



Back on Track 2

More users' experiences of Buckinghamshire Council's Reablement Service

September 2021



What was the project about?

Buckinghamshire County Council (now Buckinghamshire Council) asked us to get more feedback from people who use their Reablement Service. We compared this to the [Intermediate care including reablement](#) NICE guideline (NG74).

We asked service users:

- how they were referred to the service
- if they were told about how the service could help them
- how involved they felt in the planning of their care
- if they thought the service met their needs
- how they felt when their support came to an end
- what they thought of the service.

We also heard feedback on other services.

Why did we do the project?

One of our priorities is adult social care. In January 2019 we published a [report](#) about the experiences of people using the Council's Reablement service and the Buckinghamshire Healthcare NHS Trust's Rapid Response and Intermediate Care service. We also did a [follow up report](#). In this project we talked to more people about their experiences of the Council's Reablement service.

What did we do?

We talked to service users or a relative over the telephone. The Reablement team at the Council obtained permission from service users for us to contact them. We had planned to visit people in their homes in March but as a precaution we switched to telephone interviews. This means we haven't compared the findings with those from the first project because the feedback was gathered in a different way.

We used a set of questions to prompt an in-depth conversation. This meant we didn't ask everyone each question. The questions were like those used in the January 2019 project.

More details about how we delivered this project are in Appendix 1.

We have grouped some views by theme rather than under the question when a comment was made. This reduces duplication and gives a clearer picture of the key issues raised. The full set of questions is at Appendix 2.

What did we find?

The feedback in this report relates to experiences of the service before the coronavirus (COVID-19) outbreak.

Who did we speak to?

We talked to 12 people during March 2020. Of those we asked, most had finished using the service between one and two months beforehand. For one, the service was just about to stop.

We have used the term ‘carers’ when summarising the feedback. We understand, however, that those who support service users under the reablement service are known as reablement workers.

A summary of those we spoke to is below.

- We had conversations with eight separate people (six service users and two relatives). Two interviews were with both the service user and a relative.
- We spoke to six men and six women.
- People were in the following age ranges: 46-55 (two people), 66-75 (four people), 76-85 (four people), 86+ (two people).
- We spoke to eleven people who described their ethnicity as ‘White British’ and one said they were ‘White Other’.
- Eight people that had been referred to the service following a stay in hospital (two from Wexham Park Hospital, two from Wycombe Hospital, two from Stoke Mandeville Hospital, one from Amersham Hospital after being in Stoke Mandeville and the other from a care home having been moved from A&E at Stoke Mandeville). One said they were referred by their GP.

Entry to the service

‘When planning the person’s intermediate care: assess and promote the person’s ability to self-manage, tell the person what will be involved, be aware that the person needs to give consent for their information to be shared, tell the person that intermediate care is a short-term service and explain what is likely to happen afterwards’ (NICE recommendation 1.5.7)

‘Ensure that an intermediate care diary (or record) is completed and kept with the person... who should be encouraged to read and contribute to it...’ (NICE recommendation 1.6.5)

Information

Most of the people we spoke to said they were clear about the help that they would be getting. They seemed to get the information at their initial assessment on the day (or soon after) they came out of hospital.

Some additional comments included the following.

- + One person said the information was very detailed and that the assessment visit took two hours on the day they came out of hospital.
- + Two people said they weren't sure when the service became involved. One explained that the first person to visit (the day after discharge) was an Occupational Therapist (OT). They weren't sure whether they were from the hospital or part of the service. The other said they weren't sure when the service got involved because the OT did a home assessment before discharge and decided on equipment.
- + Two mentioned still having the 'blue book' containing information about their care. We understand this should have been taken back at the end of the support.
- + Two people felt there wasn't really any explanation [of the service] and another two said they didn't have a leaflet.
- + One relative said the only information they had was that the service user would be discharged.

