July 2023

healthwatch
Wigan and Leigh

Care Home Project

Exploring the experiences of Care Home staff in accessing Health and Adult Social Care services for their residents post Covid pandemic.

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Contents

healthwatch Wigan and Leigh

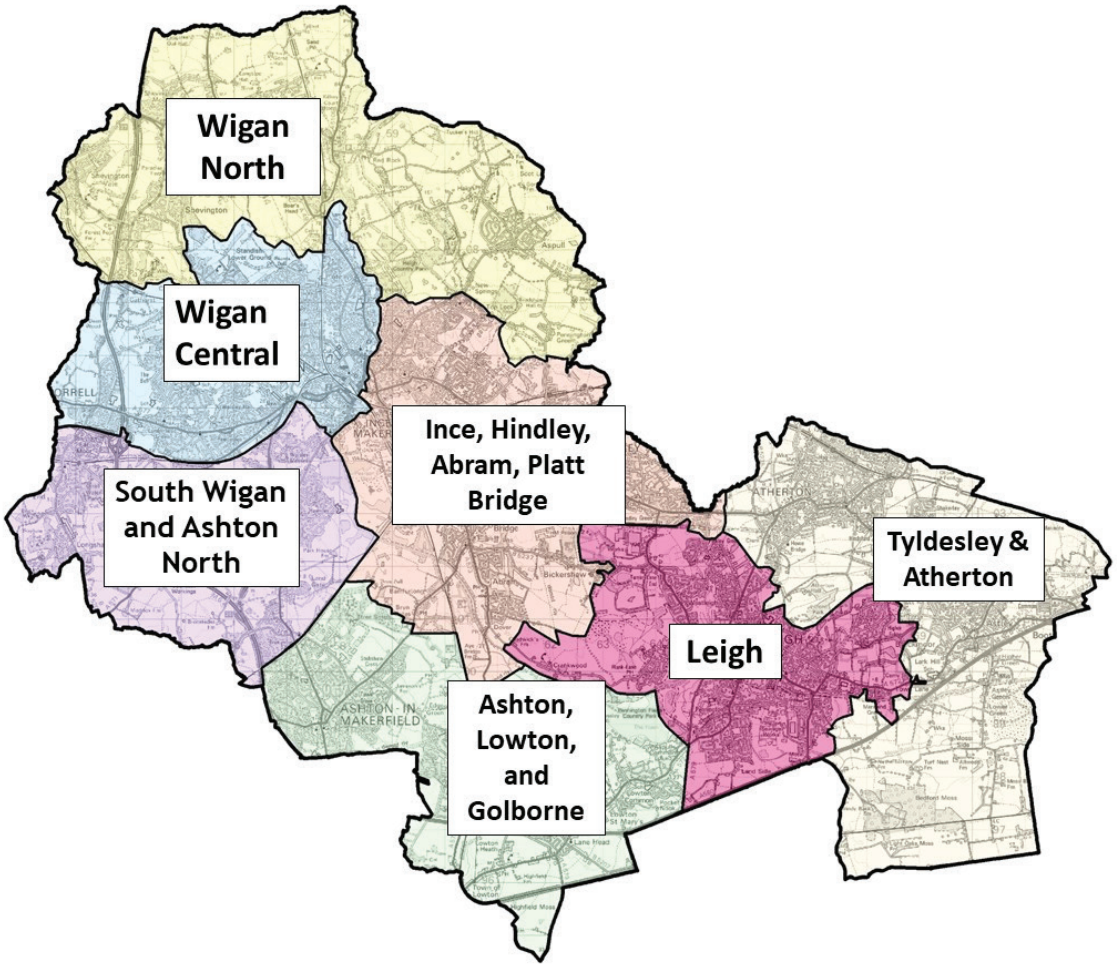
"In the last ten years, the health and social care landscape has changed dramatically, but the dedication of local Healthwatch hasn't. Your local Healthwatch has worked tirelessly to make sure the views of local people are heard, and NHS and social care leaders use your feedback to make care better."

Louise Ansari, Healthwatch National Director

About Us

Healthwatch Wigan & Leigh is your local health and social care champion.

Healthwatch Wigan and Leigh are the independent voice for the people of the Wigan Borough. We are the independent 'consumer champion' for health and social care. We exist to help the people of this borough to have influence and a powerful voice in how services are run and how they can be improved. The map shows the seven Primary Care Networks (PCN's) across Wigan Borough. A PCN is where General Practices work together with community, mental health, social care, pharmacy, hospital, and voluntary services in their local areas in groups of practices.



Healthwatch Wigan and Leigh exist to :

- Help people to make informed choices about health and social care
- options available to them.
- Listen to the views and experiences of local people about the way health and social care services are commissioned and delivered.
- Allow the people of this borough to have influence and a powerful voice in how services are run and how they can be shaped and improved.
- Influence how services are set up and commissioned by having a seat on the local Health and Wellbeing Board
- Share local intelligence with Healthwatch England and Care Quality Commission.

Summary

This report contains the findings of a project undertaken to explore the current situation in care homes in accessing health and adult social care services. This was in response to anecdotal reports to Healthwatch Wigan and Leigh that some services were still running pandemic style models of service delivery.

The project group initially consisted of 11 volunteers supported by Healthwatch staff. Fifteen care homes responded to requests for visits and invitations to be part of the project.

