Integrated Community Rehabilitation Service/Bridge 24: Independent evaluation report and recommendations

Contents

Contents .... **Error! Bookmark not defined.**

Introduction 3

About the ICRS/Bridge 24 3

The evaluation 4

Overall findings 4

Clients' experiences 6

Physical and mental health 7

Support planning 7

Activities 8

Clinical input 8

Support staff and managers 9

Physical environment 9

Move-on planning 9

Aftercare 10

Recommendations for Commissioners: 10

Recommendations for the SPA panel and ICRS clinical team: 11

Recommendations for the ICRS/Bridge 24 service: 11

Conclusion 14

Thank you! 14

1. Introduction

Healthwatch Kingston upon Thames (HWK) conducted an independent evaluation of the Integrated Community Rehabilitation Service (ICRS) between 15 November 2023 and 10 January 2024. The evaluation was commissioned by the South London Mental Health and Community Partnership (SLP), Complex Care Programme.

2. About the ICRS/Bridge 24

The ICRS/Bridge 24 is an innovative pilot providing nine month's intensive rehabilitation in the community for 12 people with complex mental health needs after they are discharged from hospital inpatient care.

The service is jointly delivered by South West London and St George's Mental Health NHS Trust (SWLStG) who provide clinical in-reach, and the voluntary sector organisation Bridge Support which provides the accommodation, support workers and managers.

The service aims to provide a 'bridge' back into the community from hospital for people with complex mental health needs. Bridge staff provide direct "enabling" support and key working to clients while the ICRS clinical team provides clinical support and advises on rehabilitation interventions.

The service aims to develop clients' independent living skills, self-esteem, and confidence so they cope better when they move back to the community. It aims to provide recovery and rehabilitation in the "least restrictive setting", while delivering efficiencies for both health and social care.

The service is provided in supported accommodation at two houses in Kingston. Each house accommodates up to clients. During our evaluation, the service had 10 male and two female clients. Clients have history of hospital admissions and are on a mental health rehabilitation pathway in Kingston, Merton, Richmond, Sutton, or Wandsworth.

3. The evaluation

The HWK evaluation assessed how the service was delivering against its key objectives six months after the service mobilised and focused on:

- Service quality and service user experiences and outcomes.
- Partnership working within the organisation and the SWLStG multidisciplinary team.
- Development within the service.

The HWK evaluation team interviewed eight clients, including one former client, 13 staff, including service managers, and clinicians providing clinical in-reach to clients. We interviewed service commissioners and other stakeholders and reviewed clients' support plans and other documentation. We used semi structured interviews to interview stakeholders, with one question framework for clients and another for commissioners and providers.

4. Overall findings

The ICRS/Bridge 24 provides a safe, homely, supportive, and well managed service for people with complex mental health needs. Most clients said their mental health had improved since being in the service and they felt safer and more independent in some areas of their lives.

Clients benefit from access to high quality clinical interventions and support with a consistent focus on developing their daily living skills, confidence, and self-esteem. The service helps clients to take greater responsibility for their physical health and how to manage their medication.

Bridge 24 managers have learned from incidents and made improvements to benefit clients' progress. Most clients used personal health budgets (PHBs) to engage in activities in their home boroughs.

Rehabilitation input for clients improved after the service employed a full-time occupational therapist (OT). The OT provided structured, tailored interventions. By the start of 2024, the service was once again without an occupational therapist. The service needs to focus on recruiting a full-time replacement.

Plans are underway to upskill support workers with additional training to engage and motivate clients who struggle to develop routines and progress towards their goals. Bridge 24 managers are hands on and "go the extra mile" to eliminate potential barriers to clients moving back into the community.

There is an excellent working relationship between the clinical team and the Bridge 24 managers. Support staff are committed to supporting clients to move towards greater independence.

Having clinicians on site ensures clients and staff have timely access to advice and clinical input if they experience a deterioration in their mental health. In three instances, input from the clinical in-reach team collaborating with Bridge staff ensured clients avoided readmission to inpatient care.

We found poor levels of engagement from some care coordinators during their client's stay, particularly among borough-based care coordinators. Care coordinators are responsible for working with services to develop care plans for people with severe mental illness and 'involve the person and work with services to address clients' social care, housing, and physical and mental health needs as well as their substance misuse. They provide any other support that may be needed, including coordinated, flexible individualised care.' (NICE guideline: Coexisting severe mental illness and substance misuse: community health and social care services.)