Equipment and exercises

A few people told us they already had the equipment they needed, and others said they had been provided with equipment. Two said equipment had been ordered by the hospital or they had been assessed by the hospital before discharge. One thought the GP had arranged the equipment to be provided. One person had been given exercises and another said that equipment wasn't needed.

A couple of specific concerns were mentioned.

- + A relative said the equipment wasn't discussed with them. It was just delivered or the team turned up. However, six weeks after discharge some equipment still hadn't arrived and this meant the service user was sleeping in a chair. They later said they had raised this issue twice with district nurse and the reablement team. They said it had been ordered but they don't have any control over when it is delivered.
- + One service user had the equipment but was still waiting for the help to use it.

What would happen next

Two people said they were clear what would happen next. Another two said that they knew how many visits to expect, or when the carers would be coming and two others said "not really".

A relative added that the initial explanation by the OT was well done. They were given a list of contacts and how it would work. They noted that the OT visits dropped off quickly (from twice a week) to short sessions less frequently. They wondered if that was because the resource was stretched in the county at that time.

Use of the service

Ensure that the person using intermediate care and their family and carers know who to speak to if they have questions or concerns about the service, and how to contact them (NICE recommendation 1.1.4)

Offer the person the information they need to make decisions about their care and support, and to get the most out of the intermediate care service. Offer this information in a range of accessible formats (NICE recommendation 1.1.5)

Initial assessment

When we asked if people knew what the service was for, what it would do and what it would not provide there was a mixed response.

A few (three) said they knew what the service would provide, though two didn't know what it wouldn't provide. Another person said someone had talked to them about what care was needed and they had chosen to have two visits even though three had been offered.

Two people said they didn't really know. One relative mentioned that nothing was known before discharge. They had chased because they were aware that sometimes "things get lost in translation".

Involvement of service user (family and/or carers) in planning support

We heard a range of feedback to this question.

One positive comment was that the staff discussed [the support] with them. They said that they have been offered choices, but some weren't wanted.

Others gave more mixed feedback.

- + One service user and their relative said they felt they were involved in the process. The service user said they felt ignored during the first visit by one of the assessors because they only spoke to the relative. Another assessor wasn't very sympathetic.
- + One person said, when they came out of hospital, someone sat down with them and discussed what was going to happen, but they couldn't remember being involved much with the decisions made.
- + A relative said they didn't have any contact with the team and were just told what was happening by the OT/hospital. [Note: we spoke to them just before the service was due to end and they were expecting a call].
- + Another relative said they really only knew what the carers and OT would be doing during their visits but that the goals weren't clear at the start and that more could have been done earlier to set these.

We asked a couple of people whether they were clear about what they needed to do to make the most of the support. One service user said they were asked. Their relative was expecting a plan. The assessor doing the midpoint review explained that help to prepare a meal was part of the service. The 'blue book' was updated but the relative didn't know that was part of the service until then. They also wondered why washing up wasn't included as well.

Other organisations that could help provide support

During service support

Six people said they hadn't been told about any other organisations that could give them support them while they were receiving the service. People added that they:

- knew other services were available but not free
- had leaflets from the Stroke Association
- had had good support and nothing else was needed at the moment.

After support had finished

Three people mentioned who they'd contact, said they had other support or that they had information. However, three others, who had finished the service, didn't seem to have been given information about other organisations that could support them.

One who said "no" added that it would be handy but it didn't worry them.

One person mentioned a stroke leaflet while another said that they weren't given information about a local stroke group. They said the hospital hadn't passed this information on either.

How the service handled and responded to worries/concerns/questions and how people felt they were treated

We heard feedback about the service in response to several questions. For clarity, we've summarised all the comments in this section.

Overall, almost everyone had positive things to say about their carers. A few said they didn't have any issues, had no worries or concerns, or just accepted it.

A couple of people described the carers as very nice. Another said they were nice people and sometimes apologised for coming late.