Authorised representatives who are volunteers for Healthwatch conducted the visits to care homes across the Borough. Findings were mixed for many of the services with homes experiencing largely good services but others identifying where things could be improved. Without exception, the homes expressed concern regarding the service from Speech and Language services which clearly caused them some anxiety.

We shared the aims of the project with both Health and Social Care providers and invited all care homes across the Borough to share their experiences.

The report will be shared with relevant parties via the Healthwatch Board of Directors and Chief Officer.

Introduction

From March 2020 the Covid pandemic had inevitably led to many restrictions on visiting in care homes for both family members and peripatetic health care staff. As a result, services adapted how they provided an input to this cohort of the population. Many assessments and advice were delivered via Zoom and Teams in a bid to keep people safe. In addition, at the height of the pandemic some but not all GP's provided remote access services instead of in person visits. Quality checks and Inspection visits by the Local Authority and Care Quality Commission became very restricted as well. There have been anecdotal reports of ongoing difficulties accessing some services; for example podiatry, dietetics and speech and language services, to name but a few, since restrictions have been lifted. Healthwatch Wigan and Leigh (HWWL) has received anecdotal reports that in some care homes visiting restrictions are still in place. It was identified at HWWL Advisory Board that it would be appropriate to conduct an engagement activity to explore the current situation.

Therefore, the aim of the project were to:

- Engage with Care Home residents, relatives/friends and staff to determine the current situation regarding residents' access to health care services;
- Understand the experiences of care homes and the impact on their residents;
- Explore and identify current visiting arrangements for friends and relatives;
- Identify and seek to understand any ongoing restriction to visiting;
- Report findings to Healthwatch Wigan and Leigh to share with appropriate third parties and request a response from service providers;
- To give a voice to care home residents and significant others in identifying any real or perceived gaps in access to healthcare services and care home visiting arrangements whilst being mindful of individual care home covid situations.

Method

It was felt that an engagement approach would be most appropriate. Whilst HWWL has the power of 'Enter and View', it was agreed this was not appropriate as we were to target specific issues that would not normally be the subject of an enter and view visit. (This power to 'Enter and View' services offers a way for Healthwatch to meet some of their statutory functions and allows them to identify what is working well with services and where they could be improved).

Instead, a group of volunteers, all trained authorised representatives would visit the homes to engage in conversations about the current situation associated with visiting professionals. (AR's take part in an informal discussion with a Healthwatch Wigan and Leigh representative, undergo a DBS check, complete a full induction, and undergo training relevant to the role).

In addition, we took the opportunity to explore current visiting arrangements.

The project was volunteer led but supported by HWWL employees.

A group of 11 Authorised Representatives underwent a period of preparation which included:

- Enter and View training – whilst we were not using this process it was felt that the Authorised Representatives would benefit from advice on the behaviour required to conduct a visit. This would also increase the pool of Authorised Representatives.
- Dementia information session.
- Safeguarding Adults.
- Care Home visit preparation and debrief.

Authorised Representatives visited the homes in pairs with one often leading the conversation whilst the other made notes.

A visit pro-forma was developed which would offer guidance to the Authorised Representatives and provide a template to aid analysis. Care home staff were given the opportunity to share any additional information they felt was relevant. This unstructured approach allowed the Care Home staff to identify the issues that were of greatest importance to them. Hence, not all services were mentioned in each home. As each home may have different requirement this will affect the services they need to access. For example there would be a difference between nursing and residential homes.

The project preparation started in July 2022 with visits running from October 2022 to March 2023.

The Covid status of all care homes would be checked before any visits. On the day of the planned visit, the Authorised Representatives were to contact the care home to determine their current infection control status.

All Authorised Representatives were to be free from any symptoms of Covid or other suspected infection and to cancel any planned visits if symptoms arose on the day.

All Authorised Representatives would wear a visible ID Badge and if possible, a HWWL T Shirt or Hoodie.

Method

All Authorised Representatives involved in the project will have undertaken Authorised Representative training.

A risk assessment form would be completed on the day of the visit.

To introduce the project to the Care Home Managers, the Lead Volunteer and a Healthwatch Engagement Officer attended the Care Home Forum which is run by Wigan Borough Council. This was an opportunity to meet key staff and resulted in several invitations to homes. As a follow on from this forum, all Home Managers were contacted via email with a letter of introduction and explanation of the project.

Demographics

There are 52 care homes within Wigan Borough with a mixture of registrations ie. - residential, nursing, dementia, and enduring mental health. These services are provided by a variety of organisations ranging from large multisite providers, individual care home providers and the local council.

In total 15 care homes were visited/contacted.

A cross section of homes was aimed for with the intention of providing representation from each PCN:

- 3 Wigan North
- 3 Wigan Central
- 3 Leigh
- 3 Ashton, Lowton and Golborne
- 1 Hindley, Ashton, Platt Bridge and Ince
- 1 Tyldesley and Atherton
- 1 South Wigan, Ashton North.

