



Back on Track: finding out about users' experiences of Reablement, Rapid Response and Intermediate Care

January 2019



What was the project about?

Healthwatch Bucks wanted to find out about the experiences of people using Reablement and the Rapid Response and Intermediate Care services. We worked with the people who run these services on what to ask people about their experience. We also used NICE (National Institute for Health and Care Excellence) guidelines [‘Intermediate care including reablement’ \(NICE Guideline NG74, 2017\)](#). We asked service users;

- If they knew who made the decision to arrange their care
- If they understood what the service was for
- If they were involved in planning their support
- How they felt when their support from the service came to an end
- What they thought of the service

We also got feedback on other services used by our interviewees.

Why did we do the project?

Social Care is a priority area for Healthwatch Bucks. We knew that the Reablement service and the Rapid Response and Intermediate Care services in Buckinghamshire are in the process of aligning and joining together. We wanted to find out more about the patient experience to help inform the services on what they do well and what they could do better. This project allowed us to talk to people about their experiences in an area where we get limited feedback.

What did we do?

We put together a set of questions to use as part of an in-depth interview. We knew it would be hard for us to find people to talk to about reablement and intermediate care services. So we worked with Buckinghamshire Healthcare NHS Trust and Buckinghamshire County Council, who found us ten interview candidates.

We undertook the interviews from December 2018 to January 2019. We spoke to 4 men and 6 women. Their ages ranged from 56-66 (1 person), 66-75 (2 people), 76-85 (4 people), 85+ (3 people). Most were White British (9) and one was White Other. The experiences of services in this report took place in 2018.

Our report is about the experiences of the Reablement and Rapid Response and Intermediate Care services.

What did we discover?

Do you know who made the decision to arrange your care?

‘At all stages of assessment and delivery, ensure good communication between intermediate care practitioners and...people using the service and their families and carers.’

*‘Ensure that intermediate care teams work proactively with practitioners referring into the service so they understand the service and what it involves’
(NICE)*

Seven people knew who had made the decision to arrange their care. The majority had been referred through a GP or Hospital.

“They wouldn’t let me home until care was in place. They did a good job”

Three people were not sure who had arranged their care.

“I wasn’t anything to do with it. It was all arranged, and it was all organised”

“No information except we will get in touch with home care staff. The carers staff arrived, and that was that”

Did you understand what the service was for?

‘When a person starts using intermediate care, give their family and carers information about the service’s aims, how it works and the support it will and will not provide’

‘Explain clearly ...that intermediate care is designed to support them to live more independently, achieve their own goals and have a better quality of life’

‘Give their family and carers...information about the service’s aims, how it works and the support it will and will not provide’ (NICE)

Five people told us the service was explained to them.

“Help. Just general help”

“They just told me what they could do”

“They explained enough before and as soon as I got back home, the very day...explained exactly what they were going to do”

Five people did not have what the service was for explained to them. Two of those people had not experienced care before.

“Basically, get X more mobile to get him back in to the home environment. It was never actually explained to us but um...it would have been helpful in a way as there wouldn’t have been that worry about oh I’m going home now is it going to work?”

“I didn’t understand, and it wasn’t explained to me. They didn’t explain the full details of this that and the other. I didn’t know anything about the service at all but I’m not unhappy with the service I got”

“I wasn’t told what to expect, what they were going to do, and you don’t like to ask them”

Two people told us they were not always clear on what support staff could and could not do for them.

“I think one team (*support staff*) is able to pull the stocking up and the others are physically unable to because they’ve got medical problems”

“Some of them helped, others said ‘No we’re enablement you HAVE to do this yourself”

How were you involved in the planning of your support?

‘When planning the person’s intermediate care: assess and promote the person’s ability to self-manage, tell the person what will be involved, be aware that the person needs to give consent for their information to be shared, tell the person that intermediate care is a short-term service and explain what is likely to happen afterwards’

‘Ensure that an intermediate care diary (or record) is completed and kept with the person... who should be encouraged to read and contribute to it’

‘Review people’s goals with them regularly. Adjust the period of intermediate care depending on the progress people are making towards their goals’ (NICE)

All of the people we spoke to were not aware of any goals that had been set. Most people we spoke to did not seem to have been very involved in the planning of their support or care.