Earlier involvement of borough-based care coordinators and adult social care would be beneficial for preparing clients for their move back to the community including conducting Care Assessments at month seven of clients' stay.

Strengthening the involvement of care coordinators and adult social care is key to ensuring clients move seamlessly on to appropriate supported housing, social housing or back to their own accommodation in their home borough. Additionally, the evaluation team felt support plans could be improved to incorporate move-on planning, to reassure clients who are anxious about their next steps.

5. Clients' experiences

- Clients typically described the ICRS/ Bridge 24 as "safe" and "calm".
- Clients said support staff were "kind", "friendly", "supportive" and "trusted".
- Clients appreciated having regular access to the psychologist, psychiatrist, and occupational therapist.
- All valued the greater freedom and autonomy in the community setting compared with the restrictions on inpatient wards. "They've left me to do what I need to do. They don't push me and are respectful of me and my space."
- Some clients reported developing areas of their independent living skills during their stay. "It's helped me become more independent doing my washing and taking my own medication."
- Clients expressed anxiety about not knowing where they were moving to next, what support would be available and how they were going to cope.
- The service encourages clients to maintain links with friends and family.
- Some clients are very socially isolated with no family or friends. They need bespoke support and encouragement to engage socially.
- Clients mainly looked forward to moving into the service, but some struggled with the greater freedom. "It felt weird being in a new place. It took me a while to settle."
- Some clients are volunteering or doing work experience, but most felt this was not a priority for them.
- Clients receive a welcome brochure when they first move in and can spend one or more trial night at the service, depending on their needs and history.
- Most clients had only a hazy recollection of how long they had been in the service and few remembered details about moving in.
- One client did not know why they had been moved to the service: "I've been moved around a lot. I'm not sure of the reasons or received explanations for the moves."
- Clients valued support from the OT and the substance misuse worker.

6. Physical and mental health

- Most felt their mental and physical health had improved since being in the service.
- All clients were registered with a GP, either near the service or in their home borough.
- No client had seen a dentist since moving in. Three clients told us they had dental pain. One had lost a tooth. Two clients were on waiting lists to see a dentist. Their dental issues were not mentioned in their support plans.
- All clients are supported to self-administer their medication, some can take their medicine without supervision.
- Close and timely working between the clinical in-reach team and the Bridge staff has prevented three clients from being readmitted to inpatient care.
- Clients with a dual diagnosis of mental health needs and substance misuse have access to a specialist substance misuse worker.
- Clients felt confident talking to support staff and their psychologist and psychiatrist about their mental health. They felt "listened to".

7. Support planning

Support plans are co-produced with clients and are updated after regular keyworker sessions when clients use the Mental Health Recovery Star. The HWK evaluation team reviewed eight clients support plans and found:

- Support plans varied in quality, some were comprehensive, others lacked data on clients' achievements.
- All plans detailed clients' aspirations and activities.
- Most plans were not SMART (specific, measurable, achievable, relevant, and time-bound) enough and lacked plans for a clients' move-on.
- One plan was incomplete with only two out of eight activity areas filled out.
- Three plans lacked information on clients' achievements and progress.
- Feedback from formal clinical OT assessments was not integrated into the plans.

8. Activities

- Clients took part in a range of activities including walking, watching TV, board games and shopping.
- One client had engaged in swimming lessons, guitar classes and open mic sessions.
- Some clients had joined the gym using personal health budgets (PHBs). One had used their PHB to get cinema membership.
- Clients liked playing chess and board games with support staff.
- Some clients wanted more organised/group activities like visits to museums.
- Staff support clients to visit and take part in activities in their home boroughs where possible.
- Weekend staff shift patterns can inhibit the ability of support staff to accompany clients to activities in the home borough on Saturdays and Sundays.

9. Clinical input

- Clients benefit from regular clinical reviews with the in-reach clinical team via integrated working.
- The presence of an OT ensures clients can make progress with cooking, shopping, and engaging with others, however the service has struggled to retain a permanent OT due to recruitment challenges.
- Access to the substance misuse practitioner is valued by clients with substance misuse needs.
- The clinical team and Bridge Support managers work closely and effectively to support clients with their recovery.
- Some care-coordinators do not regularly attend their client's clinical reviews despite being able to attend remotely online.