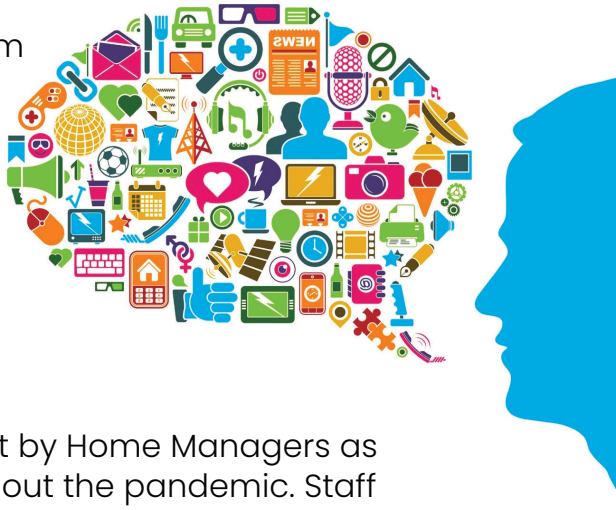
And included residential, nursing, mental health and both private and council funded facilities.

The profile of the homes was as follows:

	Registration of Home	Number of available beds
1	Residential/dementia	34
2	Nursing	48
3	Residential/dementia	40
4	Residential	41
5	Residential	15
6	Nursing/IMC	49
7	Dementia nursing	48
8	Residential	18
9	Residential	76
10	Residential	40
11	Enduring mental health	19
12	Nursing/residential/dementia	50
13	Nursing	50
14	Residential/EMI	56
15	Residential	32

The care home managers/deputies/other staff were very willing to share their experiences. Whilst the focus of the project was on health services, other issues that had an impact on residents and staff were raised with the team. These will be discussed later in the report. The most frequently used services were those provided via the local NHS providers. These included:

- Speech and Language Therapy (SaLT)
- Falls service.
- Tissue Viability service (TVN)
- Continence services
- GP
- Advance Nurse Practitioner via Crisis response Team
- Ambulance services
- Wheelchair services
- Funded nursing care
- End of life support



Each service will be discussed individually below:

Speech and Language Therapy (SaLT)
This service was the one most frequently identified first by Home Managers as continuing to use the service model delivered throughout the pandemic. Staff identified this service as the one having most impact on the delivery of care to their residents.

Pre-pandemic, swallowing assessments were conducted in person with Speech and Language Therapists visiting the home to conduct the assessments. During the pandemic, this moved to assessments via Teams or Zoom. This has continued since the covid restrictions have been lifted. The main impact of this move has been on staff time. Assessments can take up to one hour and with some residents requiring the assistance of two staff. As assessments largely occur at mealtimes, this takes staff away from serving and assisting other residents to meet their nutrition and hydration needs. This obviously has a knock-on effect on the wider resident population within the home.

Whilst few homes felt there had not been a significant increase in the number or frequency of respiratory infections which could be associated with swallowing difficulties, others did, therefore raising concerns of the quality of the assessment. They did feel they had become much more cautious and reported they would often resort to a nil-by-mouth status and refer to SaLT more readily. The Home Managers did think this may have increased the number of referrals and consequently pressure on the SaLT service.

One home reported that the change from in person assessments created difficulties for the staff when trying to explain 'feeding at risk' and end of life decisions. Staff felt it created difficulties if the coroner was involved; for example, if aspiration had contributed to a resident death. Some of the comments made by staff are shown in the table on the following page:

Findings

Positive experiences	Negative experiences
It's getting better now; they have been coming out more in person to see patients.	We have difficulty accessing face-to-face consultations, and this concerns us as there is a real risk of the resident aspirating and choking when being fed.
They have carried out one face-to-face visit in recent weeks.	We are often asked to carry out consultations over zoom, this is time-consuming as we must get the resident ready and then to be observed eating. We feel that this is unsafe and causes staff anxiety.
Haven't really seen an increase in residents with chest infections.	We can only describe the current service as dangerous as they are managed over zoom. It is not thought that they can see the swallow properly. It is high risk and I think it's scary .
We have adapted to video calls being used to diagnose by SaLT.	We are wary when giving residents food and drinks there's been a noticeable increase in choking episodes, aspiration, and chest infection. We see this as a direct result of a lack of face-to-face assessment.
The SaLT tend to carry out most assessments via video link. Whilst at times this can be problematic it is mostly satisfactory.	The length of time zoom assessment takes is approximately one hour. This takes staff away from supporting other residents.
	The taking of videos of residence, eating or drinking is undignified.
	The face-to-face observation of the person has not been good since the restrictions have been lifted.
	SaLT done by teams. It takes 45 to 60 minutes per assessment. This takes staff away from other care duties. It will be better if they were done in person. Staff feel it has led to an increase in referrals.
	SaLT have been doing assessments via zoom since Covid.

One observation made by a Registered Nurse expressed concern over the safety of staff 'feeling for the swallow'. She felt the assessment was reliant on the experience and knowledge of a trained nurse and that staff with less experience or knowledge may not know what to look out for.

Podiatry

The care home staff's experience of Podiatry seemed to be mixed. Whilst some homes said they received regular visits, others reported delays and one home was resorting to bringing in a private podiatrist. The major concern seemed to relate to residents with diabetes and them not all receiving a regular check.

Although one home was receiving regular visits and were happy with the frequency of the service, the staff did pass comment on the Podiatrist's request that all residents are seen on that day in the communal lounge. Staff felt this was undignified for the residents who should be provided treatment in the privacy of their room.

