

Experiences of discharge to assess pathways in Coventry

June 2019



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1. Introduction

1.1 About Healthwatch Coventry

Healthwatch is the champion for users of health and social care in Coventry. We give local people a voice - making sure that patients, service users, carers and public views and experiences are heard.

We are independent of NHS and care services and decide our own programme of work. We have a statutory role and legal powers including the right to request information and to get a response to our reports and recommendations.

We work to influence the planning and delivery of NHS and social care services based on what local people tell us.

1.2 What is discharge to assess

‘Discharge to assess’ is an overarching term for people returning to community based services or services at home following a time in hospital.

In Coventry the name ‘Discharge to Assess’ refers to 3 programmes (pathways) of care/support aimed at either enabling individuals to regain their ability to live independently or to have their ongoing care needs assessed once they are discharged from hospital.

Reablement also known as ‘enablement’ or ‘re-enablement’ is intensive short-term support to help people to relearn daily skills and regain confidence to live independently. Daily skills could include preparing meals, washing, dressing and toileting.

Reablement support is provided by a coordinated approach between agencies to support a person for up to six weeks to regain confidence and skills that may have been lost while they were suffering from illness or disability in hospital. It uses a therapy model and is intended to enable people to remain in their own home as independently as possible.

For those who have higher levels of needs and therefore are less likely to be able to safely live independently a period of up to 6 week allows for the assessment of care needs for the future with the aim of identifying where that care will be provided. Assessment away from the hospital environment acknowledges that people often function differently once outside the hospital environment.

1.3 Why we undertook this work

The Healthwatch Coventry Steering Group added this piece of research to the Healthwatch Coventry work Programme for 2018-19 because we gathered concerns related to the home support element of the Discharge to Assess during our 2017-18 work gathering user feedback on home support/care.

Healthwatch Coventry also gathered intelligence through work looking at hospital discharge processes; enter and view visits to care homes and links with housing with care provision developed through community outreach.

Through our involvement in the local Sustainability and Transformation Partnership and knowledge of the new 'Out of Hospital' model we were aware of the challenges of ensuring people get more support within the community to prevent unnecessary admission to hospital.

Healthwatch could not identify any other mechanisms by which those experiencing these services were asked for their views/feedback.

Therefore, the following aims for this piece of work were agreed:

- To seek to understand the different pathways within Discharge to Assess and how they worked
- To gather the feedback and perspectives of patients and family carers
- To gather the feedback and perspectives of staff involved
- To reflect these perspectives to commissioners for consideration in the future development of Discharge to Assess and also the broader framework of 'system planning' and preventing hospital admission and re-admissions.

1.4 Reasons for discharge to assess/reablement approaches

One of the challenges within local health and care systems is how to ensure people are discharged from hospital in a timely way when they are medically fit to be elsewhere.

When someone remains in a hospital bed when there is no longer a medical need this can be referred to as 'bed blocking' or as a 'delayed transfer of care' because the patient is considered to no longer require the hospital bed and these beds are not available for the treatment of other people until discharge takes place. This can block the flow of patients into as well as out of hospitals.

There has been much focus on this issue nationally by NHS England and locally by health and social care planners and providers due to the knock-on impact it has on the ability of hospitals to treat people in A&E and to have beds available for planned operations.

Discharge to assess and reablement approaches aim to:

- Reduce time spent in hospital
- Benefit individuals by ensuring they continue to live independently
- Allow more time for continuing healthcare or social care needs assessment to be completed
- Reduce the need for admission to hospital by providing support to stop someone becoming so ill they need to go to hospital
- Potentially reducing costs of NHS treatment and/or ongoing social care support

It has been shown that a long period in hospital can damage people's recovery, resulting in:

- muscle degeneration
- lack of confidence and skills
- additional infections and low mood/depression

The Kings Fund says: *“for older patients, a delay of more than two days negates the additional benefit of intermediate care, and seven days is associated with a 10 per cent decline in muscle strength due to long periods of immobility in a hospital bed”*¹

The Social Care Institute for Excellence (SCIE) says *“reablement requires a move away from commissioning on the basis of time and tasks, instead it should be commissioned on the basis of the outcomes that the service will support the individual to achieve”*²

The National Institute of Clinical Excellence (NICE) writes in 2016 that Discharge to assess/reablement pathway should be person centred and based on the goals that people set for themselves. A joint plan is created that involves Occupational Therapists, Physiotherapist, doctors, medical staff and social care that supports the person to work toward those goals.³

1.5 CQC System review

In 2017 Coventry received a review by the Care Quality Commission (CQC). One of the drivers for these reviews was data collected nationally regarding delayed transfers of care. The CQC's review focused on:

- The interface between NHS and social care
- Look at how older people (over 65) move between NHS and social care including delays in transfer of care
- Look at how services are commissioned across health and social care
- Look at joined up working between health and care agencies

¹ <https://www.kingsfund.org.uk/publications/delayed-transfers-care-quick-guide>, Kings Fund, 2017

² <https://www.scie.org.uk/publications/guides/guide49/>

³ <https://www.nice.org.uk/guidance/ng74/chapter/Recommendations#core-principles-of-intermediate-care-including-reablement>

Three key lines of enquiry were used looking at how:

1. The wellbeing of a person in their usual place of residence was maintained
2. Crisis situations for individuals were managed
3. Individuals were supported to return to their usual place of residence and/or in admission to a new place of residence

This review provided impetus in Coventry for NHS organisations and Coventry City Council to come together and develop their approaches for working jointly to ensure patients were discharged in a timely way. ⁴

1.6 Services provided in Coventry

The discharge to assess model in Coventry has been operating for approximately three and a half years from June/July 2016 and it is jointly commissioned by Coventry City Council and Coventry and Rugby Clinical Commissioning Group (CCG).

There are three programmes or ‘pathways’ each with commissioning leads.

Coventry City Council are looking at their specifications for providing reablement support at home and for care homes providing bedded support.

A summary of the discharge to assess pathways can be found in appendix 1

1.6.1 Reablement support in own home - pathway 1

This aims to provide up to 6 weeks of support within a person’s own home in order to enable them to regain the strength, mobility and day to day skills to continue to live in their home. In Coventry this support is commissioned from 3 Home Support/Care agencies:

Pathway one: reablement support in own home

Name of provider	What is commissioned	Hours
Radis	50 to 60 people	585 hours per week
Sevacare	50 to 60 people	665 hours per week
Accord	50 to 60 people	585 hours per week

Support provided might typically include a package of care such as a visit by care staff 3 times a day to help the person with meals and drinks, or helping people to get up or go to bed, depending on the needs of the person.

The occupational therapists and physiotherapists help the person to achieve goals that they set by making a plan for the person, looking at equipment within the home, before the person is discharged from hospital or returns home. They look at

⁴ <https://www.cqc.org.uk/local-systems-review#reports>

what tasks the person might need to be able to complete to be independent, for example being able to walk around the home safely or make hot drinks or food.

At the time we undertook this work, support was commissioned during the day. However, Coventry City Council began to pilot ‘mobile night carers’ from 28 January 2019. This provides carers available between the hours of 22:00 and 7:00 am to make planned and unplanned visits to people in their own homes. People in receipt of service have a phone number they can call for the care agency if they need someone to visit. The initial pilot ran until 31 March 2019 and the Council was looking to extend this. Two of the 3 care providers had taken part.

1.6.2 Reablement beds - pathway 2

This aims to provide up to 6 weeks of support to enable people to regain mobility, skills and confidence to live independently again through a placement in a bed within a residential care home or in a housing with care unit.

Coventry City Council commissions 72 beds for this pathway from the following providers:

Pathway 2: bedded reablement provision care home and housing with care

Type of provision	Name of provider	Number of beds commissioned
reablement residential care home	Sovereign House	16
reablement residential care home	Bablake House	10
reablement residential care home	Charnwood House	6
reablement residential care home	Eric Williams House	10
	SUB TOTAL	42
reablement housing with care	Knightlow Lodge	7
reablement housing with care	Harry Caplan Lodge	8
reablement housing with care	Cottage Farm Lodge	5
reablement housing with care	Quinton Lodge	5
reablement housing with care	Copthorne Lodge	5
reablement housing with care	Elsie Jones	0
reablement housing with care	Ribbon Court	ends 31/3 2019
	SUB TOTAL	30

Housing with Care reablement beds (also known as short term beds) are provided in independent dwellings (a small one bedroomed flat) in a complex of flats with communal spaces for socialising/eating and where the main daily lunch meal can be catered for (at an individual’s expense) if this is required/wanted.

In Coventry these services are delivered in Whitefriars Housing’s buildings. The in-house care and support services are all delivered by Coventry City Council staff, however in occasional circumstances where care needs cannot be met by in-house staff, external care providers are contracted in to deliver specific care to ensure care needs are met.

The short-term beds are in the same buildings as long-term beds, where all long-term beds are occupied by tenants in their own right. Care is provided by the same staff that provide care and support for tenants who live in their independent flats (the long-term beds).

Reablement in Coventry was described to us by a Senior Support Worker as being: *“A package of up to 12 weeks for an individual working with a Social Worker, Occupational Therapy and Housing with Care staff. Six weeks is granted/funded and then reviewed, patients must then self fund. This can be extended for a further 6 weeks if necessary”*.

This model of reablement started in April 2017; the co-ordinator role was established in November 2017.

1.6.3 Care home beds for assessment - Pathway 3

Pathway 3 is called ‘Discharge to Assess’ because its focus is to provide care for people in a non-hospital setting for up to 6 weeks to allow time for further assessment of their future care needs.

Placements in this pathway can either be funded by Coventry City Council or Coventry and Rugby CCG. The City Council funds those who are already known to social care services and they arrange the bedded facility and have their own occupational therapists providing support. Coventry and Rugby CCG funds beds for those who are not already known to social care services.

Pathway 3 beds commissioned by Coventry City Council in 2018-19

Locations	No of beds
Coundon Manor	10
Compton Manor	5
Grove House	4

The Pathway 3 beds funded by Coventry and Rugby CCG provide care within either a nursing or residential placement for up to 6 weeks. There is no therapy as part of this offer. If a need for therapy input has been identified in a hospital setting prior to discharge the patient would go to Pathway 2. If an individual is identified as needing therapy during their 6 weeks on pathway 3 then a referral would be made through the GP to access core funding (this is funding that comes out of a specific GP practice fund in the usual way to fund their patient’s care).

We were advised by the Coventry and Rugby CCG that historically there has been a 50/50 split between residential and nursing beds since the pathway’s inception in November 2017.

In total 51 beds are commissioned by the CCG with a further potential to spot purchase up to a further 49 beds. These are based on clinical needs; some beds can be out of Coventry and Warwickshire (out of area) if local providers cannot meet needs.

Pathway 3- discharge to assess beds funded By Coventry and Rugby CCG

Location	No. of beds	Category
Sovereign House	9	Residential
Beaufort	5	Nursing
Evedale	5	Nursing (Dementia)
Arden Park	4	Residential
Alambie	6	Residential
Ashleigh House	6	Residential
Buttscroft	6	Residential
Maple Leaf	6	Nursing (Dementia)
Victoria Park	5	Residential

2. What we did

In order to review these services and gather feedback from people who had experienced them we undertook a number of different pieces of work covering the different pathways between 25 October 2018 to 6 February 2019.

2.1 Visits to care homes

Between October 2018 and February 2019, we made 10 visits to the care home providers of discharge to assess beds, these are Bablake House, Sovereign House and Charnwood House. We carried out observations, interviews with managers, therapists, care home staff and with patients and relatives (see appendix 2 and 3).

2.2 Housing with care

We visited four separate Housing with Care units: Harry Caplan, Knightlow Lodge, Quinton Lodge and Cottage Farm Lodge. We did not visit Copthorne Lodge. Whilst there are 30 beds delivered across 5 units. There were only 1-3 beds occupied in any of the units we visited therefore this limited the amount of people in short term beds we were able to speak to. Some of these people were unavailable due to prior personal commitments.

Managers, staff and people on their reablement journey were asked to share their views and experiences about reablement to inform this piece of research. Research was carried out by Healthwatch staff.

A group meeting with service managers was also held.

2.3 Support in people's homes

We carried out Interviews with the managers of the 3 home support agencies providing this service: Radis, Accord and Sevacare.

In order to reach people who had experience of reablement support in their home we worked with Coventry City Council. The Council identified approximately 280 people who experienced the services and sent out a letter and participation form on our behalf. This was originally scheduled for October 2018 however there was a delay and the sample was checked and reduced to approximately 203 people when it was sent out 28 November 2018.

Individuals made contact with us to consent to take part. We undertook interviews by phone or in person, visiting people in their home or provided a self-completion survey (see appendix 4 and 5).

2.4 Discharge to assess beds - pathway 3

We interviewed a care home manager responsible for pathway 3 and we interviewed three people within a care home on pathway 3.