Other positive comments we heard included:

- + The service user looked forward to the carers visiting as they were on their own.
- + The carers were very helpful and answered any questions.
- + They took time out and they really cared. They didn't just come in and rush me.
- + Very kindly and [treated them] with respect. The service user said the carers encouraged them to be independent (for example by helping them to work out together how to get dressed). They thought it must have been frustrating for them and must have wanted to help.
- + Thought they were excellent. This person said that over five weeks 10 different carers came in and all were excellent.
- + One said the carers made them "feel at ease". Once out of hospital couldn't fault the carers.
- + One service user felt the carers were time pressured but very good.
- + The carers were very good. All were professional but one wasn't "warm and friendly".

Some comments about other issues are below.

- + One issue (that happened twice in the evening) was that the service user wanted a wash and to clean their teeth but the carers said they just had to go to bed. One carer said they'd never helped someone have a shower before. The relative felt the carers were rushed and under time pressure.

- + Another comment was that someone felt the main job of the assessors was to get the service user off the books. They had the feeling that other people needed their support more than they did.
- + One service user told us about an occasion when they had been upset by a visit from the assessor.

Two relatives had specific comments about the service not responding to a concern.

- + One had been told carers would wear protective covers on their shoes but this never happened. [The service coincided with a very wet and muddy time]. They rang Aylesbury to ask (because the offer had been made) but no action was taken. They also said that they never saw a carer wash their hands entering or leaving the house (though they recognised they could be using hand sanitiser in their car) whereas the GP did.

Understanding of the service

'...Explain clearly: that intermediate care is designed to support them to live more independently, achieve their own goals and have a better quality of life...'(NICE recommendation 1.5.1)

'... give their family and carers: information about the service's aims, how it works and the support it will and will not provide ; information about resources in the local community that can support them; opportunities to express their wishes and preferences, alongside those of the person using the service; opportunities to ask questions about the service and what it involves' (NICE recommendation 1.5.2)

Satisfaction with the service

We heard some really positive feedback about the service. Two people said they were “Very satisfied” and another that they were happy (other than two issues mentioned elsewhere).

Some of the other comments we heard are set out below.

- + One person said that it was an excellent service but highlighted timing (see below).
- + Another said they were satisfied and they had begun to do more for themselves. They explained that they felt insecure with the equipment but the carers had helped them.
- + The carers didn't have a lot to do (because of the timing of visits - mentioned below).
- + One person said that, within the constraints, they would rather have had the service than not. They would have appreciated more OT but the biggest issue was timing.
- + Another view was that the service had enabled the service user's partner to provide support and it worked much better than them doing everything independently again. They added that people never turned up on time and the reablement team manager wanted to cut back visits.

“We felt enabled to run the household again.’Reabled’ us as a couple but didn't ‘reable’ [the service user].”

How the service met needs

Five people said that the service met their needs or had positive things to say about it.

Other comments that we heard are summarised below.

- + The service user could do what had been planned and the service was stopped at the earliest opportunity.
- + One person said that the carers had asked for one hour but were given 45 mins (even though they were already taking longer than that).
- + As the service was coming to an end, the visits were gradually cut down to one a day. They said that the aim was to live self-sufficiently (ie making a cup of tea, microwave a meal etc.) They added that they weren't paying for the service but, if they were, they would have wanted them to come earlier.

Areas where the service didn't meet needs

Timing

One main concern raised in response to different questions was about the variable timing of visits. For ease, these are all summarised here. This was raised as an issue by four people and mentioned by a further two. One of the latter said the carers came at different times of the day (sometimes early or late) but it didn't bother them.

“At first they came at 7ish but after a while it was 9.45 - too late so I was waiting a long time.”

Some comments are set out below to illustrate the issues created by variable visit times.