10. Support staff and managers

- Bridge 24 managers help clients maintain links with their home boroughs.
- Managers have a "can do approach" and proactively work to address any barriers to clients having a smooth move-on back to their local area.
- Support staff struggle to motivate some clients who prefer to isolate and may need additional training to work with clients with specific mental health conditions.
- Clients liked and trusted Bridge 24 staff and felt confident raising issues and telling them if they felt their mental health was deteriorating.

11. Physical environment

- Both houses providing accommodation for clients were clean and homely.
- Idmiston Road lacks space for private practitioner-client consultations.

12. Move-on planning

- The service could keep clients better informed and reassured about their next steps.
- Support plans would benefit from detail and milestones for clients' support planning. This could be improved with earlier completion of Local Authority Care Assessments.
- Some clients are not always ready to move-on after their nine-month stay.
- Some care coordinators do not regularly attend clients' clinical reviews during their stay which can sometimes inhibit a clients' smooth move on from the service. "If the care coordinators aren't invested, you can't move things forward."
- Managers spend a lot of time chasing care coordinators to get arrangements in place for clients moving back to their own accommodation.

13. Aftercare

- Two clients moved on successfully during the evaluation period.
- Transitional support from Bridge 24 is offered to all clients for 4-6 six weeks after they move-on.
- 4-6 weeks' transitional substance misuse support is available for clients who have received substance misuse support during their time in the service.

14. Recommendations

Recommendations for Commissioners:

Recommendation 1. Review care coordination arrangements to address poor levels of engagement from some care coordinators (CCs) for ICRS/Bridge 24 clients, including attendance at clinical reviews. Options might include more robust monitoring of CC engagement during a client's stay or exploring the benefits and drawbacks of creating a single dedicated CC post to care coordinate clients while they are in the service.

Recommendation 2. Through ICRS/Bridge 24 contract monitoring and partnership working with local authority mental health and wellbeing leads, encourage earlier adult social care engagement during each client's stay at the ICRS/Bridge 24, in line with the service operational policy.

Recommendation 3. Include tracking of standardised clinical measures and assessments undertaken with clients at expected intervals in KPI reporting, including DIALOG and Model of Human Occupation Screening Tool (MOHOST)

Recommendation 4. Work with Bridge Support to identify practical ways to improve the communal and office space configuration at Idmiston Road to expand the communal space available to clients, improve client and staff safety and provide space for private conversations between practitioners and clients.

Recommendation 5. Commissioners and ICRS/Bridge 24 providers to consider ways to raise awareness of the service across the local NHS system including primary and urgent care and Place partnership boards/committees

Recommendations for the SPA panel and ICRS clinical team:

Recommendation 6. Ensure Bridge 24 managers receive all necessary client information, including risk profiles, prior to ICRS/Bridge 24 undertaking face-to-face joint assessments to determine their suitability for the service, in line with the existing referral process. Commissioners and the ICRS/Bridge 24 to agree a fast-track process providing the same level of information for clients who need to move more quickly, from acute hospitals, for example.

Recommendation 7. Ensure Bridge 24 managers receive invitations to all SPA panel meetings for clients being referred for assessment to the service.

Recommendations for the ICRS/Bridge 24 service:

Recommendation 8. Work with commissioners to put in place measures to ensure care coordinators fulfil their responsibilities for arranging clients' medication appointment ready for when they move into the ICRS/Bridge 24.

Recommendation 9. Recruit a 0.5 full time equivalent COMHAD (dual diagnosis substance misuse practitioner) in line with the original service specification to ensure all clients who need it get adequate support with substance use. The Bridge Support worker providing this service only has the capacity for 0.2 full time equivalent.

Recommendation 10. Explore creative ways to ensure Bridge support staff have adequate time to accompany clients to their home boroughs at weekends to help them initiate and engage in activities. This could be achieved by using bank staff or sourcing volunteer befrienders in local voluntary, community, and social enterprise organisations/groups, who can accompany clients until they feel confident to visit independently.

Recommendation 11. The ICRS/Bridge 24 to identify and proactively link isolated clients with community projects in their home boroughs, e.g. community cafes and befriending schemes, specifically designed to tackle social isolation. (HWK can provide the ST&R (support, time, and recovery) lead

with information on community projects in Kingston and connect them with Healthwatch signposting leads in the four other boroughs).

Recommendation 12. The ICRS/Bridge 24 to link clients who feel ready to start paid employment to Individual Placement Support in Community Mental Health Teams for help to find and stay in work.