We spoke to the Head of Commissioning and Provision at Coventry City Council.

It took some time to find the appropriate people to talk to within Coventry and Rugby CCG. We met with the Clinical Commissioning Manager and Clinical Lead, Discharge from Acute Beds/Brokerage for Continuing Healthcare in February 2019 - near the end of our piece of work.

2.5 Our sample

We spoke to 47 people who were either using services or were relatives of people using services.

Location	Number
Care in own home	13
Care home	24
Housing with care	10
Total	47

Of these 12 were male and 28 were female, and seven people did not answer this question.

25 people said that they considered themselves disabled, nine people considered themselves to not have a disability and 13 people did not answer this question.

Ethnicity of respondents

Ethnicity	Number
British	34
Irish	5
Indian	1
Other	1
Did not answer	6
TOTALS	47

Age of respondents

45-54	3
55-64	5
65-74	1
75-84	13
85+	18
Did not answer	7
TOTAL	47

We also spoke to:

- Three managers of home support providers
- Three managers of care homes. One assistant manager from a care home
- Three managers of housing with care units, and the care coordinator for housing with care
- Two therapists in a care home
- Three senior support workers from care homes
- Four support workers from care homes

We also attended, observed and spoke with the Multi Disciplinary Team meeting at Sovereign House, consisting of Senior Social worker, physiotherapists, a broker, an occupational therapist, manager of pathway 3 and the care home area manager.

3. Findings

3.1 Reablement in the home environment

We interviewed the managers from the three agencies Coventry City Council commissioned to provide support to people in their homes during their reablement package under pathway 1. These are Accord, Radis and Sevacare.

3.1.1 Assessment

All providers interviewed indicated that after an assessment of the person's needs at hospital the person is then allocated a number of hours of support to help them with daily activities, encouraging them to regain skills and confidence to be able to manage their daily activities on their own.

A social worker or occupational therapist is responsible for an assessment with them in their own home to identify the person's goals and needs for regaining skills and abilities which will become part of their overall care plan. Home support staff should follow this plan and it is usually recorded in a folder the person holds, encouraging the person to gain skills and independence whilst they are providing a level of care and support. Occupational therapy should check where people are with their plans and whether they are meeting their tasks to become independent, and whether to continue or reduce their service.

Examples of how staff explained this are:

- *“Initial assessments and risk assessment are from the Council, they are taken with the folder [which] has to be communicated at first visit first meeting with family which looks at medicine etc find out as much information as we can. Collects as much information as we can from family members and the client”*
- *“We have a pack of information - the blue folder with plan and goals in, we have a smaller amount of carers so we have to be more proactive. Have a weekly meeting feedback from carers, Social Services, Occupational therapists, [physios, goals are normally set by the social services but can change”*

3.1.2 Training for staff

All providers interviewed said they had training programmes in place, approved by Coventry City Council including promoting independence training, and other training which is identified and delivered through the Council, such as mandatory training (including Manual Handling, First Aid, Medication and so on that was for all care workers.

Care staff were also entitled to regular supervision and support from their line managers.

Reablement staff were seen as those who had more experience, confidence, skills and learning within their role.

3.1.3 Communication

Providers outlined a variety of ways that they communicated with all the people and staff involved in a service user's care.

We were told that discharge assessment is communicated through an electronic file from the hospital, which is then followed up by the manager or deputy. They then talk to the person and family about what the person's needs are and whether they can take the person as a client in their home

We were advised that there are quality monitoring checks where a senior officer or manager will contact the person and their family to make sure they are happy with the service they are receiving. Service users are given a number to ring at the initial assessment to contact the service provider if there is an issue or concern.

At the end of the reablement package service users are encouraged to complete a survey which is within their folder. Providers said it was sometimes difficult to get everyone to complete the form eg:

"Exit survey completed at end support worker communicates with client and office throughout. Surveys are completed 60/70%".

We asked providers what worked well in the way services were run, they identified good support from the commissioning team, and through meeting with each other at the providers forum where they could look at what was happening and identify good practice to take to their teams.

All of the providers saw the Multi-Disciplinary Team approach as a good way of working as it facilitated being able to share information about cases, make decisions and update everyone involved in the cases.

- *"MDTs good places for sharing information"*
- *"The commissioning team are pretty good, you can go to them"*.

3.1.4 Joined up working

The main challenge with joint working identified by the care providers was through the initial discharge from hospital, and also with the process at the end of the pathway, particularly when funding is being reviewed.

In the initial hospital assessment, it was thought that service users were sometimes discharged from hospital without the correct medication or without equipment at

home to enable them to be safe. Issues were also highlighted about people being not being discharged at a time when care support staff would be able to begin their package of care. One specific comment was:

- *“Discharge are appalling at communicating. MDT okay as we speak in between and send emails we have three quarters assessments done, but rely on hospital to complete their part and get people discharged on time with medication - we have sent people back [to hospital] we would hope they were discharged in a ‘timely manner’”.*

3.1.5 Challenges identified by home care providers

A) Taking referrals:

- Having to take clients from within their geographic area, not being able to refuse a client who is referred to the pathway

B) Queries about whether people are discharged on the correct pathway:

- Some people are returning to hospital following illness and starting the process again. Does this mean the process has not got the right criteria for people who are going through reablement or that assessment is not correct?
- How individuals are tracked: *“Certain clients are recurring every 6 to 8 week cycle - does anyone monitor that? Is there anyone monitoring the service to stop people falling through the gaps, additional work to link events together”*
- Providers feel there may be an issue with the original assessment as to whether people can receive reablement at home for example a comment that, *“A lot of the people who are coming through the service need palliative care”.*

C) Providing care:

People receiving packages of care are not aware that they have a two hour window when their reablement care will be delivered to them, which can cause conflict between the providers and the people receiving reablement. Providers need to prioritise people who need medication or who can't get out of bed, which means other people might be have longer to wait.

D) Future care:

- There is an issue of timing when a social worker needs to sign off people or agree additional carers' time for the person at home to meet their future care needs. The move from reablement pathway to long term care

provision, care home residency or nursing care can result in delays and problems with funding depending on who is funding the person

3.1.6 Reablement at home service user's feedback

We surveyed 13 people who received care at home; seven people were visited at home, and six people completed self-completion surveys.

The service users interviewed were experiencing the reablement process were often not well, and this may influence their ability to answer and their feelings about their experiences.

3 people were not clear on how long they had been receiving reablement support for and the rest said they had all been receiving it for over 5 weeks with 2 people saying it was longer than 6 weeks.

3.1.6.1 Discharge and information

We asked people how they felt about information they received at the point of their discharge from hospital and whether they understood where they were going and what was happening.

Of the people who returned the self-completion surveys three people said they were very informed, one person said they were a bit informed and two people did not answer. Of the people we interviewed at home two were positive about information and support received at discharge, for example:

- *“Through discharge I was given lots of support from nurses from hospital. They were turning me every 2 hours, made sure I had all the facilities had social services assessment to get ramp and equipment.”*

Four did not feel they had enough information/understanding:

- *“Basically didn't get enough information I have to ask for information, just said are you going to pick up her tablets (mum was discharged early in the morning without medication, had to ask nurse for it, nobody had phoned me to say she was ready said she was there at 8.00am I phoned at 11.00. no meds one nurse said she thought she had given them to her”*
- *“[I was] in hospital before Christmas, nothing really someone will phone or come out to see me, I was very ill when they spoke to me really didn't understand or take it all”*
- *“You were given nothing”*
- *“I wasn't given any information, they said that someone would come and look after me, 3 times a day at house”*

Two people said it was 5-6 days after discharge or assessment that their reablement support started. The rest said it was within a day:

- *“When I came out of hospital they came in the following day”*

3.1.6.2 Goals and planning

We asked people about their experiences of talking about and setting goals for things they would like to be able to do by receiving reablement support and received the following responses:

Response	Number
Very	7
Partly	2
Not	3
Not answered	1
TOTAL	13

Four people were negative about being involved in setting their goals, as they were unsure of what their goals were, however, some were very clear about what they wanted to achieve.

Whilst most people said they were satisfied, as a Healthwatch we did not feel that we had a clear view of how people were involved in setting their goals and plans and whether these reflected the person’s views and opinions. We were also unsure whether their goals continued to be supported within the reablement package.

- *“Yes, but not quite there but on the way. I am on the way”*
- *“I was mum’s lifeline I did everything for mum if I hadn’t she’d have died a long time ago”*

3.1.6.3 Quality of support

We identified that people appreciated the service they received and they valued it in terms of providing a “safe” space to recover and grow their confidence and skills:

- *“I received this help because I live alone, no close relatives and I had broken my arm). [It is] Much appreciated.”*
- *“They [the social worker] gave me the option of going to a care home but I didn’t want to go. I wanted to go home I have improved much since I have been here in my own space. People come to visit. I can sleep upstairs. My daughter comes from X every month.”*

All but one person thought that carers treated them/their family member with respect.

Some concerns were raised about the timings of visits:

- *[calls at] Seven to eleven am & seven to eleven pm is too long to wait. I quickly learned to do my own care rather than wait up to 4 hours*

- Another said that carers were ‘in and out’
- *“Bit rushed sometimes; takes me an hour to get dressed with help its ten minutes”*

Three people felt that they were not given enough time for their carers to support them to develop to enable them to live independently.

One person commented that carers were ‘*invariably late*’.

The issue of a loss of confidence and skills was raised by two of the people interviewed who felt that a longer time with a carer would give them more time to practice their skills in a safe environment.

Three people highlighted that the carers did things for them, rather than supporting and waiting for them to do things by themselves.

Comments included:

- *“Would like to go out but have lost my confidence in everything I do - the time they give is not enough”*
- *“No, I need more time to let me do more, [feel safer when the carer is here to do things] everything changes when the carers came - they didn’t really have enough time to provide the support you need”*

Issues such as continuity of carer and creating relationships with the people who care for you within the reablement package were important to people. When different carers arrived one person was worried about her care, especially if it was a man.

One person disagreed that the people supporting them were well trained.

Case study

One family carer spoke of their parent who had been given a reablement package after a time in hospital. The care agency worker had left the door to their house unlocked on two occasions.

Unfortunately, the family carer arrived home to find the parent very unwell (the care worker had not spotted this). This parent was readmitted to hospital and then re-discharged to a reablement package at the end of which the person passed away. The person felt: *“it was a difficult time fighting our corner, no one wants to listen it’s disgusting”*

3.1.6.4 Therapy

Three people said that they would benefit from a longer time with a therapist, to help them reach their potential and not just a basic level of ability and skill to enable them to stay at home:

- *“Yes, hospital physio and support at beginning was good, but not taken beyond base of trying to sit up in bed, I couldn’t do it myself without encouragement from carer”*
- *“I now pay for my own physiotherapist and have care plan for support with council. First physio was alright but didn’t go far enough, this physio is much better”.*
- *“Physios only came a couple of times, I need to be steady on my feet”*

Two people said that they could have done with more time when people could sit with them to allow them time to do things by themselves. This is important in terms of people being able to reach their goals of what they want to achieve.

3.1.6.5 Equipment

Three out of the seven people interviewed in their home were okay with the equipment they had and some had already received equipment and adaptations to their homes before they went to hospital and received a reablement package.

- *“made sure I had all the facilities had social services assessment to get ramp and equipment”*

However, some issues were identified from what people said:

- *“I need a ramp at the front of the house. I have difficulty getting up and down the steps”*
- *“I am frightened putting on socks in case I fall, they have a leg hoist but it won’t work. So, they have fixed a handle on my bed for me to use. I use it quite a bit. Some nights I have to sleep in my chair because I can’t hoist my legs onto bed”*
- *“I got [equipment] in a care home, they do nothing to help you, The Occupational Therapist came she did me on the stairs, she was quite good, but at the end of the day I've got nothing”*

Out of the six people who had returned their self completion forms four said they had all of the equipment they needed, one said they did not need any equipment and one did not answer. When they were asked how useful the equipment was Two people said the equipment they received helped a lot, one said that it had made a small amount of difference the others did not answer.

3.1.6.6 Communication

We asked questions to get an understanding of how people felt about communication and if they felt able to ask questions about their care and knew how to raise a concern or complaint.

Overall the picture was mixed with four people saying communication was good and others highlighting limitations or not being sure what information they had received.

Two mentioned their support plan/folder. One said they “*would like to be able to ask more*”.

Seven people said they knew how to raise a complaint if needed; five people said they didn't. One did not answer.

- *“That lady came in once a week to ask how they were doing, put in a complaint about Sevacare”*
- *“I would contact the district nurses, they would raise any issue they know me so well. Would go to doctor GP - he is a good GP who listens”*
- *“Number on folder”*

3.1.6.7 What happens next - ongoing care

We asked people if they know what was going to happen at the end of their reablement period. Eight people said they did; five said no or could not say.