Communication also appeared to be an issue as the residents' records were not updated by podiatry staff and information was not always related to the care home staff. This created gaps in the residents' care plans, especially if they were having dressings applied to wounds. The care home staff expressed the following:

Positive experiences	Negative experiences
No issues experienced and feedback is well communicated to staff.	We are not getting regular 12-week visits, and we have concerns regarding our diabetic residents.
No concerns. Face to face visits are happening.	We are now seeking a private podiatrist, just to get a resident seen.
A private chiropodist visits regularly and NHS chiropodist every 12 weeks.	We are struggling to access podiatry. They will visit but not as often as pre-Covid.
Visits regularly and conducts 3 monthly reviews.	Podiatry haven't been for months and there is a long wait even for a diabetic patient.
Easy to make arrangements to see the residents.	Don't always write in the resident's notes so there can be gaps in the care plan.

Tissue Viability

There were very mixed experiences of this service across the homes visited. Some homes did not refer to the Tissue Viability service or raise it as a concern. It is not clear if this service is delivered from a central hub or if teams are based in different centres across the borough. Some homes reported an excellent service with regular visits and training. Staff reported how supportive this service was and that the team used all opportunities to teach the care home staff when visiting, assessing, and treating residents. However, other homes seemed to struggle to get a timely response. It was difficult to unpick the potential reasons for this perspective.

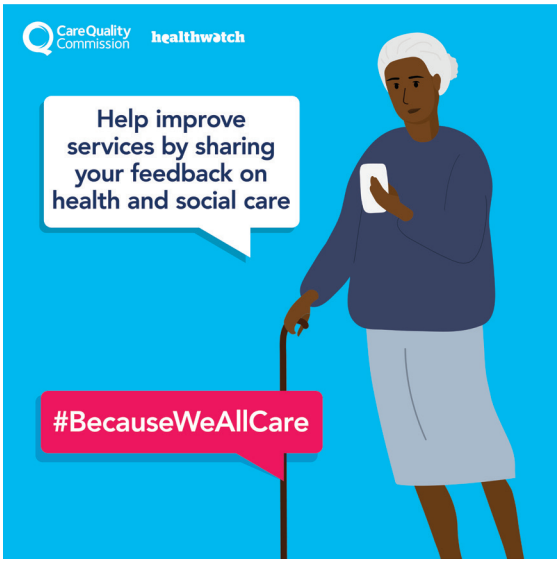
Comments from staff included:

Positive experiences	Neutral	Negative experiences
In person visits occur occasionally.	We have mixed views. On one hand, the response time is quicker than pre-pandemic, staff email photographs. However, face-to-face is preferable to reassure staff that the treatment they are giving is appropriate.	Pressure sores are not being assessed in a timely manner.
The TVN service is excellent. They are responsive, supportive, and educational. They use visits to reach staff with individualised patient interventions.	No face-to-face visits. Have mixed views about this. Makes the service quicker.	We are seeing unprecedented numbers of residents being admitted directly from hospital with pressure sores. These are not being seen on a face-to-face basis, only via photos and zoom calls.
		The team request photos rather than come in person.
		The request for photographic evidence is unsatisfactory. Also, there is a question of confidentiality of staff and residents as staff are using personal phones.

One area that all homes felt uncomfortable with, was the requirement to take photographs of wounds to send on to the team. Some staff felt that the quality of the photographs was not good enough and this could compromise the assessment.

Other staff thought the assessment was potentially incomplete if the wound could not be seen or any odour noted.

The issue of general data protection regulation (GDPR) was also raised by staff as the phones used to take the photographs were often their own.



Falls service.
There were also mixed reports of the service received from the Falls Team. Whilst some homes expressed significant satisfaction with the service others felt they could provide more support.

Positive experiences	Neutral	Negative experiences
Service is very good. Will visit all residents referred and provide full assessment and any equipment needed. Will always follow up residents regardless of how many times they are referred.	Falls team take a while but will come in and provide equipment.	We have difficulty accessing help from the falls team an example of this being an 82-year-old fell from bed. The home needs support re-preventative assessment and advice.
	Falls team is visiting although it might take a week or two to visit after making a request.	They have not adapted well to service requirements post-Covid.

Dietetics
Most homes were complimentary about this service. They were described as responsive and provided good written information for each resident. However, it was noted that they rarely visit in person. Most reviews/advice is provided via telephone.

GP
The services provided from GP practices varied widely. Most care homes were linked to a local GP practice. Pre-covid, the practices largely provided a weekly 'ward round' which supported regular review of the residents and particularly those with long term conditions. Through the pandemic, this moved in many instances to a weekly telephone review with GP's only attending the home when an acute problem arose. Many practices now employ Advanced Nurse Practitioners (ANP) who have in some instances taken over the weekly reviews.

Positive experiences	Neutral	Negative experiences
GP does a weekly ward round.	A weekly ward round on a Wednesday, but we struggle if anything happens during the time before then.	Sometimes it can be difficult getting them out, we can be waiting or battling to get them to come out on other days. We get a different doctor and lots of locums - no continuity.
A weekly ward round is conducted by either GP or Advanced Nurse Practitioner (ANP).	Some of our residents have not been seen by a GP for 2+ years.	The GP service is very hit and miss.

The home will press for on the day visit if the resident requires it. This can usually be obtained.		We no longer have weekly GP visits when they do come, they restrict the time and example of which is 4 residents needed to be seen, but due to time constraints, the doctor would only see two.
Residents in the Discharge to assess (D2A) service usually receive a different, prompter response from a different GP service.		The length of time between residents being seen by the GP is a problem. An example being that by not being seen for several months should the resident die, it could trigger an inquest and a possible post-mortem. This puts extra and undue stress and anxiety on the relatives at what is already a very sad time.

