

## **Healthwatch Salford**

### **Review of Patient Experience of Salford Intermediate Care Services**

#### **Report Summary**

The purpose of the report was to gather views from people using the Salford Intermediate Care services at the following locations:

- Hartley Green
- The Limes
- Barton Brook
- IV Services

Intermediate care services are provided by Salford Royal in partnership with Salford Council and other private healthcare providers. Most people using the Intermediate Care services have recently been in hospital for treatment or operations. Intermediate Care services are there to give lots of support, very quickly to help people get back on their feet and back to their usual daily routine. Following a period of intensive support, usually lasting for no longer than six weeks, most people will then go back to where they live, with support in the community.

This report looks at small scale, in depth patient feedback. Seven people across the range of services were interviewed by a Healthwatch Engagement Worker about their experience of using the intermediate care services. Their views and experiences were collected using a case study approach.

Additional comments were sourced through online and social media requests for experiences through the Healthwatch Salford membership.

The information was gathered using a qualitative approach, with trained volunteers supporting patients to tell their stories. The Healthwatch Engagement Worker supported volunteers in this role. Volunteers were all members of the Salford community and had been trained to gather information in a supportive way by Healthwatch Salford staff. The information was gathered during a number of visits to the services, usually within the breakfast club sessions. Themes were gathered from the information and used to develop recommendations for improvements as well as highlighting things that people felt worked well.

#### **Summary of findings**

The main highlights identified in this review were:

- Goal Setting - staff and people using the service were working together to set goals to work towards supporting recovery
- Joint Working – staff in the service were working with lots of partner organisations in Salford to make sure that people’s needs were supported when they were leaving the unit.
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The main challenges identified in this review were:

- Information and Expectation – Making sure that everyone using the service has enough information to understand what the service would involve
- Mental Health Support - developing joined up working to support people’s physical and emotional wellbeing.
- Communication – awareness of people’s communication needs, including people with Autism
- Referral – clear messages about why someone has or has not been able to get support from the service.

## Background Information

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- Hartley Green
- The Limes
- Barton Brook
- IV Services

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This report looks at in depth patient feedback from a small number of people. This is not a full review of the service. Instead, it is a snapshot of experience from people using the service. Seven people across intermediate care services were interviewed by a Healthwatch Engagement Worker about their experiences. Their views and experiences were collected using a case study approach.

The purpose of the review was to inform the wider review taking place in intermediate care services by providers and commissioners.

## Methodology

Healthwatch Salford visited the intermediate care services across a number of sites including:

- Hartley Green
- The Limes
- Barton Brook
- IV Services

We spoke with seven patients using these services. Most of the people interviewed were over 65 years of age, with one person being under forty. The patients were of mixed age, ethnicity and ability. Some patients we spoke with also had experiences of dementia, drug / alcohol use and additional physical illnesses. We spoke to people at different stages of their treatment, including people who had just been referred as well as people who were due to be discharged. We also received information through electronic and social media methods from Healthwatch members who had previously used the service.

We asked 13 detailed questions about people's patient journey. These questions looked at expectation of the service as well as referral and discharge experiences.

As the information was gathered through a case study approach, the quotes below are not all direct quotes from the individual. Instead, where people may be identified, the information shared by the person has been transcribed as 'I' statements to illustrate their experiences anonymously.

This information was then thematically analysed to find areas of good practice as well as things that could be improved.

## **Findings**

### **Expectations of the Service**

There was a mixed understanding of the service from the people we spoke to. Some people were very clear about what to expect in the service and felt that they had a good level of information about the treatment they would be receiving.

*“The staff at the hospital explained it very well. They told me about the physiotherapy and occupational therapy before I came here. I knew that they would help with washing and dressing, as well as moving about so I wanted to come straight away”.*

Most people had some understanding of the therapeutic interventions they might be receiving at the service and were able to describe it as ‘therapy’ or ‘physio’. In some cases, explanations of the service were communicated to the carer rather than the person using the service.