- + One said the main problem was the timing of the morning visits. The early morning carers sometimes came as late as 11.20-11.30. Then the lunchtime visit would be much too soon afterwards (11.45-12.15). The relative said that the timings on weekdays was generally fine but it was weekends when it was a big problem. When the service user commented on this to carers, they were told they were "too busy".

“Sometimes it was a waste of time because it was too late.”

- + Other said they never knew when the carers were coming. For example, they had to get up early to have a shower in case the carers came early or didn't know when to have tea to avoid the time they were coming.
- + Another view was that carers didn't have a lot to do. The person explained that they had carers to get them up in the morning. However sometimes the carers didn't turn up until 10-10.30 by which time the service user had already got themselves up. Also, in the evening the carer came at about 8pm to help the service user get ready for bed. However, they then came back into the living room to watch TV because they didn't want to go to bed so early.
- + One person said they understood that a service user had to accept the slot they're given because others have priority. In this case the service user had to go to bed by 8pm but sometimes the relative had to do what's necessary because the carer arrived later. They noted that the service did address the issue after it was raised. They also said that the timing of visits was totally random, both in the morning and the afternoon, and consistent scheduling would help.

Other areas

Other comments we heard are below.

- + One person said that they couldn't think of anything more that the service could have offered or should have offered.
- + Another said it took four days for anyone to get the service user downstairs. They thought perhaps in the first few days the carers believed the service user wasn't able to but when the carer followed the book (on day four) it got simpler.

People generally didn't highlight any specific gaps when we asked what the service didn't provide that people thought it would.

- + One service user agreed with the decision to stop the late afternoon/early evening visit after three weeks because it overlapped with other carers coming in.
- + Another service user said the carers had helped by suggesting a way to help them dress independently (even though in the end a solution wasn't found)
- + A relative said that they wanted more reassurance about the transition from hospital to home and for there to be better communication in the hospital setting. They wanted to know that everything was in place. They described the feeling as like stepping onto a bridge but without being able to see the other side.

Leaving the Service/Support

'...There should be a clear plan for when people transfer between services, or when the intermediate care service ends. This should: be documented and agreed with the person and their family or carer, include contact details for the service, include a contingency plan should anything go wrong...' (NICE recommendation 1.7.2).

Give people information about other sources of support available at the end of intermediate care, including support for carers' (NICE recommendation 1.7.3)

When we asked how people felt when the support finished, we heard a mix of views.

Three service users said they were happy or relieved (the latter for the wrong reason) when the service came to an end. Those who said they were happy said:

- it was because it meant they didn't need the support.
- they were pleased with what they achieved.

Another said it was "fine" because they were better and the visits had reduced by then anyway.

One service user said they were:

| "...sad when the support finished. They were fantastic."

Some people said they had concerns or mentioned issues that had arisen. For example:

- there had been a lack of communication between carers from different services. This meant that the new [long-term] carers didn't get any feedback from the reablement service carers.
- the end of the service felt too abrupt. They just had a phone call to say that there would be no more visits. They suggested a conversation about what support was needed to be put in place going forward would be helpful.
- a relative said the service user felt they needed two extra weeks help at lunchtime.
- the support just petered out because by the time the service finished (after eight weeks) they just needed one visit a day instead of four. They would phone to say they didn't need help that day (for the last 10 days).

Did the service help people achieve what they wanted

Many people had positive views about what the service had helped them to achieve and that the needs outlined at the beginning were met.

- + One service user said that the service allowed them to get out of hospital. That was what they wanted because they preferred to be at home than in a hospital bed.
- + One said reablement didn't get the service user into any better state but really helped their relative in between carers.
- + Another felt that there wasn't any more the carers could do so they both agreed to end the service.
- + One relative felt people needed more help to get used to the 'new normal'. They commented that, at the moment, it feels like falling off a cliff when the service ends.

No one mentioned anything else that they would like to have been told at the beginning. One person commented that they would say to someone starting to use the service that they need to understand the limitations, be proactive and be prepared to help (eg make sure family members are around or other carers). They felt the service as it stands can't really help people in the way it wants to.