Mental Health services.

One home, struggled accessing mental health services despite being registered solely for residents experiencing mental health issues. The Home Manager reported long waits for Best Interest meetings, Mental Capacity assessments and Deprivation of Liberty (DOLs) authorisations. At the time of the visit, 5 residents were awaiting review with only 1 having been seen.

Homes reported issues accessing Community Psychiatric Nurses to administer depot injections to residents:

"CPN will not visit to administer the depot injections. Our staff are now required to take the residents monthly to the hospital by taxi. This is a cost implication to the home and staff time."

In contrast other homes were complimentary about these services and reported timely review following referral. However, several homes reported long waits for DOLs authorisations following decision and authorisations only being granted for periods of 3 months at a time. This led to a significantly increased workload as assessments and authorisations requests had to be repeated 3 monthly.

Wheelchair Services

"This was better pre-pandemic. It is worse now post-pandemic. We are reliant on families and the home to fund aids for the residents to use. Failing that we use any that have been donated."

"We experience a lot of difficulty just trying to get through to the department."

Funded Nursing Care

All of the care homes we visited made similar comments about Continuing Health Care assessments. Some homes were not clear who was responsible for completing a checklist which is the start of the assessment process. There were some differences between residential and nursing care homes in this process. Residential homes struggled the most with what they saw as inconsistencies between district nursing and social workers in completing this.

There were many comments about how long the process took to complete all stages. Pre-covid, multidisciplinary meetings were held within the home with representation from all involved parties, including relatives. During the pandemic and since, these have been conducted via a Teams meeting.

One Home Manager reported that pre pandemic, there would be a maximum of one assessment per day and it would be in person with sufficient notice for staff to be prepared. Now, with just a few days' notice, staff may have up to 3 reviews in a day with little notice. Staff felt unprepared at times. As each review can take approximately 1 hour, this had a big impact on staff conducting other duties.

One residential care home commented on cancellations "one resident is awaiting a Continuing Health Care (CHC) assessment which has been cancelled four times. It was planned to be conducted via Teams."

End of Life support

The level of support provided to homes is dependent on whether it is a nursing or residential home.

One residential home told the Authorised Representatives of a traffic light system implemented during covid. This states if a resident is red/amber/green level of concern and is reviewed accordingly on the monthly visits conducted by the 'Hospice' Nurse. They had also recently identified training needs for staff in:

- end of life care
- catheter care
- oral care

which the nurse had agreed to deliver.

District Nursing

District nursing services provide nursing care for residents in residential homes only. The care home staff were very complimentary about this service and often commented they were the only service who continued to visit during the pandemic. The only issue that was raised related to confusion regarding completion of the checklist for Continuing Health Care funding.

Positive experiences
No issues with District Nurses - get a good service. The easiest service to get information or help from. Nurses are good they turn up when they say they will.
No issues regarding District Nurse or vaccination visits.
District Nurse's come as needed.
The District Nurse visits twice a day.

Incidental findings

Whilst the focus of the project was on peripatetic health services, several other issues were raised with the Authorised Representatives. Some of the concerns were long standing ie in existence pre-pandemic, other problems had developed or got worse since Covid. The challenges that concerned the homes the most came from the services identified below. Again, it was a mixed bag across the borough with some homes experiencing greater difficulties than others. The evidence is anecdotal as this is an engagement project. It was important to Healthwatch Wigan & Leigh to listen to their experiences and share them appropriately.

Ambulance service.
The Ambulance service was identified by a couple of the homes as offering poor service both before and after the pandemic and examples have been given. However, one of the homes concerned was keen to point out that in the example given the service was under undue strain and that the crew was not from the local area. Nethertheless they did state that the level of care, attention and service should not be compromised because of this.

"We sent for an ambulance team for advice as a resident was unwell with a water infection. The ambulance came out but wouldn't see the lady stating she had had a stroke and to get a nurse and another ambulance as they were not paramedics. The second ambulance was sent for but on seeing the resident they were not happy as the lady had not had a stroke. The first team had not done proper checks and had made a judgement based on the fact the lady was slumped to one side, but once lifted, there were no signs that the resident had had a stroke. The first ambulance team, then raised a safeguarding incident against the home. The manager felt that it took longer for them to carry out the safeguarding report than they spent with a resident in question".

"The home has been safeguarded by ambulance staff on numerous occasions, examples include having crumbs on the clothing and on the floor around a resident. They had been waiting 17 hours for an ambulance after a fall and had recently been given tea and biscuits not long before the ambulances arrival".

"The home has also been safeguarded due to dementia locks. They do not understand their purpose. They claim that the care home is locking residents in their rooms".

Some homes provided care for residents with tracheostomies, which may require attendance at an outpatient clinic outside of the borough. On these occasions a Paramedic Ambulance is required as the person may require suction en-route. The homes describe how challenging this can be as often a non-paramedic ambulance would be sent. This then delays or can prevent the resident accessing their appointment.

Inpatient hospital service.
During our project, hospital inpatient services received a considerable amount of criticism and created a cause for concern for many of the homes we visited.

Most areas of concern were based around communication between the hospital and care homes staff. It was pointed out by many of the care home managers and staff that often they were the only people with any connection to the resident. However, staff felt that this had little, if any, impact when it came to getting information regarding the resident whilst they were in patients.

This pattern is a continuation from the difficulty experienced in lines of communication pre-pandemic but thought by the homes to have become worse since.

