has mental health difficulties, learning disabilities or is vulnerable. Learning could be had from Age UK Lewisham and Southwark's Safe and Independent Living Programme (SAIL) for discharge assessment - e.g. pendant alarms, safety.
3	**Develop a 'how to stay well' pack to leave with the patient.** Suggested information to include: • Patient's discharge summary letter. • How to stay well information, e.g. diet.	HWS interviews: Some patients felt anxious about their ability to cope without the service. The care plan might be taken away at the end of the service. Workshop discussion:

	- How to notice signs of common problems, e.g. chest infections, UTIs, mental health problems. - Onward signposting resources, such as Healthwatch Southwark, Community Southwark, Southwark Wellbeing Hub. - Key independent living resources, such as Age UK Lewisham and Southwark - Safe and Independent Living Programme (SAIL), Southwark Wellbeing and Support at Home (SWISH). - Crisis planning information – mental and physical.	It would be helpful to review where onward referrals currently go, including for example the breadth of voluntary organisations considered. It would be good to customise the pack depending on patient interests/need.
4	**Gather patient and staff feedback of Intermediate Care to monitor and evaluate patient experience, service delivery and effectiveness.** **Explore independent patient engagement in April 2019.**	HWS interviews: Several service users had a good relationship with their carers or physiotherapy staff; positive staff qualities have included taking initiative and listening well. Patients have told us they feel treated with dignity and respect. To ensure that this continues, all users should be enabled to give feedback about the service. Workshop discussion: A discussion around follow-up calls and how this might work within intermediate care, who would conduct these, record and manage the follow up.

Recommendations for other health and social care services

Communication		
#	**Recommendation**	**Reason**
1	**Intermediate Care should be communicated comprehensively to all potential referring professionals**	HWS interviews and workshop discussion:

	(e.g. hospital Occupational Therapists).	Some opportunities to refer patients at an earlier stage might have been missed. Discussion around promotion of Intermediate Care, ensuring staff are aware of the referral criteria and limitations of the service.
2	**Care agencies: Patients' preferences around their routine and care should be discussed and written into the care plan, and arrangements explained.** This should include the gender of carers that support patients with their personal care, patients' preferred timing for visits, and expected behaviours (both carer and patient). Patients should be asked their preference of contact method by all services, as mail or email are not appropriate for all. Along with other providers, care agencies should provide formal information about how carers will gain access to home (e.g. key safe policy and procedure). Carers should never be required to phone a client to ask for a key safe number. Health and social care services should review the ability of care provider firms to make carers available at appropriate times of day, to coincide with clients' daily routines (often, earlier morning starts, later evening appointments). This should also	HWS interviews: The timing of care visits is particularly important for a Reablement service, to ensure that people can get back to their routines. Other topics such as the gender of carers or how they will access the home can also be a concern. Workshop discussions: Patients are able to request a female carer, but this has always been a challenge. Care organisations should already have a policy about home access and key safes.

	include the ability to provide consistent carers for each patient.	
3	**Care agencies: Further attention should be given to timeliness of carers.** Care provider organisations should implement an effective system to monitor start and finish times of appointments (perhaps using GPS-enabled mobile phones). Travel time must be adequately allowed for and compensated.	HWS interviews: Carers being late was an issue for some of the patients and disrupted their routines. Workshop discussions: It is useful to ask what other services a patient is getting support from, to be aware from the start and know who to liaise with.
4	**Care agencies: Review policies/contractual agreements around care workers entering into private care provision arrangements with discharged patients (where the patient was previously supported via a service such as Intermediate Care).**	HWS interviews: Patient experience of a care worker offering to provide private care after the service ended. Workshop discussion: Concerning to hear this. Patient preference is important, and some patients do need ongoing care but it should be at the patient's initiative via established procedures.

Recommendations for the wider system

Communication		
#	**Recommendation**	**Reason**
1	**Build on good practice and continue to develop data sharing protocols, to allow information sharing across health and social care systems.** Services such as Intermediate Care benefit from being 'linked into' wider services and to receive updates from as many relevant services as possible around the patients that they are supporting.	HWS interviews: Reablement were made aware of some users' contact with other services (e.g. hospital visits and SELDOC/GP contacts), which patients found helpful. Workshop discussion: Aware that sharing patient information is challenging and bound by Information Governance (IG). However, services such as

	Develop straightforward systems for frontline community staff to access patient information in a timely manner.	Intermediate Care would benefit from getting an overview of the care patients receive in a wider context. The GP is a permanent link for the patient, would be good if they were part of the multi-disciplinary team.
2	**Develop robust links with Local Care Networks and GPs to allow Intermediate Care to access existing care plans (with patient consent if data sharing is a barrier) and seek out other appropriate referrals, including to the voluntary sector.** A copy of the care plan produced by Intermediate Care should also be provided to the patient's GP and other services supporting the patient.	HWS interviews: Respondents benefited from wider connections through faith groups, local charities and residents' groups. Some people might have found further connections in the community helpful, including before discharge from the service. Workshop discussion: Discussed the fact that care planning is happening in several pathways at the moment; staff need to know if the patient has already had a care planning conversation as part of Local Care Networks (LCN) work with their GP. Develop the mechanism to be able to signpost out to the voluntary and community sector. The Red Cross provides important follow-on services, but other referral routes should also be explored (e.g. by leveraging Southwark's social prescribing and community asset initiatives)
3	**Improve gaps in data systems and share information outside the Intermediate Care system after discharge.**	HWS interviews: Transition of information and plans to services receiving onward referrals was not always smooth.

Conclusion

All the stories we heard were different, and we did not aim to represent the experiences of everyone that is referred to these services. However, these stories did give us rich insight into the journeys and progress of the patients.

All the people we spoke to were happy to have been offered support from the ERR, Reablement or Supported Discharge services. There were several positive experiences - to give a few examples, the speed at which people received support or equipment, useful discussions about how to meet some goals, coordinators hearing about hospital admissions, proactive work by a physiotherapist, good relationships with some of the carers, and a positive onward referral to a class.

However, there were also inconsistencies, for example in communication and expectation-setting, goal-setting conversations and support to reach goals, and the way discharge was handled. There are also improvements that can be made in the use of care agencies.

Our workshop discussions were largely around how the new service can ensure that good practice happens in every case. This includes ensuring that all staff have the skills, time and guidance needed to focus the patient’s care around increasing their independence. We had some interesting discussions about ways to meet the broad, holistic needs of each patient, including their mental health and social needs. We also considered ways to engage and empower patients in goal setting and care planning.

With the help of frontline staff and managers we have coproduced recommendations.

We aimed to draw on our wider experience of engagement around health and social care locally. This is reflected in our inclusion of system-wide recommendations, which we feel will support the success of Intermediate Care. We particularly note that care planning and goal setting is a topical issue across health and social care, and we hope that the findings here can contribute to broader discussions.