3.1.6.8 Positive aspects

People identified the following positives from the reablement packages they had experienced:

- *Helping my husband regain some mobility. Providing equipment to help with this. Helping my husband regain his confidence.*
- *The friendliness of most carers.*
- *All of it people are very kind and I am very grateful of any support I can have or do get*
- *I regained some mobility*

3.1.6.9 Suggestions

We asked if there was anything people thought would improve the reablement care and suggestions focused on physio/supporting people to do things themselves; communication and care.

Reablement approach:

- *“More time with physio, more time to do things myself knowing someone is there in case falls”*
- *“More physio. Went to a COPD class on Spon Street which really helped breathing, mobility. More communication”*

Care:

- *“Not quick enough response time in attending to his needs”*
- *“The response time when needed would sometimes be too long e.g. toilet requirements”*
- *“Surely an agreement could be worked out that carers attend at reasonable times, not too early and not too late”*

Communication:

- *“Telling clients approximately when they can expect a carer”*
- *“Perhaps a little more time, but I know everything as always busy and there are a lot of people worse off than me, so that is why I am grateful. Thank you”*
- *“They all filled in a book but despite three phone calls have not collected it. I finished ‘care’ in mid October or thereabouts”*

3.2 Reablement in Housing with Care

3.2.1 Receiving referrals

Managers told us that there is one point of contact for a referral. This is the ‘Bed Co-ordinator’. Once a referral is received the Co-ordinator goes to the hospital, reads through the notes, and speaks to the person and their family to explain the process of reablement. If that is what the person requires and they are in agreement an assessment is carried out and the referral paperwork is sent to the Housing with Care unit to request a short-term bed for the person to move in.

Sometimes a reablement assessment is carried out when there is an emergency, e.g. when someone’s home environment has been deemed to be highly unsuitable, for people to be able to access housing with care. These people must have critical or substantial needs (these needs are defined by Coventry City Council).

Managers felt that it has been working well with the current Bed Co-ordinator and said that at the time we spoke with referrals were being turned around in 2.6 days. The skills of the bed Co-ordinator were praised as they were *“so good at releasing people from hospital”*.

3.2.2 Staffing

3.2.2.1 Number of staff

Managers described the staff to support reablement as a coordinator and three senior carers trained to do assessments. There are 300 care hours which equates to approximately 10 care hours per flat for staff. If more care is needed then care staff are provided through care packages organised in hospital. Social workers work with people on packages of care.

We spoke to 8 members of staff across the 4 different sites. This group of staff was made up of 1 Assistant Manager, 4 Support Workers and 3 Senior Support Workers. Many of the staff were well established in their roles and had been doing the role for several years. Most staff said they enjoyed their work.

The support workers describe their jobs as very busy and varied providing support to both tenants in long term beds and people who come in for reablement in the short-term beds. They described their work in the context of reablement as:

- *“Responding to needs”*
- *“Getting people to their best”*
- *“Respond to needs, sometimes a lot of needs”*
- *“I promote independence; let them do what they can”*

3.2.2.2 Training and support for staff

All staff had access to mandatory training and E-learning and had regular supervision and attended team meetings. It is their responsibility to keep their mandatory training up to date which is checked up through the Supervision process.

One support worker who was asked what training they had received answered: *“Meds, Manual Handling, Health and Safety, it’s an individual responsibility to keep it up to date. Have regular supervision, quarterly staff meetings. I’ve not received specific training on reablement but have had “promoting Independence” at the Opal Centre.”*

The majority of staff said that they had received training on “Promoting Independence”.

All staff were very clear about channels of reporting and raising issues/complaining. These were described as:

- Through supervision and 1-2-1s
- Speak to the Manager
- The Union
- Team Meetings
- Raise it in line with policy

3.2.3 Assessment and referrals

Senior support workers have the responsibility to receive the referrals that come in and set up the files ready for the person arriving as well as providing hands on support.

Managers explained that Occupational Therapists and sometimes Physiotherapists set goals for the person to work toward and that three senior members of staff are trained to do assessments.

Assessments are carried out prior to the person arriving at the Housing with Care unit. Other than assessments that are carried out by the Occupational Therapist as these have to be carried out in the real environment where the person will be carrying out particular tasks e.g. people must be assessed doing 'Kitchen Skills'. It was said that *"They don't always work, because in hospital isn't like being in a flat"*.

Staff said that assessments received from the hospital were not as accurate as they could be and sometimes information was missing, we were told:

"We need to receive accurate assessment in order to have things ready for a person arriving from hospital for short term. Mistakes can happen. E.g. Received an assessment form last Friday for someone arriving on Monday, it stated no special aids needed when in fact the person needed a hospital bed, that's the reason why a bed wasn't here when they arrived".

It is unclear from our conversations whether all Housing with Care units implement the same processes when a person arrives. It was described by one unit that when a person arrives a formal meeting with a senior and members of the care team takes place:

"The person on reablement leads on this. This is to find out more detail than the Housing with Care unit receives from the hospital referral as there is limited medical information included."

One staff member observed: *"[we] don't get much medical history but maybe notice that there are some cognitive issues. In this case we get GP to visit to confirm this. This will get a referral sent to the consultant for a CT scan to confirm whether there are cognitive issues. We would then hold a best interest meeting by involving Age UK"*.

"Someone once stayed here 11 months. If someone goes in and out of hospital after 72 hours the case closes and someone must start the process again".

In circumstances where cases are closed due to the length of stay in hospital this means that the whole referral process must be implemented again using the whole amount of resources that were used on the first referral.

One support worker described their role as:

"Normally 70-80% of support is with meals and personal care. Help with individual goal setting (this means supporting people to move closer towards objectives set e.g. being able to make a cup of tea and take it to their table by the chair they like to sit in). Work from progress sheet that has come from their

assessment. Care staff work with the Service User (person receiving reablement) and Occupational Therapist”.

We were informed that 3 hours per week is allocated for support staff to complete tasks with someone on their reablement journey. We were told that this is not always enough to complete tasks that are set by the OT: for example, when tasks are set like ‘walk the corridors’ to improve mobility skills. Support workers were very aware that their role was to promote independence and to encourage people to complete tasks independently but some felt that in reality this didn’t always happen, it was explained by one staff member as:

“People [those on reablement] let you do what you will, should take a step back and encourage them but when you are busy, under pressure, easy just to do it”.

One support worker also described issues when a person in a short-term bed did not want to/felt they couldn’t be supported to increase their independence this was described as: *“Facing a losing battle. Like when someone spends all day in bed and wants you to do everything. I can pull time from my tenants (this means spending less time supporting people who are in long term beds in that particular Housing with Care Unit) but that’s not fair. Thinks it’s a hotel”.*

3.2.4 Linking with therapists

Senior workers participate in weekly meetings MDT where they are able to discuss the person’s progress. The Housing with Care managers have set up a data base/spread sheet that has a list of all the people, their goals and progression, this is updated by the Occupational Therapist every week. Shows progression of how people are getting on which everyone can access.

A manager of housing with care said: *“this is very useful as staff at the hospital used to ring up every day for every person but now have data sheet that they can access it which saves everyone time”.*

3.2.5 Outcomes - what happens after reablement

The managers group considered that good rates of people who go through reablement are able to go home, although no numbers were quoted.

If someone is unable to ‘step down from unit’ (this means to move on to accommodation with a lower level of support. This is usually their own home, with or without a care package), or they go to residential home or stay in housing with care and become a tenant.

It was mentioned that there were currently two people who were on the reablement pathway who were waiting to become long term tenants in Housing with Care in the same unit where they were staying for reablement.

3.2.6 Things that could be improved

Managers highlighted that issues recognised were that it can take 3 days to get a referral into the unit for reablement and that when a person is ready to return home it can be difficult to get equipment delivered to their home, it was not explained as to what the difficulties were.

Staff were asked to think about what could be improved which would help them carry out their jobs and enhance the experience of the person on reablement.

A) Response time from Occupational Therapists:

Some staff felt there was a considerable delay for Occupational Therapists to make their first visit, and there were often times when this has to be chased up. This impacted on a person's progress in their funded 6 week reablement programme.

One support worker commented "Having progress sheets on day one would be an improvement, can be delayed up to 2 weeks. Can't support properly until these are in place. If a person's progress sheets are not made available to use for 2 weeks this represents a third of their funded provision in reablement having passed by with no formal progress recorded or possibly made".

'Progress sheets' outline the tasks that a person wants to achieve to promote their independence. This document is the result from the initial Occupational Therapist visit where goals and aims are set. Records are made of progress towards these targets.

B) Issues in referrals:

Various issues were raised about the quality of referrals to include:

- Equipment needed
- Care needs
- Medical background that may impact on communication/care needs
- Health status

All of these factors can impact on whether the referral fails at the outset or fails due to a readmission for more than 72 hours.

An example of referral which did not work - this happened prior to the interviews taking place. It frames the difficulties that Housing with Care face and the decisions they have to make.

Person arrived by ambulance at the unit for their reablement package. The person was unable to get off the ambulance due to mobility issues. The ambulance driver asked the staff member to get a wheelchair. They explained that they did not hold spare equipment. The patient had to be returned to hospital. The social worker at the hospital phoned and spoke to the responsible officer at the Reablement Unit and suggested that they should borrow a wheelchair. The Officer explained this was not a practice they would follow for various reasons. The Social Worker said that if they didn't take the person they would be reported to the CQC. The responsible Officer felt threatened and suggested the Social Worker should do what they felt appropriate.

This situation appeared to have happened as the Social Worker did not understand what Housing with Care Reablement was and what the bounds of what it provided were and thinking it is the same provision as a care home.

This is not an isolated incident of health/social care professionals not understanding what Housing with Care is.

C) How people and their family/carers are helped to prepare for their time in a short term bedded accommodation:

There were several comments on the issues around this. Staff suggested that more information was made available to people before they are discharged from hospital or when planning their stay to ensure that firstly they are clear about what short term bedded accommodation is and the reason they are going and secondly that they have all the practical things they need for their stay: eg toilet paper, kitchen cloth, towels, bin liners etc. (the everyday things that we all use at home).

One of the comments we received was: *“communications breakdown between hospital and here sometimes in the discharge process. Family and person think that everything is provided when they come here 'need to think it's like going to a caravan' (the inference here was that nothing was provided for the person to use). Should be the Social Worker or Assessor who shares this information. I've never seen any information like this. Puts pressure on staff here to source things”*.

D) Physical environment:

It was highlighted by several staff that the accommodation needed updating and its physical location could be a challenge, one staff member shared:

“Some of the flats need updating, they all should be on the ground floor next to each other, nearer to the lounge to help it be more accessible for

those with mobility issues, and to make it easier for staff. All bathrooms need doing up”.

Another commented: *“Having fit for purpose flats, need updating, gloomy”.*

Another suggestion for improvement in the accommodation was to have a TV in the bedrooms as this often reflects normal life for people and would also reduce the problems staff have when creating a rota of times people are supported to get into bed. Due to the time staff finish late shift the latest support that is offered is 9.00 pm therefore some people have to be supported to go to bed as early as 8.00 pm.

E) Having more time:

It was widely considered that support staff are not given enough time to complete tasks with people on the reablement pathway to be able to ‘promote independence’. They felt they cut corners at times to save time. The most widely spoken about element for having more time was *‘to settle people in when they arrive’*.

F) Medication - use blister packs:

It would be helpful if medication arrived in blister packs as this would reduce the time staff spend on ‘Meds admin’ (recording information about medication that people bring with them when they arrive. It was described by one member of staff that *‘some people bring bags and bags of medication with them’*.

G) Return of equipment:

Often hospital equipment is left at the Housing with Care unit, and to return it to the Wisdom Centre (at UHCW) would take valuable resources. It was thought that this was *‘No one’s responsibility specifically’*.

3.2.7 Views of those receiving housing with care reablement

3.2.7.1 Overall

At the time of carrying out our engagement work with people using reablement beds the units were heavily under occupied. We spoke to 9 people across the 4 units who were at different points of their journey. This ranged from being at the accommodation for 2 days to someone having become a long-term tenant after being in a short term reablement bed.

Everybody thought that it was a good service for people *‘in my situation’*. All but two of the people that we spoke to went to their reablement service directly from hospital. One person had been to Sovereign House in between leaving hospital before arriving at the Housing with Care environment. The other person had gone directly to the Housing with care environment from home as whilst they lived independently a lot of care was provided by a family member who was going to be

temporarily unavailable to provide care due to a planned admission to hospital. People's hospital stays varied from 1 to 6 weeks.

Seven of the people informed us that they had a family member who had liaised closely and lead on communications with health and social care staff at both the hospital and the transition into a short-term bed, all of these people felt the experience overall was good and were seemingly happy to go with the judgement of their family carer holding all of the information.