The staff in the homes visited often cited this as a top issue for them and one that caused most stress, instead by not being able to find out the health status of the resident, or the fact that medication had been changed, removed, or added without informing the home.

Hospital staff often quoted GDPR legislation as the reason why they could not share information with the care home staff. However, the staff and often the resident and relatives, see the home staff as an extension of the family. The care home staff are the ones who deliver care to the resident daily and therefore need to be aware of what care, treatment, and on-going investigation the resident has had or is undergoing in order to ensure appropriate care and preparation for any investigations.

Negative experiences
Despite the home being contracted by the NHS the hospital refused to communicate as they do not recognise the home as having any right to information.
There are inappropriate discharges from hospital and back to the home. The home has a 6 pm cut-off point.
Clothing which has been soiled whilst the resident has been in hospital is returned in an unwashed condition. This happens even if the resident had been in hospital for two weeks.
A resident was returned to the home from hospital in an open back hospital gown, late at night.
Barriers gaining information regarding resident's progress and ongoing treatment, plus planned discharges are common as we are not classed as next of kin.
Residents have been discharged back to the home without a discharge plan. They are dismissed as not being important and return to the home in various states of undress. An example of which is a resident returned to the home with a plastic bag of soiled clothing which had gone mouldy.
We struggle with hospital staff not being prepared to speak to us about our residents. This occurs even when the Home informs the hospital at the fact that the resident has no relatives.
We are very concerned about the fact that following reassessment, which must occur when resident is showing increased nursing needs, and as such seen as not suitable to return to the residential facility, that we have been accused of trying to make the resident homeless.
The discharge team ring the Home to inform us that the resident is ready for discharge (usually Friday afternoon). When we make enquiries with the ward regarding the discharge, we find that the discharge team have not spoken to the ward, the resident is not seen as being ready for discharge, according to the ward, nor have they been officially discharged by a doctor.
Some residents have been returned without us being informed first.
Some residents have been returned without us being informed first.
We often get no discharge documentation.
We find that there is missing medication and equipment.
There is no sharing of information, so we don't know what investigations or treatments have been done or are required.
We get a lot of pressure to take residents back when they can't meet their needs.
Safeguarding concerns raised by us against other services are never fed back, so that we don't know what action has been taken or are able to learn anything from the issue.

- There is a strong feeling that the wards do not have enough insight, knowledge, and awareness regarding the individual with dementia. The effects of the change of environment can lead to behavioural difficulties and has an adverse effect on the care that they receive.

Accident & Emergency

Accident and Emergency (A&E) also came in as a cause of concern for care home staff. The issues were similar to those relating to In-patient services and largely centred around communication. When residents attend A&E, it is often the care home staff who accompany them. Despite being present they often feel that information isn't shared with them. Some of the comments made are shared below:

"There is very poor communication. They refuse to give care staff information about patients as we are not seen as relatives "

"Communication is not good, they will talk to us, but they do not relay much information."

"The patient was brought back from A&E with no medication. We were told that the resident's family had been given the medication and some antibiotics. After speaking to the family, they claimed they had never received any medication of the hospital staff. The contact of the hospital was rude about the situation claiming the family must have lost their medication. The medication has never been identified since. Same patient also came back to the home without a DNAR and statement of intent. The care home was chasing this, and it was received not long before the resident passed away."

"A resident had been on a trolley in the corridor of A&E for three days and came back to the care home with bedsores. The home now monitors residents' health and well-being before going into hospital or A&E."

"Residents have been in hospital/A&E for long hours without food or drink. The care home now sends care packages were possible however, it is not our role to do this."

"There is very poor communication. They refuse to give care staff information about patients as we are not seen as relatives."

"Communication is not good, they will talk to us, but they do not relay much information."

"We get late discharges, for example 2 or 3 am."

Adult Social Care

All the homes visited commented on how much pressure all the services were under and these included elements of Adult Social Care. For some care homes, close working with social workers was vital in delivering services such as Intermediate Care and Discharge to Assess. Whilst good working relationships on an individual basis were the norm, waiting times for service user review was problematic.

Intermediate Care and Discharge to assess are both time limited services and had a maximum length of stay identified when commissioned. Home managers' report that this is often exceeded and can cause distress for individuals who are anxious to return home but who are delayed awaiting assessment for community services.

A particular source of frustration expressed from the care home staff related to the issue of Safeguarding. Previous examples of this have already been described within other services. Staff felt there was a significant imbalance in raising safeguarding concerns to their disadvantage. The general impression left with the Authorised Representatives was one of unfairness. That the homes felt people were quick to raise concerns against them which were then investigated sometimes with what had been described as a heavy hand. However, they reported receiving very little feedback if they raised a concern against another service, especially the hospital. In the absence of any information, this left them feeling ignored and that the concern was not taken seriously or even investigated. It also left them without any opportunity to learn from incidents and to work together with other services to prevent issues happening again.

- "We are finding that Adult Social Care services are reluctant to attend the Home post Covid."

- "We do not receive any feedback from safeguarding issues."

- "We struggled to access six weekly reviews, so new residents are not being reviewed and long-term decisions cannot be made."

- 'Where there is a safeguarding issue rather than visit to have a case conference, they now insist on the home sending all the notes over to them. This is both time consuming and unsatisfactory'. (All notes must be photocopied)."