*“I was told by the staff on Ward 7 that I would be going somewhere to help me recover and go home. They didn’t explain that it was called intermediate care and what would happen. I assumed that there would be lots of physiotherapy and that they would be able to help me learn how to wash myself and move between the bed and toilet”*

*“I was told that The Limes was a ‘lovely rehabilitation place’ by the staff at Salford Royal. I didn’t know what intermediate care was but I know that it was ‘some type of home where they would help me get back on my feet”*

*“I had a care co-ordinator who did my discharge and set me up to come to The Limes. They discussed it with my daughter mostly. I wasn’t sure what it was and I didn’t know that I would be having physiotherapy”*

Other people at the service did not have a clear understanding of why they were there or what to expect from the service. This had resulted in misunderstandings about the service and the types of activities that people would be expected to undertake.

*“I have been at Barton Brook for three weeks and I wasn’t sure what to expect when I arrived”*

*“I was told that it was a place I could relax. I didn’t know that it was about therapy”*

Communication was a reoccurring theme across the feedback we received, and the needs of people who are autistic were highlighted as a particular communication issue to be addressed.

*“People with Autism need specialist advocacy to support their communication needs. Communication needs to be better between staff and patients”*

### **Referral**

The people we spoke with had been referred to the service for lots of different reasons. Some people had been admitted to hospital following treatment at Accident and Emergency, whereas others were referred following difficulties in the community. The referral process to the intermediate care services seemed smooth and joined up for most people and was managed well by the staff.

*"I had two falls in one day and my son rang an ambulance. I went to A+E and stayed for two weeks"*

*"I came into hospital as the district nurses thought I wasn't looking after myself. I could not stand or walk"*

*"I fell at home going from the bathroom to the living room. I pressed my call button that I wear every day and the carers called an ambulance. The paramedics came in and made me feel calmer. They put me in the ambulance and took me to Accident and Emergency. I went home the same day. I had lots of pain in my shoulder and I was struggling to use it. I went back to the hospital and an x-ray said that I had broken my shoulder. They put my shoulder in a cast and I had to wear a brace. I stayed on the ward for two weeks and then went to The Limes".*

*"I have been having some problems walking and so when the district nurse came, she said that I might need to go and stay somewhere to have physiotherapy to help with moving about"*

*"I knew I needed to get back on my feet and support myself"*

For some people, the move from hospital setting to intermediate care felt like it happened at the wrong time, particularly when the situation before the referral had been traumatic.

*"I felt that it was too soon after my operation and I hadn't recovered from the shock. When I arrived at Hartley Green, I still felt too unwell to take part in my rehabilitation plan. I was very anxious and upset and my hair fell out from the shock"*

Some of the feedback we had from our members highlighted issues around access to the service. One person thought that they should have been offered intermediate care support when recovering from a fall resulting in a broken collar and ribs.

*"I thought that physiotherapy would have helped me learn to strengthen my arm without putting pressure on it. I didn't get any information about what exercise would help, and what to avoid. If I had been given physiotherapy, I wouldn't have needed to take strong painkillers for so long. I now have to learn to 'live with the pain'"*

### Staff Interaction

The feedback about staff in the intermediate care service was very positive and people felt that they were doing an excellent job. People talked about their experiences with the staff in a positive light and, in the main, felt that they were being treated with dignity and respect. People felt that the level of support given by the staff worked well and painted a picture of the staff operating as a safety net, providing support to people to motivate and encourage their recovery.

*"The health assistants in the hospital were fantastic, they helped me and cheered me up. The staff at Hartley Green were very understanding and supported me to go at a pace that worked for me"*

*"I was very independent. I was worried about how my husband would care for me and my child. The staff are working with children's services and safeguarding to make sure someone can walk them to school and make sure they are eating properly".*

*"They have helped me but not pushed me too hard. Things have been at the right level. The staff are reliable and have a good attitude. It helps my confidence, which helps me get better quicker.*

*“I have been able to talk to the staff and agree what I want to achieve. I feel in control of my care. The care at The Limes is fantastic and I’d give the staff 200 out of 100!! Your personal privacy isn’t taken away and they communicate with you. If you haven’t done something for a while (like washing or shaving), they encourage you”*

### Staff Engagement

Whilst attending the units, the Healthwatch Staff and volunteers observed the staff practices with people using the service. Whilst the observations generally demonstrated good practice, some issues may be useful to highlight:

The atmosphere on the units was very busy. The ratio of service users to occupational therapists and physiotherapist was high. The Healthwatch Engagement Worker had some conversations about this with the staff which indicated that this acted as a barrier to recovery, as it reduced the amount of time that staff are able to spend delivering interventions to an individual or group basis.