Contacts for worries/concerns/questions in the future

One person said they knew who to contact if help was needed. Another would contact their current carers. One service user and their relative mentioned that the 'blue book' has day-and night contact numbers but this was taken away when the service finished. They mentioned they had phoned the contact number once and couldn't get through.

Reflections - Is there anything you thought was particularly good or bad about your experience/the service?

Six people had further positive feedback about the service or said that they hadn't had any bad experiences. People made comments such as:

- happy with the daily visits
- the service didn't stop until other carers were in place. The service was excellent
- the carers supported independence and were encouraging
- carers were marvellous - would recommend them. They provided reassurance.

Four people mentioned some negative aspects. This included comments about the timing of visits, that one hadn't had an OT despite requests and that the service needed to be more personalised. It was suggested that a key set of core services should be provided.

What people would like to be done differently if using the service again?

Two people gave further general positive feedback about the carers. One added that they were:

| "...very lucky to have all the care when I came out of hospital."

Other comments are summarised below.

- + Carers were not able to keep to the timetable and rescheduled.
- + People recognised that the carers were under pressure.
- + One also mentioned that the assessors were also under pressure themselves but got the impression that they were interested in getting service users "off their books".

Two people suggested how visits might be better scheduled. These were:

- + could the carer ring in advance to let the service user know when they're coming. They understood that carers were busy but also wanted the service to recognise that they had to organise other aspects of their life around carer visits.
- + could the service send an automated message to say when carers were scheduled to visit. The relative said the schedules are done in advance and they could ring to find out when the carers are coming the next day.

Feedback about other services

We also heard feedback about Wycombe Hospital and Westongrove Practice.

Our recommendations

We heard in-depth feedback from a small number of people who had used the service, or their relatives. We recognise that these views may not reflect the experience of everyone who uses the service. We haven't compared the findings from this project with the first one because the feedback was gathered in a different way.

Most people we spoke to had positive feedback about the service provided by the reablement workers (usually called carers). Some mentioned the prompt way the support had been put in place. Others were pleased that the service had been flexible and continued until other carers had been arranged.

Some areas where improvements could be made have been highlighted below.

Communication before leaving hospital

We recommend that the Council's rehabilitation service:

- improves communications before the service user is discharged from hospital to give:
 - reassurance that support will be available at home immediately and that the right equipment will be in place at the service user's home before discharge
 - information about what the service will provide.

Communication at home

We recommend that the service:

- involves service users and relatives more in developing their support plan and discussing what they want to achieve and how the service can support them to do that as they towards a more person-focused service
- manages the expectations of service users and relatives from the outset about what the service can provide. For example, this could include letting people know about likely variation in the timing of visits
- consider possible ways service users and/or their relatives could be informed of, or find out about, the reablement workers likely visit time or a change to the schedule.
- emphasises to reablement workers the importance of following what's set out in client's personal file ('blue book'). This will be more important as the service becomes more personalised to reflect goals specific to each individual.

Communication as the support finishes

- We recommend that the service provides more information and contact details of other organisations that could provide support during and after the service has ended.

This report is based on peoples' experiences before the coronavirus (COVID 19) outbreak. One person mentioned the lack of visible hand hygiene. We anticipate that carers will be very aware of the vital importance of following the necessary guidance under the current circumstances.

The Council's response to our earlier report mentioned that a leaflet about the service was being developed. The feedback we heard suggests there is still a need for this. It would help service users and their relatives to have a clear understanding about what the service can and can't provide, before the service starts.

Acknowledgements

We would like to thank all the service users and their relatives who talked to us.

Our thanks also go to the volunteers for their hard work on this project and to Buckinghamshire Council staff for their support.

Disclaimer

Please note this report summarises what we heard from the people we interviewed. It does not necessarily reflect the experiences of all service users.