Dentist

Access to Dental services is a national problem that has been raised with Healthwatch in the past. It is difficult for anyone to access regular and timely appointments and anecdotal reports that many Dentists are no longer accepting NHS patients are widespread.

The population of care homes are a particularly vulnerable group with those experiencing communication difficulties potentially suffering the most. It is generally accepted that poor dentition can affect nutrition and hydration. One Home Manager reported that the Care Quality Commission see oral health as a major issue but that the home struggle to get help or advice regarding oral care especially for those residents with dementia who may not be able to articulate pain. In some homes, residents have resorted to private dental care as it the only way they can see a dentist. However, many can't afford to do this.

Other comments received include:

Positive experiences	Negative experiences
Not experiencing any issues, no issues getting a dentist to visit.	There are no domiciliary visits this impacts on the levels of nutrition, plus dental pain effects, the behaviour of dementia patients.
	One home informs that there is a massive impact on the residents. The Dentist, that they were using no longer offers extractions to homes, caring for patients with dementia.
	"Getting a dentist to attend is still a struggle. We will leave messages for them, but it can be months before they return the calls."

Visiting arrangements
When the project started in October 2022, there were still some restrictions related to visiting which had been introduced during the height of the pandemic.
These included:

- Wearing of masks
- Visiting in residents' rooms
- Restrictions to the number of visitors at one time
- Booking visiting appointments

Lateral flow testing had ended for visitors and staff.
The homes were all following local and national advice and they responded accordingly as guidelines changed throughout the project.

Mask wearing was largely accepted by all even if personally disliked. However, it did have an impact on arranging social events for residents as masks interfered with the experience from visiting entertainers. Residents and staff reported it was a struggle to clearly hear singers who were wearing masks as their voices became muffled. As many residents experienced hearing difficulties, this certainly spoiled the occasion. Some homes had therefore, suspended this type of social event.

Restrictions on the numbers of people allowed in a space at any one time had certainly had a negative effect on many of the residents who staff reported had become withdrawn and isolated.

Local guidelines were still in place for managing an outbreak which was classed as 2 or more cases at one time. One home that was visited in March had been in continuous 'lock down' since Christmas and the home manager was very concerned about the impact of this on residents. The restrictions had been lifted just a few days before our visit. Many home managers referenced this as a source of frustration as having 1 or 2 cases had such a negative impact on the rest of the residents. Whilst they understood the reasoning it did create many challenges in attempting to minimise the impact for others.

Despite the ongoing challenges of delivering care in such a climate, the homes had become resourceful in offering alternative arrangements for relatives and residents. Some homes had been able to adapt rooms for family group 'get- togethers' and others with larger communal areas used these for family events e.g. birthdays. Indeed, one home had celebrated 200 birthdays in the last 12 months, accommodating family celebrations in the bar area.

The care home managers all praised the support they receive from the Infection Prevention and Control Team. They gave very positive feedback on the support they had received during and since the pandemic. The response time when contacted and the information, advice and support they received was very welcome and of great value in keeping the residents and staff safe.

Conclusions

This engagement event was aimed at identifying how staff are able to access services for their care home residents across Wigan in the post pandemic era. The event took place across a six-month period and involved 15 homes in total. It was unfortunately, very difficult to engage with residents on this subject therefore the information was gained largely from staff. Some homes had sought feedback from relatives prior to the visits so were able to provide insight from their perspectives.

As can be seen in the body of the report, the experiences of the care homes appear to be quite mixed across the borough. Some of the differences can be explained by the differing registrations i.e., nursing home or residential home. Yet other services which you would expect to be delivered equably across the area seem to differ from home to home. It is difficult to fully understand why this would be without having a full description of each services delivery model, which is beyond the scope of this project.

One service which the homes all commented and agreed on was Speech and Language Therapy (SaLT). Without exception, the homes expressed concern at the method of assessment of swallow that has been adopted since the pandemic. Even when other services have returned to normal and restrictions have been lifted, this service continues to largely have continued assessments via Zoom. Staff expressed how time consuming this is for them, taking staff away from other duties for lengthy time periods. They were also concerned about the safety of the assessments as they did not always feel they had the right knowledge and skills particularly to 'feel' a swallow. The Home Managers raised concerns about staff becoming more risk averse and the potential increase in the number of referrals back to SaLT.

A recurring theme across the homes seemed to be the inconsistency of service delivery. Some homes appeared to be very satisfied with some services whilst others struggled to access consistent input. Whilst this is in some way understandable for the GP services, who are largely independent of the local NHS organisations and therefore more autonomous. The same cannot be said of services such as Tissue Viability or the Falls service as examples.

This inconsistency makes it very difficult for the homes and leaves them feeling embattled. Staff reported to the volunteers that it could often feel like they had to fight with services to get a response. This often left them caught in the middle when residents and/or their families were requesting information and they often became scapegoats for their dissatisfaction or frustration.

Care home staff left the volunteers with the feeling that they felt isolated and not part of the community of health and social care. This was confirmed by some home staff who expressed feeling that they are 'left to it'. This was a strong feeling held by some of the care home Activity Co-ordinators'. One of whom questioned why some of the activities or focus by 'Be Well Wigan' couldn't offer support or input into care homes. Once a person becomes a resident in a care home it is down to the care home staff to provide all aspects of care both physical and social.