For the 2 people who did not have any family support one person described themselves to be *"happy and grateful to be able to stay local"*. This was because the short-term bed they had been allocated was in the local area where they lived and in a familiar place. This enabled their neighbour to visit.

The other person described their arrival at their short-term bed as *"I felt a bit bewildered, a bit dumped"* and described having to wait for what felt 'like ages' for someone to arrive. They felt that having some leaflet with some visual information as well as written information about the Housing with Care scheme where they were staying would be really helpful to help them to get a bit of understanding about where they were.

3.2.7.2 Support plans and support received

Support planning is a defined process which helps people set their own aims, and then secures the support and care that are needed to achieve them. The support plan should be developed with 'the person' at the heart of the plan and the plan its self should be developed around the person's wants/needs whilst remaining realistic within the abilities of the person.

A Support Plan is the result of the support planning process which outlines an individual's aims, progress made towards this and all care and support that has been provided to help make progress for an individual to meet their personal goals. It is a live document which should be updated every time any support/care is provided.

All of the people interviewed knew that there was a support plan in their flat, usually located in the kitchen area but only one person said they knew what was in it, some comments received about support plans were:

- *"I know I have a support plan, but I haven't looked in it I thought it was private"*.
- *"Yes, I know what's in it"*.
- *"There is a blue folder in the kitchen, I see the girls write in it, not sure what for"*.

Seven out of the nine people interviewed had family members providing input into the support planning process.

Four people thought that they had not yet seen an Occupational Therapist, these people had been in short term beds for between 2 days and 4 weeks. Three people were unsure about who they had seen, some described it as:

- *“Think I've seen an Occupational Therapist once, not sure who I've seen, no one leaves any information”*
- *“No, not that I know of. But a lady in a nurse's uniform came once and said she'd come back but hasn't”.*

Only 2 people were clear about understanding the support they had received from an Occupational Therapist. One person knew that they had been provided a long handled bath sponge to help with their bathing and the other person knew that they had completed paperwork on one visit and the second they had returned with a bath board for bathing.

One person who had progressed through reablement and become a long-term tenant informed us that they were unable to carry a drink from the kitchen to their table without spilling it and this had always been the case. They were asked if they had a 'rambling trolley' (which is a wheeled frame with handles that has a small flat seat which can be used as a seat or to move small items like a cup or plate from one area to another across a flat surface). The person did not have one nor ever had. The person gave permission to us for this to be raised. The Manager was unaware of the need and said they would address this to enable the person to be provided with the required equipment.

Five of the people interviewed clearly recalled seeing either a GP or community nurse during their stay in a short-term bed and had a clear recollection of what the visit was for.

3.2.7.2 Information and communication

All said they were not given any information in a written format on their arrival or during their stay (other than the support plan that remained in the living accommodation). However, those who had family carers felt that if they needed to know something their family member would know or if they did not, they could find the information on their behalf.

Whilst no one was given any information one person who was in a short-term bed said that when they arrived there was 'a sort of shopping list' on the table which was a list of useful/essential things that they might need to buy for their stay in short term accommodation. It is not known whether this is a routine piece of information that is left for new short-term residents as no one else had mentioned this.

When one person was asked what information they had been given they replied *“Not a lot, but I've been asked to sign something that I didn't really know what it was. It wasn't explained to me, but it was about money. I felt bewildered and vulnerable, don't like to ask, since being more dependent I've lost my*

confidence". The interviewer asked if they had a copy of this document, the person had not been given a copy.

Two people commented that when they arrived, they were told about meal times in the communal dining room. Four people felt that if they needed to know anything, they just had to ask someone.

Two people felt that it would be helpful to have things in a written format as this would help them remember new and possibly important information. When asked about whether information was given to them in a way, they understand one person commented:

"Not really, would like it in writing. People just tell you things that you don't understand so you don't remember".

No one had been given a particular point of contact. Most people thought that they would just speak to one of the care staff that came in at certain points of the day or ask a family carer. One person we spoke to commented: *"No, don't really know, I would like a point of contact"*. Another commented: *"No one particular, just ask a lady who comes in"*.

3.2.7.3 Taking part in activities

All people said they did not take part in any activities. Three of these people knew that there weren't any formal activities to take part in. One person had been informally told by a member of staff at the lunch table that *"sometimes there's entertainment in the community lounge"* but did not expand any further. Another individual said that they didn't know if there was anything to do but the main reason, she wouldn't take part is the lounge was a long way away.

3.2.7.4 Quality of care

Generally, everyone felt they were treated with dignity and respect other than on two separate occasions:

- In the first instance someone had felt they had been spoken to harshly by a particular member of care staff who had asked the person to sign some formal document relating to finances without explaining exactly what it was. This was done in front of the person's visitor. This person felt they didn't want to make a fuss but would have liked to know what they had signed.
- On the second occasion a person who arrived at their short-term bed accommodation after having an extended journey on non-emergency ambulance transport asked to be able to lie down as it had been an uncomfortable journey due to a hard seat which wasn't helpful for their long-term health condition. The person was told *"you are not in hospital now you know and it's not bedtime"*. The person complained about being spoken to in that way. However, she did not receive an apology.

Someone explained that care staff arrived at 8.20 pm to support them to go to bed as they were unable to do this independently. They understood the issue was limited staff, however felt it was unreasonable to expect someone to go to bed at this time particularly when there isn't even a TV available in the bedroom and all of the good TV programmes are on at 9.00pm. They also shared that they had not had a shower since being in the facility: just over 1 month. The person explained they were told 'bath night is Sunday at 6.30'. They thought it sounded 'a bit institutionalised' and that this put them off. They went on to say:

"I refused as I didn't feel confident about the help. It might have helped to be invited to go and have a look. They've given me a long-handled sponge to wash with".

3.2.7.5 Making a complaint

Having the right to and feeling confident to make a complaint is an important part of any service. It is good practice for the service provider to look at how they can continually improve the services they provide to frail/older people.

Manager told us that Coventry City Council's generic Comments, Compliments and Complaints process is used to gather customer/service user feedback although it was not explained how this process was implemented nor how users/customers were informed of the process itself.

There are 2 champions of people receiving feedback but managers did not articulate how this happens or how the gathered data influences continuous improvement in terms of service delivery or whether the information is treated in isolation to deal with complaints.

People were asked if they knew how to and who to complain to if they wanted to raise something formally. No one knew how to do this; the most common response was that they would ask one of the carers that came in during the day. Comments included:

- *"Just mention it to the girls that care for me"*
- *"Tell a staff member unless it was about them. Had a complaint but it was dealt with"*

One person had a complaint about a member of staff and had raised this by speaking to a different member of staff. The complaint was resolved informally and the person was satisfied with the outcome.

Another said that they did have a complaint about being asked to sign something in relation to finances that wasn't explained to them. They felt they didn't want to raise it as they would be perceived as 'being difficult' or a 'trouble maker'. They added that it had made them realise how vulnerable they were. This person was supported by the Healthwatch Officer to make an enquiry about what document they had signed and to request a copy of the document.

3.2.7.6 Planning to move on/return home

We spoke to people at varying points in their journey through short term reablement the answers we received about the plans for the future reflected this.

Some people who had only been in short term accommodation for less than 2 weeks generally felt that it was too early to discuss this.

One person had transitioned to become a long-term tenant at the same Housing with Care provision where they received short term reablement and another person was waiting for the same confirmation.

One person was confident that they wouldn't be able to live independently and felt that they also would like to become a long-term tenant in the same place they were receiving short term reablement and the final person was hopeful they would return home but this hadn't yet been planned for.

Only one person knew when they would be discharged which they had been told would be in the next 2 days. This person didn't really understand what they were waiting for and did not have a family carer to help with any planning. This person lived alone at home and had not previously had a care package at home. They explained that they did not know the detail yet but would have hoped to have had the conversation by now. The social worker had visited 2 weeks previously but they had not heard anything since. They explained that staff had said if the person hadn't heard anything, 'not to worry' as the social worker would contact them once they were back home. This person was worried about how to get their personal belongings home and how they would be able to do things like 'the washing'.

The housing with care managers said that people at the housing with care unit have a social worker who check people's continuing eligibility for care at the unit. Sometimes someone on a reablement package who wants to stay after their six weeks has finished is unable to do so as they no longer meet the criteria of "critical, severe and enduring" needs to stay at the unit so they have to find alternative housing.

3.2.7.7 The best bits of being in a short-term bed

Everyone who was interviewed was asked what the best thing about their experience of reablement was. It was clear from findings the feeling of being safe, not worrying and having their own private space were the most important things. Some comments that people shared are:

- *"Being in a place where I have private space, nice tree with a pigeon and a squirrel"*.
- *"Been good as I couldn't go home"*.
- *"Made me more independent"*.
- *"It's strange, very different, had a nice little bungalow before at home"*

3.2.7.8 What could be improved?

Everyone who was interviewed was asked what could have been better during the time they spent in their short-term accommodation. Responses were varied.

Two people spoke of their arrival experience both in terms of settling in and having the right equipment and facilities and having some information in writing about what would happen whilst they were there and what the next steps would be. This relates to a hospital bed not being in situ upon the arrival of the person and a bathroom that was very unkempt with a smashed bath panel in the bath. Whilst this person was not mobile enough to use the bath it appeared unsightly, unwelcoming and gave the look of being unclean. The bath panel remained in the same state for the next 2 days and beyond that was unknown when it was cleared.

Five people were not able to think of anything that could be better, two of these people were/had become long term tenants. Two others of the same 5 said that whilst they couldn't think of anything that needed to be better commented '*What was the alternative, they had to come here*'.

One individual shared that they were not allowed to use the oven, they weren't aware of the reasoning behind this. This limited a person to using the microwave.

It was also commented that there wasn't a tin opener to be able to use which limited what someone could heat up in the microwave that was non-perishable. This could limit the amount of 'kitchen skills' that a person could regain.

3.2.7.9 The physical environment - observations

The interviewer used a small compact mobility scooter which is 42 cm at the widest point and has a tight turning circle. Whilst the communal areas and reception areas in Housing with Care were all easily accessed some of the private spaces for individuals in the short-term accommodation was very difficult to navigate. This was due to narrow doorways and right angled turns with little space to make reversed turning an option.

This was equally a problem in some of the kitchen spaces where there was not enough space to turn around to come out forwards. The only option was to reverse out. This could present potential danger should someone be doing this with a hot drink or hot food.

Part of the reablement process in this setting would be to regain skills in the kitchen e.g. making a hot drink or microwaving food and being able to get it to the dining table/lounge chair safely. This would not be easily achieved for a wheelchair user or for ambulant disabled people with high mobility support needs.

One of the sample group was a full time wheelchair user who could not independently navigate around their personal space.

All of the communal/public areas were furnished and decorated to an acceptable standard or above. Some of the private spaces for individuals were in places shabby. Some of the kitchen areas were very out of date.

Managers of Housing with Care indicated at the manager meeting that refurbishment work was being undertaken including widening doorways, and room for hoists for five rooms. We are not sure in which unit/s this was taking place and did not see any work taking place. Unit staff did not mention this to us.

3.3 Reablement in a care home bed

We spoke to 21 people about their experiences of their reablement package and of the care they received in the care homes. Sovereign House 8 people, Charnwood House 2 people and Bablake House 11 people.

We spoke to the managers of each home, one deputy manager. A pathway 3 manager, two therapists and five care home support workers.

3.3.1 The providers

A) Sovereign House

Sovereign House has 16 beds for Pathway 2 reablement, with a facility in a modern building covering three floors. The reablement residents were mainly based on the ground floor, people with dementia care needs are on the first floor and nursing care on second floor. Sovereign House also provides 'Discharge to Assess' care under pathway 3.

On our four visits to Sovereign House we felt welcome and were offered the opportunity to join residents for lunch food. Four authorised representatives tried the food at the Sovereign House and thought that it was of good quality.

The staff were very helpful and supported us to identify and speak with people on reablement pathways. Some of our Authorised Representatives thought that the reablement floor had a clinical feeling and was less homely. Reablement therapists from the Multi-Disciplinary Team meeting thought this made their job easier as people focused on the getting well part of their goals and were able to carry out their therapy actions more effectively.

Whilst we were visiting on different occasions, we observed one person on a reablement package being supported to sit in a chair in the lounge by a staff member operating a hoist. We observed three people watching television in the lounge. We observed one nurse who was checking equipment and filling in the resident's folders. We observed carers speaking with other staff members and nurses to check times and actions.

Therapists said Sovereign House had a kitchen set up upstairs for use for therapy and that they supported people in their ensuite bathrooms and used the stairs at the bottom of the corridor to support patients to practise stairs.