“I didn’t know what their end aim was going to be - that wasn’t explained out”

“I don’t quite know what’s happening next”

“You don’t like to ask them or tell them what they’ve got to do”

Two people did feel they or their family were involved in the planning of their support.

“She had a plan, right..... and I thought ‘Alright I’ll work with you’”

“The family just got involved”

One person we spoke to did not find the planning of the support very helpful.

“What I didn’t like was that Mum only knew what was happening a week at a time because the assessments were on a weekly basis.....and that week would go by really quickly and I felt it created a lot of unnecessary anxiety. Had it even been two weekly it would have been easier to catch your breath in-between”

Five people spoke to us about their care book (intermediate care diary or record).

“They left their file on the table so if I wanted to I could go through it if I wanted but I didn’t because I felt it was their property.”

“It was all logged - everything had to be written down”

“I don’t look at it”

Two people told us no one had come to take their book away once finishing support.

“Nobody’s picked it up - it’s still there look - all about me”

“Oh and the blue book they were supposed to take with them”

One person told us the planning for their equipment was good.

“The supply of the equipment, more than everything sometimes, they were very organised and when something wasn’t suitable they changed it”

Three people told us that they felt the support did not meet their needs.

“Some of them helped, others said ‘No we’re enablement you HAVE to do this yourself’ - and that’s what I’m saying... has certain things she just can’t do because somebody’s standing watching her isn’t going to you know she wasn’t going to be able to do it before she was ill - that’s just absurd”

“I said to them ‘I’ll have a go at it’ because I just want less pain and hopefully if it works it will give me more movement but unfortunately it doesn’t seem to have done that”

“*Service user* ‘I even had a man one morning. Gave me the shock of my life!’
Service user family member ‘When the assessor came Mum did say no male home care staff’”

How did you feel when your support from the service came to an end?

‘There should be a clear plan for when people transfer between services, or when the intermediate care service ends.... Give people information about other sources of support available at the end of intermediate care, including support for carers’ (NICE)

Most people told us they felt sad.

“I was sorry to see them go because I felt some of them I got quite pally with”
“I think really, he was a bit sorry when they were finished. Well he was a lot sorry. He was worried about what would be happening”

Three people felt the support they had ended too soon.

“I felt in a way a bit choked at the time cause I only had them for five days”
“I thought they might have been able to carry on for another fortnight or something like that.”
“I mean that was very clear you know ‘up to 6 weeks’....but then it’s over and out for us to sort out.”

Two people told us they were worried about support from new care agencies once their reablement support ended.

“I was concerned when we were changing from reablement to an agency”
“What it will be like with ongoing care I don’t know. You hear so many stories because it’s agencies they use”

What did you think of the service?

Everyone we spoke to told us that they felt treated with kindness and respect. Many recommended the service and support staff very highly.

“As far as I’m concerned, they’re brilliant - wouldn’t fault them at all - I’d recommend them to anyone”
“I was 100% satisfied with it. I can’t fault their attitude, the way they were. They were just so caring it was really really good”
“I never had care before. You feel a bit ashamed really in the way you’ve got to have it. But they were always kind and respectful. It was odd for me but they did just make me feel good in my own space”
“The support staff did not rush, not at all”

Two people told us about instances where they didn’t feel acknowledged by the support staff.

“Well they knew each other and sometimes they’d chat away and I’d think what am I doing here?”

“Her phone went....but she could have said ‘I’m sorry I’m seeing to a patient’ or whatever but she didn’t”

Some people we spoke to told us they felt the support staff were under pressure or rushed.

“They did seem under pressure”

“They were so short staffed one day”

Two people told us that encouragement from the support staff helped them.

“They encouraged me to do things, even when I didn’t want to”

“They were encouraging every time I did something, pleased to see me leaping around with somebody or on a stick”

Six people told us they would like support staff to come at more consistent times.

“I would like a more regular time”

“Yeah they were all alright but nothings explained they just come in and I said ‘what time do you come in?’ ...No nothings explained to you - they just appear”

“Sometimes they came in the middle of a meal and my husband had to go out”

For one person having the same carer was important.