There were discussions about carer staff absences interfering with interventions and care planning. This is because all staff would need to assist with personal care, toileting, feeding and hydration. Keeping service users safe and ensuring that personal care and nutrition is essential but if it was felt that at times this interfered with the rehabilitation programmes.

Similarly, there were a high number service users needing assistance with mobility from carers e.g. needing drinks and toileting on a continuous basis while we visited. The purpose of the service is to encouraging service users to perform these tasks as independently as possible, however it was observed that some service users would have to wait due to the amount of staff resource available on the units.

There were some conversations about whether carers were following the care plans put in place for service users or providing care that mirrored the people on the residential and nursing units. It was felt that having residential, nursing and intermediate care service users together caused confusion amongst staff and meant that service users accessing intermediate care were not having their care plans followed; affecting the time and progress of their rehabilitation.

### Treatment

The treatment provided by the service was highly praised and there was a sense that the people using the service felt that it was helping with their issues. In particular, the people we spoke to value the physiotherapy approach and felt that this was particularly helpful in helping people to get back on their feet.

*“Staff have been helping me – the physio is fantastic. I haven’t needed to use a commode after being here a week. I am trying to do as much as I can for myself but the staff are very obliging if I am struggling. I’ve enjoyed the social element of being at The Limes”.*

*“I feel like all of the things that they have shown me are working. If I struggle with the equipment, they help me develop techniques to use it. I am still struggling with leg problems and speech but I’m exercising daily. The physiotherapist has been great and the carers are helping me practise over the weekend to improve my legs”*

Those people who were clear about the reasons for their treatment talked about working together with staff to develop clear goals to achieve specific outcomes. This influenced the person's perception of control over the situation and their progress.

*When I arrived, I was asked what I want to achieve"*

*"At Hartley Green, I needed lots of help at first. I still do because I still can't move my hands. They involved me in planning my treatment and they were supportive of the goals that I set for myself."*

*"The staff talked to me about my treatment and we all agreed that I need to have help with moving about and building up my confidence. I want to be as independent as I can when I get home. The staff have been helping me get my bearings back and they make sure that I get up and move about through the day. They have helped me to work on getting in and out of bed, walking with a frame and sitting in the chair. I want to work on making drink now that my cast is off. My hands are stiff and some things are difficult at the moment. I have pain in my shoulder but staff are helping me with this. I feel more in control of my care and life at The Limes."*

From some of the people we spoke with, there was a sense that people were not always clear about their involvement in the treatment planning process. Some people described being involved in assessments and having joint discussions with the staff to plan their care. Other people talked about being told what they needed to do, which felt less collaborative for the person involved.

*"I haven't discussed my care plan with the staff but they told me what I will be doing"*

*"Staff did an assessment on me and said that I needed treatment to help moving about. They said that they would see what support I need at home. The staff are very good".*

One person commented on the difficulty in practising everyday activities on the unit because of the lack of facilities. The intermediate care units didn't have kitchens that could be used for interventions around preparing food. Most of the breakfast clubs took place in the dining room around a table. This made it difficult to simulate the experience that someone might have at home in preparing a meal; e.g. reaching to get something out of a cupboard.

*"I didn't want to come because it's not like being in your own home. I was very independent before but now I can't do much for myself and it's been a shock. I like the privacy of my own room but I would like my own kitchen and bathroom so that I can practice more. I have been here for two weeks and I will be here for another six. I'm worried about falling again and I'm glad I don't have to go home yet. Staff have been working with me on lifting my legs so that I can move better. I've been using a walker and holding onto things but I'm worried that my legs won't get better. I've been strip washing with help. I don't want to do that when I get home, I miss showers. Getting into bed is also hard"*

*"The staff helped me get out of bed at first but now I can do it myself. I need medication regularly and I have an appointment with a neurologist to see what will help"*

### Post Treatment and Discharge

Discharge seemed to be a difficult period for most people, with a lack of confidence being a specific issue faced by the people we spoke to. Most people commented that they felt under confident with coping with their problems when they returned home.