Staff said they are able to order equipment for individual patients and it usually arrives the same day

B) Charnwood House

Charnwood House has a speciality for people requiring dementia care. It is a large building with 60 beds over three ground floor units connected by through ways. Each room had a different coloured door and had a plaque with the person's name on it. Each Unit had their own communal lounge with seating and space for activities.

We found staff to be welcoming and the senior worker introduced us to the staff team as we were shown around the units. Again, we were asked whether we wanted to share food, on this occasion we were unable to stay to lunch. The environment felt homely, clean with warm colours and lots of light through windows.

At the time of our visit Charnwood House had not long ended a lock down due to an outbreak of sickness. There were only 3 people in reablement beds present at Charnwood. We also had challenges with communicating with residents.

At Charnwood House we observed a singing session where a local performer was playing a guitar and singing songs with the residents. We also observed a craft table with paper and equipment on it to make Christmas trees, there were two residents involved on the making table and approximately 12 listening to the music.

We observed the care staff were providing. The staff were very calm and reassuring and were speaking and listening to the residents very positively for example member of staff offering people drinks, one person being assisted to have a drink, the person drank it very quickly so the staff member got the person another one and a person being given a biscuit as they indicated they were hungry.

C) Bablake House

Bablake House has 45 beds in total with 10 beds for reablement. The building has two areas one is newly built area with lots of light through large windows and a wooden floor.

We visited three times. On the first visit we spoke with a senior care worker who was able to give us some of the information we were asking for. However, after we were shown the reablement residents one of the residents commented on the food, so we asked whether we could see the lunch time service. We were then made to feel uncomfortable and told that we were unable to do so except from a distance.

We organised to visit again and when we arrived felt unwelcome with one member of staff saying *“you can stay in here where we can keep an eye on you”*.

We then contacted the manager to meet to explain Healthwatch and why we were speaking with people. We were then able to continue with our interviews with reablement residents.

Whilst we were at Bablake House during our three visits we observed one technical support worker encouraging someone to use their frame to walk across the floor with support. We observed one person being encouraged to stand up and walk supported by a care worker, in a calm, gentle manner.

The staff were friendly and confident with the residents and clear in their questions.

We also observed care home staff supporting people to walk with their frames to the dining area for their lunch. We observed a person having their leg bandages changed behind a screen.

Eventually we observed a lunch of fish, chips and vegetables which looked basic but adequate.

There were lots of people sitting in chairs and watching the television. There was a busy atmosphere and several residents were seen wandering about talking to people.

3.3.2 Receiving referrals

A manager explained in detail how referrals were received and the actions the home took. The time frames for this were that the home will assess on the day if receive referral from UHCW before 2 pm, with discharge from the hospital the next day. This operated 7 days a week.

It seemed to us that this was quite a pressured process as whilst we were carrying out our interview there was a phone call chasing to see if the home had assessed a person for whom the manager said the referral had been received a couple of hours previously.

It seemed that depending on the level of referrals there could be pinch point.

Criteria for pathways not always clear eg one manger said there were no criteria for acceptance of patients into the beds.

A manager said that to start with there had been a lot of inappropriate referrals to pathway 2 but now more referrals are appropriate and more identify rehabilitation goals.

Care managers identified issues related to receiving people from hospital to the care home:

- Detail of information received
- Communication
- Timing
- Medication - sometime does not come with the person or is incorrect

“Communication with hospitals - sometimes wrong medication is sent out or no medication. Medicine is important especially when warfarin. Social workers are generally good at keeping us in the loop”

“4.00pm is the cut off point people get picked up in an ambulance and it is dark The person thinks they are going home. It takes time to reassure them, do the paperwork register with the local doctor.

One staff member said that hospitals don't know that it is a residential home, they don't explain to the people who come here that its integrated they think that we can sort everything out for their relatives.

Healthwatch looked at a revised draft specification for pathway two care home beds. This specification contains a requirement for provider to produce information about the reablement bed offer, facilities and service the individual can expect; any fees that need to be paid separately (a limited list), time limits on the service and what happens in the event that the services required beyond 6 weeks, key contact in the home, complaints procedure and discharge.

Sovereign House has produced own information leaflet and business cards to give to patients in the hospital. UHCW leaflet not being given out

3.3.3 Staffing and training

Managers explained how the way staffing and work was organised. One home had changed staffing in order to accommodate the reablement approach and the timeline for receiving referrals this involved what were described as supernumerary staff.

All three home support providers said that their care staff had undergone a mandatory level of training recommended by Coventry City Council. The three care homes also had training plans and mandatory training in place, although one care home said that there was no additional training for carers supporting people on reablement pathways.

There was acknowledgement that additional skills were needed in order to be a reablement carer.

Comments included:

- *“Our staff are already trained to manage their care, we are not a nursing home and we don’t cover people with dementia, don’t have extra training”*
- *“They tend to be more trained, NVQ 2 and they have better availability and scope, carers who are more proactive, they encourage the client to be more independent “come on you can do this, I’m here to support””*

A therapist said that if the home is short staffed this makes a big difference. Not all the carers are able to do this role.

3.3.3 Multi-disciplinary working

We received many comments about positive working relationships.

Each care home had their own therapy team and relationships with medical staff and therapy staff. Sovereign House has a nursing care floor so has access to nursing staff.

In Sovereign House the therapy team have a table in the corner of the lounge where they can update their cases and have access to each other and share information with care staff/ nurses.

In Bablake House here are two occupational therapists who visit the home plus a physiotherapist, and two technical assistants who support people with their reablement activities to develop confidence and skills.

Both Bablake and Sovereign House are covered by one Multi-Disciplinary Team which alternates their meetings between the two care homes. The MDT consists of a senior social worker, occupational therapists, physiotherapist, nursing staff, care home provision manager and a broker. The team share and update their information about each resident on the discharge to assess pathways including updates about improvements, needs for additional support or discharge from the service.

We observed a Multi Disciplinary Team meeting where individual’s cases were discussed, actions agreed and any concerns or positive improvements were updated on the spreadsheet. The meeting appeared to be a good mechanism for decisions to be made. At the meeting we asked about who would have the numbers of people who were reabled and who would have that information. The senior social worker and the broker were updating a spreadsheet with resident’s histories.

One member of staff said that the local doctor was very good at answering questions and was available day and night to help people where pain issues/had arisen.

A therapist said if the home is short staffed makes a big difference and not all the carers are able to do the reablement role.

Some people felt that they did not see enough of their therapy staff, if at all and many would have liked to see more of their Occupational Therapist and care staff to help them to regain their skills further.

- *“I think the families are always complaining that they can’t get hold of physio or Occupational Therapist - they don’t know what is going on - they might have questions but are not seeing anyone” (Bablake House]*

There was also an indication that there were not enough therapists, the Occupational Therapists we saw within the homes were always busy and we found it difficult for us to speak with them as they were rushing from one place to another, or busy providing exercises with people.

3.3.4 Experiences of residents

3.3.4.1 Length of stay

The people we spoke to said they had been on the reablement pathway for the following lengths of time:

How long receiving package for	Number
Less than 7 days	5
1-2 weeks	3
3-4 weeks	6
5-6 weeks	2
6-8 weeks	0
9-12 weeks	2
Don't know	3
TOTAL	21

All had come to the pathway from hospital apart from one person who had moved from another care home where the family had had concerns about the care the person had been receiving. The family were pleased with how their relative had progressed since this move.

15 people interviewed in the care homes were positive about their experiences.

- *“Have seen lots of caring lots of people who have really, really cared about her, even the odd job man came in and we had a nice chat”.*
- *“I like it is good I am very happy here the nurses are really good, lovely place, they do help you if you need help”*
- *“Very good all the people are all nice, even the patients are all nice”.*

3.3.4.2 Communication/information

When asked about what information people had received before they came to the care home and people were generally not clear about information received.

- *“It was a surprise to come here, but happy here”*

Some said they had received some information for example:

- *“Rugby hospital told me, didn’t know until the day before”*
- *“No not really, just said was going to Bablake House”*
- *“Somebody told me I would be coming to this care home. Told it was a temporary move. Supposed to be on a Thursday but no equipment so it was the Friday I moved”.*

Four people said that a member of their family had told them.

Similarly, only a few people could answer positively when asked if information had been given to them in a way they could understand with 4 positive and 2 partly positive responses eg:

- *“Happy with everything, happy to ask, feel comfortable, no problems”*

A relative of a patient explained their parent was visually impaired but did not think that staff were aware/taking account of this within their normal interactions. For example, if a staff member stood by the door the patient would not be able to recognise them.

Four people identified who they would speak to within the care home if they had questions or concerns, as follows:

- *I would talk to one of the nurses they are all very good*
- *I would ask the senior nurses I would have a bit of a talk to them, I get worries sometimes, my partner died in May*
- *Yes, I think they’ve got someone in the office you can speak with*
- *I would talk to one of the therapists*

Respondents could not really identify a specific route to use for raising any complaint if they had one. Some said they would speak to their relatives and others said they would talk to a member of staff.

A visiting relative felt that the liaison between the different care staff and shifts at Sovereign House did not work well and they need to talk to each other more.

3.3.4.2 Quality of care

In all three care homes residents on reablement packages said they have been treated with dignity and respect, for example:

- *“Yes, I think they have all been very good”*
- *“Yes, I have, they are really good people and very helpful”*

17 people said they had been treated with dignity and respect; the rest did not answer.

Two people mentioned noise within the environment was disturbing them. One person said they were tired *“they wake me up at 7.00am”*.

One person said of care in Bablake House: *“Only had two showers. There are not enough staff”*. They had been in the care home for approximately 2 weeks. Another Baalke House resident said wanted to have hair washed and had only had hair washed once since arrival. We do not know how long they had been in the care home.

One person commented of Bablake House that there was *“More support from some staff than others. On first morning was brought to lounge when wanted to return to room. I couldn’t go back to my room, when wanted to, lots of people here can’t speak - have to be outspoken to get things”*.

Another respondent said: *“Don’t really know [staff] names. The girls are alright. I don’t like the night nurse comes into the room, creeps in it frightens me. Staff shouted in the lounge, she did not know I was there “xx you shouldn’t be standing up by the table” Sit down!”* [Sovereign House]

3.3.4.3 Setting goals, support plans and support

Six people said they had been involved in setting goals for their reablement, ten people said no, and five people did not know or answer. One patient was unclear about their goals although their visiting relative was clearer.

However, most people we spoke to were able to tell us a bit about what they would like to be able to do, and some understood the actions they were taking to meet their goals:

- *“They keep asking me about my goals in the home but I still feel I need more help, talking about helping me at home but I do not feel ready for this”*
- *“Occupational therapy has got me to hold on the bar and walk with it, they got me a walking stick. They’ve done all that they can for me they have been very good”*
- *“I want to look after myself, in my own home”*
- *“Want to get eye sight back and go back home. Set goals - with exercises” (showed us the exercises)*

There were also positive comments about the therapy received for example:

- *“Physio and Occupational Therapist have been brilliant taught me and family. Had a shower was absolutely wonderful”. [Bablake House]*
- *“Physio comes in every day she gives you exercises for legs they don’t get weaker. They take me round the room this morning, come back and gives me exercises on the chair” [Sovereign House]*
- *“Been doing a bit of walking, they come and take you for a walk. I’ve got to have someone beside me. The physios do that.” [Bablake House]*

We also received comments about level of therapy support people received

- *“Was told that it would be intensive physiotherapy but that is not true. My nephew has to organise it”*

3.3.4.4 Activities

Out of the 21 people interviewed 7 people said they would participate in activities taking place within the care home.

People gave a variety of reasons for not taking part in activities from their unwellness, *“lack of confidence”*, not being aware of activities, to a sense that they were different from other residents:

- *“I’ve lost my confidence I feel everyone would look at me”*
- *“No, they haven’t asked me if I want to be involved. Just sat in the lounge” [Bablake House]*
- *“No would rather read a book and talk to people, the rooms are claustrophobic and dark, its lighter in here [new lounge at Bablake House]”*
- *“Went to exercises on Saturday that’s nice, didn’t go to the last one. Thought should have got up but not gone”. [Charnwood House].*
- *“[have joined in] listening to music, they listen to records and pop songs They play games. I can meet people” [Sovereign House]*
- *“No, they asked me if I want to do any activities but don’t join in can’t see can’t even read a book. Prefer to stay in room got a radio.” [Sovereign House]*
- *“No, you must be joking they go to their rooms and sleep I get bored lately I watch TV then turn it off” [Sovereign House]*

Bablake House had a light room with big windows where the majority of people on reablement packages would sit. There were also some reablement residents in the main lounge, which was across the corridor in a larger area with seating and televisions and was where the majority of the residents sat during the day.

We received three negative comments about the food at Bablake House two negative comments about the food at Sovereign House.

3.3.4.5 Ongoing care

Of the people interviewed just three people said they were involved in conversations about ongoing care. Five people were able to give us some indication of when they would be discharged from the home/reablement package. One person said they had become a permanent resident.