“If you had the same person that makes a difference. They get to know you. You get to know them”

Two people felt that they would have liked more time.

“They could have been here a little bit longer than 45 minutes”

“It could be a little bit longer as I like to chat to her”

Other Feedback

Four of the people we spoke to were unclear about what help was available for those with long term conditions and terminal illnesses.

‘When assessing people for intermediate care, explain to them (and their families and carers, as appropriate) about advocacy services and how to contact them if they wish’ (NICE)

“You don’t know what you’re entitled to, what it is. So many different people speaking to so many people it was really very hard....and because you are not aware of what is available you just don’t know”

“I didn’t know I could get home care staff through social services and that sort of thing”

“It’s when you start to look and then you get a little bit of info here and there and then you realise what is out there. And you think if only I had known this a little while ago it might have been a little bit easier. I have to admit I felt quite isolated with it all...”

“I don’t think there’s anything you can do you just have to keep asking - yourself. Perhaps if there was somebody who could tell you more...who could sit down with you.... but unless you get some sort of buddy system I don’t think that’s going to work is it really”

We received separate pieces of feedback on hospital transport, Stoke Mandeville Hospital, Bucks Memory Clinic, GPs, Oncology, Pain Clinic, Prescriptions and an out of area hospital. We will send this feedback to Buckinghamshire CCG.

For the piece of feedback on a hospital not in Buckinghamshire, we will send this to their local Healthwatch.

Our conclusions

Most of the people (6 or more) we spoke to:

- knew who had made the decision to arrange their care.
- did not fully understand what the service was for.
- recommended the service and support staff very highly.
- had a good relationship with and enjoyed the company of their support staff.
- felt sad when the support from the service came to an end, with some feeling worried about future care.
- did not feel very involved in the planning of their support.
- would have preferred the support staff to come at more consistent times.

A smaller number of the people (5 or less) we spoke to:

- did not feel the service/s met their needs.
- felt that the support ended too soon.
- felt the support staff were rushed or sometimes didn’t feel acknowledged by them.
- would have liked support staff to have more time.
- felt the encouragement they had from the support staff was good.
- were unclear about the support available for those with long term conditions and terminal illnesses.
- told us about their care record book.

The service user feedback we had across both services was similar. However, our interviews showed some differences:

- more people who had used Intermediate care did not understand what the service was for (3 out of 5 users)
- more people who had used Reablement told us about their care record book (4 out of 5 users)

Our recommendations

We recommend that Buckinghamshire Healthcare NHS Trust and Buckinghamshire County Council

- Improve information given to service users on who made the decision to arrange their care
 - + Make sure service users are aware of who has arranged their care
 - + Work with GPs referring into the services on better ways to communicate to their patients what they are doing and what will happen next
- Improve service users understanding of the service
 - + Give better information to service users and referrers about what the service is and why the service user is being referred to it - particularly for those being discharged from hospital
 - + Manage service user expectations about how the service works in terms of timing, respecting requests where possible and if not possible explaining why
 - + Make sure service users understand what the service requires from them to help regain independence
- Involve service users in the planning of their support more
 - + Agree goals with service users input and regularly review progress with them
 - + Regularly ask service users if the reablement and/or rehabilitation is meeting their needs
 - + Encourage service users to read their care record book - particularly those being discharged from hospital
- Improve the user experience of support coming to an end
 - + Make sure that service users have a written and agreed plan and are told what will happen next
 - + Tell service users what will happen with their care record book/home notes records
 - + Make sure that service users with more complex health conditions and their families have details of who to contact for future support and information
- Improve the service user experience of support staff providing their support
 - + Remind support staff to not reveal any workload pressures or have personal conversations in front of service users
 - + Make sure service users are clear on what the support staff are there for

- + Assess if support staff have enough time to spend with service users to encourage, and assist as needed with performing tasks to achieve their goals

Buckinghamshire NHS Trust and Buckinghamshire County Council should refer to the guidance set out in [‘Intermediate care including reablement’ \(NICE guideline 2007, NG74\)](#) when implementing our recommendations.

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If you require this report in an alternative format, please contact us.

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