Appendix 1

Further information about how we planned and delivered the project

Method

We used a semi-structured interview approach.

We switched from planned home visits to telephone interviews as a precaution because the work was scheduled to be delivered during March. All but one of the interviews, took place between the 5th and 16th March. They involved either two Healthwatch Bucks team members or a team member and a volunteer. The final telephone interview was conducted by one Healthwatch Bucks team member because it took place after the Government measures were introduced on the 23rd March to restrict the spread of coronavirus.

The questions we used to prompt in-depth questions were similar to those used in the first project.

At the start of each interview we explained:

- the purpose of the project
- how we would use peoples' anonymised feedback in our report
- how we would handle their personal information
- how they could withdraw their consent if they decided they didn't want to be involved in the project).

We also asked each person if they would be happy for us to take notes of their experiences and some demographic information.

We wrote to each person after the interview to confirm all this information and so that people could contact us if they wanted to complain or withdraw their consent and where they could find details of the Healthwatch Bucks privacy statement.

Appendix 2

Full question set

Entry to the service - Tell us about how you were referred to this service.	
	Who referred you to support?
	What information were you given? Were you given any exercises to do and/or equipment to help you?
	Were you clear about what would happen next at the time?
Use of the service - We want to know about your experience of using the service and receiving support.	
	In your initial assessment were you, your family and/or carers told about what the service was for what it would do and what it would not provide?
	How involved did you (or your family and/or carers) feel in the planning of your support? Were you directly involved in the planning?
	Were you clear about what you needed to do to make the most of the support (and meet your goals?)
	Were you told about any other organisations that could support you as well?
	If you had any worries/concerns/questions - how do you feel they were handled and responded to?
	How did you feel you were treated by the people you saw?
Understanding of the service - We would like to know what you were told/knew and understood about what the service could and could not do for you.	
	How satisfied were you with what the service provided?
	How well do you think the service met your needs?
	Were there any areas in which you feel the service didn't meet your needs?
	Was there anything you thought the service would provide that it didn't?
Leaving the Service/Support - Thinking about when your support from the service came to an end....	
	How did you feel when the support finished?
	Did you achieve what you wanted to? Or if not did you understand why?
	Looking back, was there anything that you would have liked to know at the beginning of your support that you didn't know or weren't told?
	If you needed further help were you given information about what to do or other organisations that could support you?
	Do you know who to speak to if you have any worries/concerns/questions in the future?

Reflections - Looking back on your experience of support.

	Is there anything you thought was particularly good or bad about your experience/the service?
	If you had to use this service again, would there be anything you would like to be done differently?

About you

How old are you?

<input type="radio"/> 18-25	<input type="radio"/> 66-75
<input type="radio"/> 26-35	<input type="radio"/> 76-85
<input type="radio"/> 36-45	<input type="radio"/> 86+
<input type="radio"/> 46-55	<input type="radio"/> Would prefer not to say
<input type="radio"/> 56-65	

How would you describe your ethnicity?

<input type="radio"/> Asian/British Bangladeshi	<input type="radio"/> Mixed Other
<input type="radio"/> Asian/British Indian	<input type="radio"/> Mixed White and Asian
<input type="radio"/> Asian/British Other	<input type="radio"/> Mixed White & Black Caribbean
<input type="radio"/> Asian/British Pakistani	<input type="radio"/> Other Ethnic Group
<input type="radio"/> Black/British African	<input type="radio"/> Traveller of Irish Heritage
<input type="radio"/> Black/British Caribbean	<input type="radio"/> White British
<input type="radio"/> Black/British Other	<input type="radio"/> White Irish
<input type="radio"/> Chinese	<input type="radio"/> White Other
<input type="radio"/> Gypsy/Roma	<input type="radio"/> Would prefer not to say
<input type="radio"/> Other: Please specify	

What best describes your gender?

Female/Male/Prefer not to say/ Prefer to self-describe (please tell us below)

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

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