One person was worried about going home and wanted to stay in the care home:
“Safe here, scared to go home Social worker says I have to go home Friday very sad. Son is at home he is my carer worried I will have an accident”

A resident explained that they had thought they were about to be discharged, having been in the care home for 5 weeks. However, they had just found out that they would not be as they needed further treatment. A piece of equipment for this had only just arrived. This restricted their mobility.

They described a delay in the ordering and arrival of this equipment, which had been organised by the District Nurse.

The resident was unhappy they would not be going home and that it had taken so long to get something it had been decided they needed some days/weeks ago.

3.3.4.6 What was good and what could be improved:

We asked people to say what they thought had been the best thing about their reablement care:

Positives

- *They take care of you, food's not too bad, got a nice room the bed is comfortable*
- *Occupational Therapist, who was very efficient, sensitive and made a positive difference*
- *Fact that knew someone there at the touch of a button - someone who cares and can help*
- *the way that they look after you, can talk to people if you have a problem, even the carers are lovely*
- *[the home is] Comfortable and safe*
- *Nice and quiet resting my leg, it's alright*
- *Everything is done for you. Take you to where you are going*
- *I feel safe*
- *Everybody so kind*
- *Nice place - better than hospital more liberty*
- *The food*

Suggestions for improvement were:

- *Done in own home*
- *Could have hearing aid in*

- *Person who is individual for you, food could be better, had to ask for a table lamp so that I could read at night*
- *Want to have hair washed*
- *There are not enough staff*
- *Either too much social worker co-ordination or too little info.*
- *Don't always understand how the system works.*
- *Better seats - more padding!*
- *Took a long time to order equipment as every time they tried to order they got the wrong thing*
- Not taking into account visual impairment

3.4 Discharge to assess - pathway 3

3.4.1 How the pathway works

This pathway has the focus of providing care for up to six weeks to allow for individual's ongoing care needs to be assessed and the way in which ongoing care is to be funded to be determined and for that ongoing care to be organised.

During our work it became apparent that there are two different strands to Discharge Assess pathway 3 and that the support individuals received may vary depending on which strand they are within.

Coventry and Rugby CCG fund 9 residential and nursing care homes providing a total of 51 beds (see page 10). They also have the ability to purchase a further 49 beds from different homes as needed. For people who are in beds funded by the CCG there is no therapy input in to care funded. Coventry and Rugby CCG officers described these beds in terms of the assessment process for Continuing Healthcare Funding. This is NHS funding available to people who meet criteria linked to having ongoing healthcare needs, rather than social care needs.

We were informed that on average two pathway 3 placements per month are 'out of area'. This would usually be for a 'complex placement' - this would refer to a placement which has a specialist element above what the normal nursing home could offer eg there has been a specific ventilation or behavioural need of that patient's care which has required this.

Coventry City Council fund 3 care homes to provide 19 pathway 3 beds. The criteria for entering these is that the individual is already known to social care services (received care). People funded by Coventry City Council can receive therapy input from the Council's therapy team.

Sovereign House is one of the Coventry and Rugby CCG funded providers of discharge to assess beds. We spoke to 3 people on the pathway and one senior worker about this specifically in Sovereign House. They are all nursing placements.

3.4.2 Receiving referrals to the care home

To receive a referral the home visits the patient in hospital to look at whether the care home can meet those needs. They must respond within 24 hours of receipt of a referral (a new contract is being formulated).

We were told that referrals come via the 'Health Team': Continuing Healthcare'. And information comes on a Care Prescription form'.

An issue was flagged that the Care Prescription form has recently changed and now does not contain as much information about the individual as it did previously. This has resulted in a need to do a more lengthy visit in order to gather the information which would previously have received.

We were told a group of care home managers approached the CCG to discuss the referral system. This has led to an improvement of assessment and care
"Assessment Continuing Healthcare (CHC) nurses were disbanded and replaced by community nurses so the style and detail of the assessment deteriorated, provider managers were not happy with standards as couldn't make a decision on the care needed, eg psychological, behaviours etc so managers had a meeting with CCG hospital team to raise their concerns, the CHC nurses were reinstated and have selected assessors who are trained to do assessments and the quality in the paper work has been improved."

The staff said that there was a fast learning curve for Sovereign House since Pathway 3 started 18 months ago.

The offer of a pathway 3 bed at the home depends on the depth of the person's need. Sovereign House can provide catheter, peg feeding and end of life packages of care where they contact Macmillan for end of life care support advice and information.

We were advised that they have had to upskill the existing staff, both carers and nurses improved their abilities to work with people on Pathway 3. RMN RGN all do additional training courses in palliative care. Nurses are trained in depth syringe drive, catheter use, care planning and advanced care planning for palliative care across the board, and peg feeding.

3.4.3 Inter-agency working

The Local doctor for Sovereign House was according to manager is "available 24 hours a day" and is very resident oriented.

"[we] have a good rapport with Social workers can sort out problems quickly. Have developed a good relationship with Multi-Disciplinary Meeting/ way of working works well" [Sovereign House].

We observed a Multi Disciplinary Team meeting at Sovereign House and the manager of Pathway 3 was present. During the meeting the group went through the notes for each person and identified how the person had progressed and what

needed to happen for the future. The people involved in the meeting were focused, caring and diligent.

3.4.4 Feedback from residents

3.4.4.1 Quality of care

One person had been within the care home for 1-2 weeks one had been there in excess of 6 weeks and the third had completed the reablement time and was staying in the home on a longer-term package of care.

They had all arrived after a stay in hospital. Two were aware that they would be coming to the care home. All 3 had family support and for one their daughter was acting as interpreter.

All said they had been treated with dignity and respect.

Two were positive about their experience and one said *“I hate it I want to go home. I have to walk first. Only had physio once”*.

One had been involved in conversations about ongoing care and for one this was no longer relevant.

None had participated in activities.

One said that they did not like the *“noisy drugs room is downstairs they are always making noises at 5/6 am.”*

3.4.4.2 Issues related to care

Individuals might be eligible for free continence pads but they need an assessment for this from the Continence Team, this can cause delay whilst a referral is made. In between time families have to buy them which can be expensive.

Some people who don't have relatives are not able to provide a basic toiletry pack eg shampoo, toothpaste, soap, so the care home keeps a variety of packs they can choose from. This ensures the contents are personalised, as staff said they are unable to buy a large stock of items as people should bring their own toiletries in.

3.4.4.3 Assessing how ongoing care is to be funded

Undertaking assessment of how ongoing care needs are to be funded is an important part of pathway 3: discharge to assess.

If an individual meets criteria for having an ongoing health need their care may be funded by Continuing Healthcare money. Whereas if they have a social care need this may be funded by the local authority. Social care funding is means tested so individuals may need to meet all or some of their ongoing care costs themselves.

Coventry and Rugby CCG advised us that the City Council does not have any input with a patient until post discharge if the patient is not previously known to social services. This means that the social work team at the hospital do not take direct involvement.

Coventry City Council advised us that for those who enter pathway 3 from hospital discharge within 1-2 weeks of discharge a review of the pathway is begun. This involves a Continuing Healthcare funding assessment and notification to the local authority. The local authority should be present at the time of the CHC assessment so that they are aware of the individual and their support needs.

Coventry City Council said that for individuals who are placed in a residential care home for pathway 3 short term support or who are receiving this within their own home a Continuing Healthcare checklist is completed by a CHC nurse and the local authority is given 28 days' notice for an all age disability assessment to take place.

We asked Coventry and Rugby CCG what the process was for applying for Continuing Healthcare Funding for people who are on pathway 3. The process was described as: on day 10 after hospital discharge at the latest, a CHC nurse provides a 'Check List' (a preliminary pre-assessment process to indicate that person is eligible for assessment). They may go straight into the assessment process if the checklist is deemed to be positive at the judgement of the assessing nurse. Family members are invited to attend the assessment.

After a positive decision the patient is moved to a permanent placement as soon as it is identified thereafter.

If a negative checklist is the outcome on Day 10, then written notice is given to the patient (if they have capacity), next of kin/family carer, the provider, LA. The notice period is for 28 days for which the Coventry and Rugby CCG will continue to fund.

We asked how care would be funded if all assessments of needs aren't completed in 6 weeks. The CCG said this may happen where a patient lacks capacity or is not medically fit to continue, in these cases the CCG would continue to fund.

Care home staff raised concerns about their experiences of the process for determining ongoing funding and care saying that:

- Continuing Healthcare Assessments do not happen in a timely manner
- Communication was not effective
- Patients are not given information about where they are going for ongoing care

We were told that the content of letters patients receive giving the outcomes of CHC funding assessments were not clear.

We were also told that social care assessments don't begin until after a negative CHC decision raising issue regarding who will pay for care in the interim and worry for residents/families. Communication with social care was an issue.

3.4.4.4 Issues highlighted regarding pathway 3

- A) Concerns about the standard of information being received about the patient by the care home prior to their discharge from hospital, as this does not always reflect the needs of the person
- B) If an individual returns to hospital for more than 72 hours the whole process starts again
- C) There was not always a bed available for people when they were being discharged from their package, some people need to go elsewhere or families have had to pay for beds to be reserved
- D) Financial assessments are not always completed within the 6-week period leading to uncertainty and worry for individuals, families and sometimes providers about how beds would be kept available or funded after the 6-week period.
- E) Correspondence regarding CHC decision making was not clear enough in setting out what would happen next both if CHC funding was turned down and if it was accepted eg if a care home bed is required what process is used and where this might be or about the social care assessment process.
- F) It would be better if social care were involved in the CHC checklist process to ensure they had information about an individual's needs earlier.
- G) A need for flexibility regarding funding from Health and Social Care. Social Care don't directly take over funding for an individual and this can lead to them moving elsewhere, even if there is a bed available at this home and they want to stay.
- H) Some people are being placed out of area as there isn't local provision to meet their needs

3.5 Cross cutting themes & areas for development

3.5.1 Positive experiences

Overall the service met the needs of a lot of the people we spoke to. There was evidence of good work happening and many people acknowledging their appreciation for the service they received, as it gave them further time for recovery and regaining their confidence and skills.

3.5.2 Multi-disciplinary working

Meetings where the agencies involved in people's reablement packages came together are good ways to make decisions, to support people with their progress through to recovery and wellbeing, as well as starting to develop ways to improve sharing information and managing expectations.

Care home staff benefitted from the multi-disciplinary approach as there was evidence that this was providing framework for reablement care.

However, it was not clear to us how staff providing care in a person's own home and staff within Housing with Care schemes could benefit in the same way.

3.5.3 Problem solving and learning

We saw that there was evidence of learning and service development through what staff told us. For example, a manager said that to start with there had been a lot of inappropriate referrals to pathway 2 but now more referrals are appropriate and more identify rehabilitation goals.

Therapy staff said that they had raised that there was a need for more in-depth information at the point of referral and were confident this is being addressed though the input they have given on the therapy transfer form.

3.5.4 Communication

Information was not being received in a way that empowered people to be able to understand the process they were going through or possibly supporting realistic expectations of it. For example, some patients said they thought they are going home rather than to a care home bed.

A) Terminology

We found that one of the issues around reablement or discharge to assess is the language that is used. It is confusing that the whole programme is called Discharge to Assess and that this contains two reablement pathways and then a pathway 3 which is also called discharge to assess.

Staff start to abbreviate and refer to D2A or a pathway number or other older terms and names such as sort term care. Ordinary people cannot be expected to understand this and should not need to develop an understanding of this kind of terminology.

B) Awareness amongst patients

In all pathway's individuals were not sufficiently aware/informed of the care they would be getting.

Patient folders and goal setting was described but patients in all settings were not sufficiently aware of what these contained.

C) Information resources

We identified that a number of different organisations have responsibility for producing written information for patients/families. This includes (there are likely to be others too) the hospital (UHCW) which has leaflets to be given out as part of the discharge process; Coventry City Council which has produced a discharge to assess leaflet; and individual care homes as their specification includes lists of information to cover in written information. Sovereign House Care Home had developed its own information leaflet and business cards to be given out when visiting people in hospital to assess them as they were concerned that information was not being given out on wards.

Despite all of the effort by different agencies none of this information is accessible, in plain English or addressing the information needs of patients and family carers. Rather than several organisations producing information there is a need for a co-ordinated/combined approach to producing better quality information and for patients and family carers to input into this.

In addition, Housing with Care need to develop a welcome pack of information to go in the flats used for reablement pathway 2 because we had feedback that people did not know where they were or about the nature of the provision they had joined.

Individuals need more information about what items they need with them and support to obtain these if they don't have family members. For example in Housing with care people need household items.

3.5.5 Hospital discharge

Effective discharge into the pathways is very important to be able to meet the needs of individuals.