Recommendation 13. Bridge 24 staff to work with care coordinators to ensure all clients are helped to register with an NHS dental service, including, where appropriate, registration with community dental services, for a check-up on arrival at the service, ideally in their home borough.

Recommendation 14. Service managers and OT to review clients' support plans to ensure they are complete, rehabilitation focussed and include SMART goals and clear actions and responsibilities for clients' move-on plans, including timelines. Ensure findings from clients' OT and psychology assessments are fed directly into support plans to help tailor rehabilitation goals and interventions based on clients' current progress.

Recommendation 15. Consider providing all clients with hard and electronic copies of their updated support plan after keyworker sessions to reinforce the idea of client's "owning" their support plan.

Recommendation 16. Ensure support plans capture clients' concerns about their medication side effects and detail support and actions to help them manage their daily activities around these side effects.

Recommendation 17. ICRS to review clinical model and clinical standardised tools used by the multi-disciplinary team including assessing the viability of the substance misuse/COMHAD working using the ASSIST-Lite tool to screen clients.

Recommendation 18. The ICRS clinical team to ensure all clients complete a DIALOG survey within six weeks of admission and thereafter at three, six and nine months, monitored via KPI reporting.

Recommendation 19. Ensure all clients to have MOHOST within six weeks of move in, and again upon discharge, monitored via Key Performance Indicator reporting.

Recommendation 20. Provide staff with face-to-face training on motivational interviewing and specific mental health conditions to enable staff to adapt

strategies to help motivate clients with specific mental health conditions. At the time of the evaluation, this was being discussed but was not in place. Given the range of clients in the service, we would also recommend equality, diversity, and inclusion refresher training.

Recommendation 21. Ensure all staff undertake neurodiversity training, for example tier one mandatory Oliver McGowan training on learning disability and autism, to equip them with skills and understanding to work with neurodiverse clients with or without a formal diagnosis.

Recommendation 22. Ensure clients' support plans include a clear move-on plan with a timeline, and actions and clarity over who is responsible for each action.

Recommendation 23. Coproduce a move-on toolkit with each client comprising key contact numbers, information on local services, building on and incorporating move-on goals and actions set out in the support plan.

Recommendation 24. Ensure clients are referred for Care Act assessment by month 7 of their stay in the service to ensure clients are aware of the support they will be entitled to on leaving the ICRS/Bridge 24.

Recommendation 25. Invite adult social care representatives from the client's home borough to their clinical reviews at three months intervals during their stay in the service.

Recommendation 26. Notify adult social care departments when clients from their borough are moving to the service. Notification should be **prior** to the clients' admission.

Recommendation 27. Share client support plans with care coordinators along with policies detailing what should happen when a client is admitted to inpatient mental health services from ICRS/Bridge 24. Explore ICRS/Bridge 24 and care coordinators cocreating clients' support plans.

Recommendation 28. With commissioners, develop and implement a communication plan to raise awareness of the service and the value of its work in the local community, and with the voluntary sector.

Healthwatch Kingston notes that since the evaluation Bridge Support have implemented changes to all recommendations raised.

15. Conclusion

The model works well thanks to the efficient and close working relationship between the voluntary sector support organisation and the in-reach clinicians. All clients felt safer in the service compared with being in hospital. Most clients said their mental health had improved and felt more independent in some areas of their life. Regular occupational therapy input has helped some clients build confidence with tasks of daily living. The patchy presence of an OT in the service (due to recruitment issues) makes it hard to assess the full impact of the rehabilitation interventions on individual clients. Managers go the extra mile for clients and have access to expert advice for tailoring support to client's individual needs including reducing their need for hospital admission. Poor engagement by some care coordinators and late involvement of adult social care during a client's stay, risks undermining clients' smooth move-on after nine months and clients felt anxiety about not knowing where they were moving to next and how much support they would receive. The pilot scheme is an innovative and potentially effective rehabilitation model for people with complex mental health needs, promoting their agency and independence in a safe, supportive setting.

16. Thank you!

Healthwatch Kingston upon Thames would like to thank all participants for their contribution to our independent evaluation of the Integrated Community Rehabilitation Service/Bridge 24 service pilot.

Healthwatch Kingston upon Thames
Suite 3, 2nd Floor, Siddeley House
50, Canbury Park Road
Kingston upon Thames
KT2 6LX

www.healthwatchkingston.org.uk
t: 020 3326 1255
e: info@healthwatchkingston.org.uk
X: @HWKingston
Facebook: /HWKingston