*“My son and daughter are working with the staff to have equipment to help me at home but I’m not sure what else they can do. I don’t think that I will be able to do what I used to do”*

*“I don’t feel like I have made much progress and I am struggling with Parkinson’s”*

For the people we spoke with, a number of practical and wider determinants of health were an issue when being discharged. People told us about worries relating to moving their belongings and housing, looking after dependants and managing their daily routines with physical health challenges. In these situations, the staff were described as very supportive, working with other services and the person’s relatives to put things in place to support them as they returned home.

*“I can’t stay in my property because of my movement, so I will be moving [into sheltered accommodation]. My son is moving things and working with the staff to put things in place for when I go home. I’m a bit anxious but I feel ready”*

*“I’m ready to go home and I’ve talked to the staff about the help I will get to keep improving things. I will be able to go home in a week”*

*“You need to support people who go home after being discharged after a fall and can’t get around”*

*“They helped me look at other problems that were stopping me from going home. The staff have been working with community teams to help me find a house with the right equipment. This would help. I would feel relieved and like my worries were gone. I’d be independent and happy.”*

Emotional wellbeing was mentioned in a couple of the case studies. These included situations where the person using the service felt that they may have benefited from talking therapies to support them emotionally, manage traumatic events and build confidence.

*“I’m still having incontinence and I can’t shout the staff quickly enough. I have phantom pains and sensations and maybe talking therapies would help me manage how I feel. I’m feeling more positive about the future now though because they said I can have a prosthetic fitted later this year and I’ll be having more physio and OT support when I get home”*

*“Older people want to be independent and they don’t want to ask for help, but sometimes they need it”*

*“I was in a lot of pain after my operation and when I realised my leg had been amputated, I screamed in shock and fear. Soon after, the consultant told me that I had an infection which was spreading to my heart. That was why they decided to amputate my leg. In the hospital, the consultant and nurses explained about the situation and the medication but no one offered me support to help me deal with losing my leg”*

One person felt that following support from the service, they did not receive a full assessment to make sure that their needs were known to help them return home in a supportive manner.

*“There was no assessment done of my needs. I am still struggling now and an occupational therapy assessment would have helped to identify my needs in the short term, with an assessment of long term needs by the Council to support me further”*

### Areas of Good Practice and Recommendations for Improvements

- **Information and Expectation:** Those people with a clear understanding of the service were prepared for the type of treatment they would be required to undergo, along with an understanding of how this will be beneficial to their particular needs. It is suggested that clear and consistent information should be provided to the individual (and their families / carers where appropriate) every time someone accesses the service. This should include what to expect when accessing intermediate care, using clear, accessible, jargon free language. It may be useful to support the person using the service to clarify their expectations e.g. understanding that they will be able to discuss goals and plan their treatment together with practitioners.
- **Setting Goals:** Good practice was demonstrated through the involvement of people using the service in setting their own goals for recovery and building their treatment plans in collaboration with staff. This increased people's feelings of control around their recovery and increased the level of ownership the person had in the recovery process.
- **Joint Working:** Staff are already working with external agencies to support people accessing the service to return to their communities. People commented on staff working with housing and other providers to resolve issues around equipment and adaptations. Expansion of this practice to include other services in the community, e.g. housing, neighbourhood management, fire and rescue services would be a positive step in ensuring a cohesive response to supporting people back into the community.
- **Mental Health Support:** It was recognised that identification of mental health needs and opportunities to utilise talking therapies to support people with their recovery may be expanded. Closer working with mental health and wellbeing services to support people's emotional needs when looking to return home would complement the physical support being offered by the service.
- **Traumatic Experience:** Working with people who have experienced traumatic situations prior to referral into the service may require a more sensitive approach between hospital staff and intermediate care staff to ensure that the transition is supportive and takes account of people's recent experiences.
- **Autism and Communication Needs:** Feedback suggested that developing communication approaches for people who require different styles of communication would be beneficial – in particular, training for staff relating to autism was identified as a potential area of development.
- **Referral:** Feedback relating to access to the service illustrated that some people were unclear about why they had not been able to access the service for support. Clarification about the referral criteria for the service, including access thresholds in a clear, accessible manner would help patients have a detailed understanding of why they had or had not been referred.



Thank You

Thank you to the people using the intermediate care services for giving up your time and sharing your stories. Thank you to the staff based at the services for letting us visit and sharing your views.

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