Staff raised concerns about the consistency, quality, and detail of the information received from the hospital at the point of referral saying that there might not be

enough information about clinical matters or sometimes important information related to equipment needs were missed.

Housing with Care staff commented that hospital staff including social workers don't know what Housing with Care is and think it is a care home and this leads to wrong assumptions.

There were issues in terms of the timings of discharge with some being timed late in the day.

Medication could also be an issue and we heard how one person's family had to return to the ward to fetch their medicine.

3.5.6 The pathways

Providers were concerned that the people being discharged to them were not always on the most appropriate pathway of care e.g. people with dementia or approaching end of life.

How the appropriateness of referrals is monitored so that learning can be made is not clear to us.

We received comments about and could see the pathways operated in quite rigidly and that this could make it difficult to address person centred needs as people might not fit in. We did not identify clear routes to move across pathways.

There is a focus in pathway 3 on which funding stream is to be used and on the funding assessment process. The focus should be broader than whether someone qualifies for Continuing Healthcare (CHC) funding as there is an opportunity to improve the health and wellbeing of individuals. People on pathway 3 may not get the opportunity for any therapy input, when it is possible that they could be supported through therapy input to not need residential care.

The rule in all pathways is that if a person returns to hospital, after 72 hours the process starts again and we spoke to one person who had experienced this.

3.5.7 End of life

We asked how end of life care fitted with these pathways and received a number of different responses. Some staff flagged up that people who were at end of the life were on the reablement pathways when they did not think they should be.

Our survey sample for people receiving pathway 1 reablement support in their own home was reduced from approximately 280 to 203 due to the number of people who had passed away. Whilst we were in Sovereign House, we were aware of one person who was at end of life. One person had been readmitted to hospital and discharged again on a reablement pathway and then died.

We are aware that end of life should not stop a person being on a reablement package, as everyone should be entitled to a time of recovery and to gain confidence and skills. However, there is an assessment and operational challenge and potentially a quality of care issue if a person's needs are increasing. The change in circumstances can also lead to difficulties with ongoing funding needs.

There are different definitions used by different agencies regarding end of life for example a 6-week period of end of life care and support provided in the last year of life. These must not act as a barrier to appropriate person-centred care.

3.5.8 Quality of care

We saw and heard about good quality care but also saw that some people were not getting enough reablement input.

Staff in housing with care schemes seemed under pressure and said it was difficult to fit in the reablement element of their work.

It was not clear the staff providing home support had enough time to provide reablement support. Some people receiving support in their own home indicated this was rushed and there was tendency for staff to do things for them rather than support them to do tasks.

Recruiting and retaining care staff in care home is a known issue and if a home was short of staff this impacted on reablement support.

3.5.9 Staff training to support reablement

Whilst it was widely recognised that the skills required to support people to regain skills are different from the other care roles the training available did not seem sufficient. One care home said that there was no additional training for carers supporting people on reablement pathways.

Those working in the community on pathway one providing support at home did not benefit from the same access to occupational and physiotherapists as workers and staff have in care homes.

Some of the people we interviewed indicated that they were not being encouraged by the people who provided support to do tasks for themselves, instead there was an overall feeling that for some people they were still being cared for, rather than encouraged to do things independently.

3.5.10 Therapy support

Some individuals and staff felt more therapy input would be beneficial.

Staff in Housing with Care described delays in the first Occupational Therapist visits and we found that 4 people had not seen an Occupational Therapist and had

been on the pathway for 2-4 weeks. Important 'Progress Sheets' were therefore also delayed and these should guide the input of the other staff.

There is need to review access to therapy for people on pathway 3 discharge to assess as Coventry City Council funded placements may have this and Coventry and Rugby CCG placements do not.

3.5.11 Reablement goals

Most people were unsure or unaware of their support plan or goals. Over 50% relied on their family members to keep up to date information and let them know what was going on through liaising with workers. This would be an issue for those who do not have relatives to do this.

Reablement should be person centred and it is important that individuals feel involved in their plan and goals.

3.5.12 Equipment

Not having equipment on time was highlighted as an issue by care homes and in Housing with Care. It can lead to delays in moving people or difficulties with looking after people safely and effectively.

We also identified an individual who did not have a simple piece of equipment to enable them to carry a drink from their kitchen. No one had picked this up and we were able to get their needs seen.

There was a storage issue when there was a delay in equipment which is no longer needed being collected.

3.5.13 Gathering feedback from service users

One of the reasons Healthwatch Coventry undertook this piece of work was that we couldn't see a clear mechanism for people who experience the pathways to feed back.

During the work we identified that Bablake House had a discharge feedback form that asked questions about what the person/family had enjoyed about their package, what could be improved and questions like have you met your goals? If a person is unable to write carers helped them to complete the form. It was unclear if other providers used the same form or something similar.

There is a need to ensure that people have routes to feedback more consistently across the provision and that ultimately patient reported outcomes should form part of the assessment of the effectiveness of the services and pathways.

Also, almost no individuals knew how to raise a complaint formally.

3.5.14 Timeliness in decision making about ongoing care

Transition between different pathways and to new care settings can be difficult for people, especially as one fund comes to an end and there is a need for financial/care assessment for eligibility to different forms of funding.

We received comments in all pathways about issues around the timeliness of decision making about ongoing care. There were suggestions that processes did not help and therefore there should be a review of processes and whether more joined up approaches to assessment across health and social care would be more effective and reduce delay.

3.5.15 Measuring outcomes

We asked in multiple places how outcomes for individuals were identified, recorded, analysed and measured.

We heard anecdotal feedback and impressions from staff about how successful the programmes were, but collated information about the success or otherwise of the reablement pathways was not evident to us. This means that information cannot be fed back to the care homes and providers.

Multi-disciplinary staff talked about data being collected and spreadsheet being in use. A care home manager reflected that they do not get feedback on what happened beyond discharge from the care home.

A suite of information should be available for service development at service level and strategically because:

- To look at people's outcomes through the pathways can help to support and enable the development of good practice across providers.
- To look at outcomes at a strategic level helps commissioners to see if what they are commissioning is working and what should be commissioned in the future. It will also identify what other conversations need to take place to further develop practice across the range of organisation that are involved.

We were told that Coventry City Council was developing work on outcome tracking and currently focused on tracking the following outcomes:

- People who no longer need a service
- Reduced ongoing packages of care
- Those who go on to have residential care

They were not currently looking at things such as readmission to hospital rates following reablement support.

Coventry and Rugby CCG spoke of their own tracking mechanisms.

Therefore, outcomes measuring is following contractual lines rather than being viewed across the discharge to assess programme and there is a lack of information to inform broader strategic discussions.

3.5.16 Leadership and accountability

We saw that reporting lines for this work go upwards through Coventry City Council and Coventry and Rugby CCG as two separate commissioning lines. Therefore, decision making sits within each organisation.

New approaches are tried for example the trial of night carers in home support but it is unclear how strategic decision making across the care system for such changes takes place.

Managers told us that the Joint Commissioning Board has an oversight role and that a joint strategy group had been created with membership from the City Council and Coventry and Rugby CCG. This is positive and there is an opportunity to clarify lines of shared accountability and delegated responsibilities.

3.5.17 Avoiding hospital visits/stays

These pathways were pulled together as a solution for delayed transfers of care from hospital and in some respects bring together different programmes which have existed for some time under one banner.

Almost all of our sample had accessed the pathways from hospital.

There is an important strategic agenda of avoiding admissions to hospital in the first place and a number of work streams are being taken forward locally. Therefore, it is time to consider how the discharge to assess pathways can support these pieces of work and how people can access 'step up' short term support without having to go to A&E or be admitted to hospital. Linkages with other areas of work such as the out of hospital programme being led by Coventry and Warwickshire Partnership Trust (in Coventry) are needed.

4. Conclusion

This report presents the experiences of 47 people and enables the reader to hear their voices, feelings and views about the care they received. The people we spoke to were some of the frailest and most vulnerable, who sometimes do not have their voice heard. A considerable amount of time has been spent by Healthwatch staff and volunteers gathering in depth information.

At times we found it hard as lay people to understand the pathways, how they worked and if/how they joined together. As we found this difficult, those who use the services are also likely to find it hard to understand the pathways.

There is good work to build on to support more people to regain skills and confidence so that people can live independently wherever possible.

We see opportunities to think further about these pathways and how they can become more flexible and person centred and also how they can help support boarder local health and social care aims to provide more care and support in the community and avoid admissions to hospital. At the moment, these pathways are largely designed to be accessed after admission to hospital rather than through other referral routes.

We heard that individuals do not necessarily fit within the defined approaches the pathways provide. Whilst the intention is for person centred care, we saw pathways that can be too transactional in approach to always achieve this and the reflections we obtained about communication and setting person centred goals highlighted that there is work to do.

We heard about the benefits of multi-agency team working, but identified challenges regarding communication at point of referral from hospital.

We heard about limitations in the amount of therapy provision and care staff training.

We saw evidence of learning and development of approaches but there is a lack of information and tracking of outcomes to inform practice and strategy.

The experience of being in a care facility for a short stay can be difficult, especially when people are unsure of what is happening. The information resources and communication described to us do not currently enable people to receive information to empower them.

The detail of the report provides many suggestions of things, which can be done to improve the quality of approaches and care experiences based on what people told us and of course highlights what people felt worked positively. Our recommendations are addressed across organisations.

5. Recommendations

Based on our findings Healthwatch makes the following recommendations to be addressed by providers of care services and therapy services, Coventry City Council and Coventry and Rugby Clinical Commissioning Group.

Communication

1. Improve information and communication with patients by reviewing how the pathways are described and co-ordinating joint work across organisations to produce accessible and use friendly information resources. Involve patients/service users in the design of this and ensure that good practice in plain English and design are used.

Produce welcome information for people moving into Housing with Care, pathway 2.

Referral at hospital discharge

2. Review referral practice at hospital discharge using input from discharge to assess pathway staff and providers to address issues with quality and flow of information and understanding of the types of accommodation people are being discharged to.

Staff training

3. Address the variation in training of staff by developing a training programme for staff working in different providers to standardise training regarding the reablement element/skills of the work.

Capacity/delivery

4. Address factors including staffing levels/availability, delays in access to therapy input and communication which impact on the available time care staff have to carry out their reablement care role. Care staff who are rushing cannot carry this role out effectively.
5. Address issues with collection of equipment and delays in getting equipment.
6. Address issues highlighted regarding Housing with Care offer: care environment, staff time for reablement support and therapy input delays.

Ongoing care decision making

7. Review processes for assessing and agreeing ongoing care needs to improve decision making times to ensure people can move on to future care arrangements when they are ready.

Patient/carer input

8. Further develop the culture of person centred care/support and the involvement of individuals in the development of their goals

9. Develop better ways for patient/user feedback to be routinely collected and used as part of quality processes. Create a programme of work to introduce patient/family carer reported outcomes.

Strategic Accountability

10. Clarify lines of joint accountability and joint strategy across health and social care regarding all discharge to assess work/pathways.

Tracking outcomes

11. Develop the ways in which outcomes for individuals and the pathways are tracked to inform decisions relating to effectiveness and service development.

Undertake co-ordinated work to identify outcomes tracking measures/processes across City Council and CRCCG.

Establish a clear feedback route to care homes, housing with care and home support care providers' for information about the outcomes for the people they have cared for so that they can see success and learn.

12. Produce transparent outcomes data which can be used in other health and social care system discussions. This should cover:
 - How many people return home or go on to other care settings
 - Readmission to hospital rates - specifically for people entering pathways 1,2 and 3 from hospital
 - Length of time people actually spent in discharge to assess funded beds/home support

Review

13. Review the programme to see where a more flexible and person centred approach can be introduced to pathways. Included a review of:
 - access to therapy provision in all pathways and consider how therapy provision can be more equitable in pathway 3
 - where the needs of people approaching end of life are best met and what part these pathways should play.
14. Look at “step-up” and “step down” support for individuals by linking to reablement pathways to support the aim of reducing admissions to hospital. Individuals who become unwell will benefit from direct access to such support from within the community.

6. Response

We met with managers from Coventry City Council and Coventry and Rugby Clinical Commissioning Group to discuss our findings. The following action plan was Co-ordinated across Coventry City Council and Coventry and Rugby CCG by Jon Reading the Chair of a Joint Strategy Group. We continue to have conversations about actions and mechanisms to take work forward.

Healthwatch recommendation	Agreed Actions in response to Healthwatch recommendations	Owner	Review date
1. Communication	<ul style="list-style-type: none"> a. Document what written information is available for patients and families in respect of D2A pathways b. Review communication material to ensure it is written in user friendly way c. Review information to ensure that people are clear about what items they need to supply when accessing housing with care for a short period d. Ensure the distribution of information about short term housing with care to hospital staff e. Review communications material in relation to “End of Life Care” 	Kerrie Manning	August 2019
2. Improve personalised approaches	<ul style="list-style-type: none"> a. Ensure appropriate therapist input for people discharged via pathway 3 b. Develop pathway 3 at home option to ensure a home based offer in addition to residential and nursing 	Jon Reading/Marie West Tracey Rabin/Rae Bottrill /Jason Bejai	July 2019 July 2019

3. Quality of Reablement	a. Review and ensure appropriate training of care staff in reablement approaches	Jason Bejai/Cathi Sacco	October 2019
	b. Review and recommission pathway 2 care home and housing with care provision.	Cathi Sacco/Lisa Taylor	March 2020
	c. Consider focusing Housing with Care reablement in fewer facilities	Cathi Sacco	March 2020
	d. Optimise use of dedicated staff teams for reablement	Jason Bejai	July 2019
4. Therapy support.	a. Complete Therapy review and implement arrangements	Marie West/Jon Reading	November 2019
5. Quality of service delivery	a. Run developmental sessions for providers to: <ul style="list-style-type: none"> • Explore good practice and support peer to peer learning e.g. regarding organising care, communicating with service users and other suggestions highlighted in this report. • Jointly address/discuss sector issues e.g. recruitment and retention etc. • Share knowledge on legislative changes or changes in service requirements 	Jason Bejai Cathi Sacco Jeanette Hudson	Ongoing

7. Acknowledgements

Our thanks to Coventry City Council for helping us to contact people receiving support through their systems, Coventry City Council Adult Social Care Team, Coventry and Rugby CCG and thanks to managers and staff of providers of reablement Home Care services.

8. Copyright

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9. Appendices

Appendix 1: Discharge to assess pathways

Pathway 1	Pathway 2	Pathway 3
Home with short term package of care - with or without therapy input	Therapy based bedded units in care homes and Housing with Care with the aim to return home	Period of assessment to determine long term needs
<p>Home based support for up to 6 weeks which includes goals based enablement: washing, dressing, meal preparation</p> <p>In addition, therapy based support to improve mobility and transfers to regain independence</p> <p>Telecare: standard packages</p> <p><i>Social care gate keep access to provision</i></p>	<p>Bed based support for up to 6 weeks to regain independence which includes goal based enablement: washing, dressing, meal preparation</p> <p>This pathway is also for patients where safety between calls and overnight needs are to be considered.</p> <p>In addition, therapy based support to improve mobility and transfers, to regain independence</p> <p><i>Social care gate keep access to provision</i></p>	<p>Patients that require a period of assessment outside of an acute (hospital) setting to determine their long term care needs</p> <p>Options are</p> <ul style="list-style-type: none"> • Home (oxygen) • Residential home • Nursing home • Community Neurological Rehabilitation team <p><i>Provider access and management by CCG</i></p>
Case manager: Integrated Discharge team/REACT Team/social care	Case manager: Integrated Discharge team/REACT Team/social care	Case manager: Integrated Discharge team/social care with CCG

Appendix 2: Interview questions for care home managers

1. Approximately how many people receive discharge to assess and reablement services from your care home under the City Council/CCG contract?
2. Talk us through what happens when you receive a reablement referral - what are the steps to getting the person here?
 - How much notice do you get? What information do you get; what preparations are made?
3. What works well and what could change about receiving new people onto the reablement pathway?
4. How have you organised staffing to provide reablement support care?
5. What training and support is provided for people who are employed as reablement/care workers in the home? (discharge to assess and reablement)
6. Tell us what sort of things your staff do to support people receiving reablement packages: the sort of day to day activities.
7. How are goals or outcomes set for people receiving reablement support? What part do your staff play in this? (discharge to assess and reablement)
8. How does communication work between different agencies involved in supporting people with reablement and planning their ongoing care?
9. How well does the process of re-assessment of individual's needs work?
10. To what extent do you think that people on the reablement pathway achieves reablement and are able to go home?

SECTION 2: DISCHARGE TO ASSESS (IF RELEVANT)

11. Talk us through the referral process for **discharge to assess** patient to you
 - How much notice do you get? What information do you get; what preparations are made?
12. How have you organised staffing to support care for these patients?
13. What training and support is provided for staff?
14. How well does communication work?

15. What happens or those awaiting further residential care packages?
16. What works well and what could change about receiving and supporting people on this pathway?

OVERALL

17. (a) How does your care home gather feedback from the people it provides these services for?
(b) What do you do with the feedback?
18. Any other comments or relevant information for us?

Appendix 3: Guided interviews for patients receiving reablement care in a care home

HOW YOU GOT TO BE CARED FOR HERE?

1. How long have you been here in this care home?
2. Did you come here from hospital?

If yes how long were you in hospital and which ward were you on?
If no where were you before?
3. How did you find out you would be coming to this care home? What information were you given about what would be happening beforehand?
4. Was there anything else that you would have liked to have known?

YOUR SUPPORT

5. Have you been involved in setting goals for your reablement: these are things you want to be able to do?
6. Do you have a reablement support plan - (have you seen it)?
7. Have your family or friends been involved in your reablement plan if you want them to be?
8. What support have you received from therapy staff whilst you have been here - and how often is this?
9. Have you seen any medical people: What did they do for you?

COMMUNICATION

10. Throughout your time here what information has been given to you and who by?
11. Has information been given to you in a way you like and can understand?

12. Who would you contact here if you have a question about your care?
Is there a co-ordinator for your care? If yes who is this?

13. If you had a complaint to make, how would you raise this?

GETTING READY FOR DISCHARGE FROM HERE

14. Have you been involved in any conversations about what support you may need once you leave here?

15. Do you know when you will be discharged from here?

16. What needs to happen in preparation?

ENVIRONMENT IN THIS HOME

15. Have you been treated with dignity and respect whilst you have been here?

16. Have you taken part in any activities organised in the home?

17. What do you think of the food?

OVERALL

18. How would you describe your experience of reablement support?

19. What were the best things about it?

20. What could have been better?

Appendix 4: Self-completion survey: reablement in the home environment

1. First part of your post code

2. Are you the person receiving services?

A. I receive reablement support,	<input type="checkbox"/>
B. My friend/relative receives reablement support	<input type="checkbox"/>

3. How long has reablement support been received?

Less than one week
One - two weeks
Three- four weeks

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

Five to six weeks
Over six weeks
Other (please say below)

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

Identifying needs

4. Was reablement support provided after a stay in hospital?

Yes No Don't know

5. If you were discharged from hospital how well informed did you feel about what would happen after you were discharged?

Not informed A bit informed Very informed Not applicable

6. How quickly after being assessed or discharged from hospital did reablement services start?

Within one day		Within 4 days	
Within two days		Within 5 days	
Within three days		Within 6 days	

Other please say

7. If you, your relative are at home, what is the name of the reablement provider?

Accord	
Radis	

Sevacare	
Other please say	

7a. If you/ your relative is being cared for in a care home or housing with care/supported living unit which one is this?

Supported Living	Ribbon Court	
Housing with care	Eric Williams House	
	Knightlow Lodge	
	Harry Caplan Lodge	
	Elsie Jones	
	Cottage Farm Lodge	
	Quinton Lodge	
	Copthorne Lodge	
Other Please say		

8. Who else is involved in providing the reablement help?

Occupational therapist		Nurse therapist	
Physiotherapist		Care navigator/broker	
District nurse		Visits from GP	
Other please say			

9. What are they helping with? Tick All that apply

Personal care (eg taking a bath or getting dressed)	
Getting up in the morning or going to bed at night	
Improving your mobility in the house	
Improving your mobility outside of the house	
Supporting you to prepare meals	

Getting to social activities	
Other - please say what	

Communication

	Very	Partly	Not	Don't know
10. How involved do you feel in decisions about care?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. How involved were you in setting goals for things you wanted to do?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

12. Is there anything you would like to be different about how you received information and gave your views?

13. Do you know who to contact if you have a question about your support?

Yes No Don't know

14. Do you know who to talk to if you have a concern or complaint?

Yes No Don't know

15. Overall how would you rate communication about your support?

Excellent Good Okay Not good

16. Did you receive information about other services, including having an advocate?

Yes No Don't know

17. Do you have an advocate - someone who represents you?

Yes No Don't know

18. How useful is your advocate?

Excellent Good Okay Not very

19. Do you agree or disagree with the following statements?

	Strongly Agree	Agree	Disagree	Strongly disagree	Don't know
The people supporting me show me respect	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

The people supporting me understand their role	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The people supporting me keep records of what they do	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The people supporting me are well trained for their role	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The people working with me give me the right amount of time to help me meet my goals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Support from therapists, district nurses, GP etc

20. Do you see medical/therapy staff often enough?

Yes No Not sure Not applicable

21. Are they helping you to meet your goals?

Yes No Not sure Not applicable

Your comments about therapy or medical support
--

Equipment/adaptations

22. Do you have equipment and or home adaptations as part of your support?

No I don't need any	<input type="checkbox"/>
No I am still waiting to get it	<input type="checkbox"/>
Yes, I have had some of the things I should have received	<input type="checkbox"/>
Yes I have received everything	<input type="checkbox"/>

23. How much difference do the adaptations or equipment make to you?

None A small amount A lot of difference Not applicable

24. Is there anything else that would help?

--

Overall

25. How well do you think the different services work together to meet your needs/goals
 Very well Good Okay Poor Very poor



<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------	--------------------------	--------------------------	--------------------------

Please explain your rating

26. Have you been involved in any conversations about what happens after the 6 weeks are over?

Yes No Not sure

27. Have you received (please tick)

Information about what happens including if you need ongoing support	
Information about other types of support available from other organisations eg community and voluntary groups	
Information about how to get more help if you need it in the future	

28. What have been the best bits of your reablement support?

29. Can you suggest any ways your care could be improved - please say how?

About you (so that we can give details of our survey sample)

What ethnic group would you say you are from?

Your Gender Male Female Transgender

Please indicate you age

Do you consider yourself to be disabled? Yes No

Thank you for taking the time to complete our survey -
We really appreciate it

Appendix 5 Guided interview for reablement support in the home

Date	
Name of Authorised Rep	
Ref No.	

About your care

1. How did you get to be receiving reablement support? What happened?

2. *Questions for those discharged from hospital only*

a) What information were you given before discharge?

b) What discussions took place with you and who was involved in this?

c) Was care/reablement package in place for when you were discharged?

d) Was an assessment carried out when you returned home, and by whom?

3. What support are you receiving in your home?

Personal care (eg taking a bath or getting dressed)	
Getting up in the morning or going to bed at night	
Improving your mobility in the house	
Improving your mobility outside of the house	
Supporting you to prepare meals	
Getting to social activities	
Other - please say what	

4. And who do you get support from?

Accord	
Radis	

Sevacare	
Other please say	

5. How long have you been receiving this? When did it start?
How long did it take to get the support in place?

Setting goals

6. What matters to you in your day to day life that you would like to be able to do?
7. To what extent have you been involved in setting goals or aims of things that you would like to be able to do yourself?
8. Have you seen a copy of your goals (what you want to achieve with the support being provided)

Yes No Don't know

Communication

9. What information has been given and who has been providing you with information?
10. Has information been given to you in a way that you like and can understand?
11. Have your family and friends been informed or involved in your reablement plan (if you want them to be?)
- Yes No Don't know
12. Do you have an independent advocate helping you?
If YES what do they do for you? How do they help? Do you find them useful?
13. Do you know who to contact if you have a question about your care or if something has not happened as it should? *(NB reablement has a window of 2 hours to carry out task - because ad hoc and short term)*

14. How would you raise a complaint if you needed to?

Quality of support

15. *Thinking about the help that [Accord, Radis or Sevacare] give you.*

16a) Are your carer helping you to build your ability to do day to day tasks?

- Do they have enough time when they visit you to provide the support you need?
- Are they reliable?
- Do they have the right skills?
- Do they treat you with respect?

16. *Thinking about the support you get from therapists, district nurses and your GP.*

16a) Are they helping you to get stronger and be able to do the things that are important to you? Tell us more about this.....

16b) Do they have enough time when they visit you to provide the support you need? (Please explain)

17. Do you have equipment and or home adaptations as part of your support?

If yes is this helping you? If not why not?

18. Is there a co-ordinator for your care? If yes who is this?

Future support

19. Have you been involved in any conversations about what support is needed after the 6 weeks are over?

Prompts: who with; is this as you would want?

Overall

20. Have you got any suggestions for reablement services?

Equal opportunities monitoring information

What ethnic group would you say you are from?

Your Gender Male Female Transgender

Please indicate you age

Do you consider yourself to be disabled? Yes No

Healthwatch Coventry
27-29 Trinity Street
Coventry
CV1 1FJ
024 7622 0381
Email: healthwatch@vacoventry.org.uk
www.healthwatchcoventry.co.uk

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