Conclusions

By not communicating in a much more accepting way and acknowledging the role of the home and its staff as/in lieu of Next of Kin there is an acute potential for incidents as described earlier relating to medication, ongoing treatments and withdrawal or change of therapies. As was described by one home when they received a resident back into the home from hospital. Medications had been changed, some removed and some added. By not informing the home regarding this, and of the reasons why the changes had been made, the resident is open to being given the wrong medication, at the wrong time and in the wrong dosage.

As with inpatient care much more collaboration is required between the home and the A&E department. Joined up working is vital if the care and safety of the resident is to be upheld. Care home staff should not have to negotiate the current barriers put up by hospital staff and managers. The authors are fully aware of the need for patient confidentiality. However, it is felt that there needs to be a change in current thinking. We have a growing ageing population. Adult social care is a huge part of the care required for the elderly and going forward the problems we are seeing now will only grow exponentially.

The ongoing requirement to 'lock down' with a minimum of two cases is preventing care home residents returning to normal life like the rest of the community. The World Health Organisation declared an end to Covid 19 as a global emergency earlier this year and the British Government withdrew its Covid Guidance to social care in March 2022 and replaced it with:

- Infection prevention and control: resource for adult social care. Published 31 March 2022.

The authors are at pains to point out that this study only covered a sample of nursing and residential home in the borough. There is much potential for these problems to be replicated.

Recommendations and next steps

1. HWWL strongly recommend that services such as SALT and Funded Nursing Care review their current offer to care homes with a view to returning to pre-pandemic models of service.

2. There is a vital need for closer working between the homes and hospital. A closely tied working group of home managers, hospital managers and relatives representing residents and residents themselves should form a more collaborative working group. This needs to look at accepting that the homes staff are frequently the only people who have current knowledge of the patient's needs, beliefs and experiences which impact on care. In addition, they are the ones who will continue to deliver any ongoing care and follow any instructions given by hospital specialist staff.

3. The Integrated Care System should review the current commissioning arrangements for GP services and hold them to account to deliver the services required to support care home residents appropriately. The current arrangements appear to differ from one practice to another.

4. There needs to be greater equality in access to services and funding for care home residents and those receiving care at home. Currently nursing home residents are unable to access some services/funding that would be available to others in a different setting.

5. Wigan Borough Council have a well-advertised campaign aimed at improving physical and mental health and wellbeing. However, this is largely aimed at children and adults who can arrange or indeed access activities themselves. Be Well Wigan have volunteer leaders in several activities. HWWL recommend that this service should consider how it might offer input to the care homes within the Borough to improve the health and wellbeing of home residents and support home staff in delivering social activities by expanding the use of volunteers of all ages in care facilities.

6. HWWL strongly advise that the current infection prevention and control guidance is reviewed and the current government guidance to adult social care is adopted.

7. The care homes managers have commented on the lack of feedback when raising safeguarding concerns relating to an NHS service. The authors recommend that Wigan Borough Safeguarding Adults Board develop a mechanism that provides information about the outcome of a concern which should be fed back to the relevant care home. This would also allow for learning and therefore close the loop from reporting to conclusion. This would go some way to developing closer links and promote value and inclusion across the health and adult social care community.

Recommendations and next steps

healthwatch Wigan and Leigh

Reflections of the AR volunteers

At the inception of the project the intention was that the work would be conducted solely by volunteers. The project timing coincided with significant changes within the Healthwatch team which left them considerably shorthanded. Whilst there was initially a group of 11 Authorised Representatives underwent preparation for the project, a variety of circumstances meant that in reality the project was delivered by 4 of the group. HWWL staff inevitably picked up some of the work to complete the project in a timely manner. This needs to be taken into consideration should any further volunteer led projects be considered in the future.

Both volunteer AR's and HWWL staff reported feeling a number of mixed emotions following their visits. They saw many examples of caring and committed staff doing their best in difficult circumstances. However, the overwhelming feeling was of resident and staff isolation. A lack of connection to the community or belonging to the health and social care family was evident. As one of the volunteers observed:

From the visits we made and previous experience it's easy to "blame" the home for failures / not doing something/not going the extra mile but it's evident their contribution to someone's life & wellbeing is rarely valued by primary or secondary care services e.g. homes are not deemed to be "next of kin" for transfer of information but ARE seen as the "responsible authority" when NHS/Social care services and families want to pass the burden of care on.'

Responses

Jo Willmott, Director of Social Care and Transformation said:

On behalf of Wigan's health and social care system I would like to extend my thanks and appreciation to Healthwatch and the Care Homes who took part in the project. Care Homes support some of our Borough's most vulnerable residents and it is very important that providers and their residents receive the very best holistic support from health and social care services. This project has identified a number of important recommendations to improve the experience of care home residents and enable care home providers to deliver outstanding care and support. I welcome the opportunity to work with Healthwatch and colleagues across health and social care to ensure these findings and recommendations are fully explored and addressed. A special thank you to the expert volunteers from Healthwatch who gave up their time to improve health and care services across the Borough.

Acknowledgments

This project would not have been possible without the welcome given to the Authorised Representatives from the Care Home Managers and staff. Their openness and honesty in sharing their experiences has painted a picture of hard working and caring staff in both the homes and the health and social care services they use tinged with frustration and at times conflict.

Thank you also to the Healthwatch Engagement staff who supported the AR volunteers by arranging the preparation sessions and supporting the visits.

Care home project visit record sheet

Care Home name: Nursing/residential/dementia	Date of visit

Notes about Access to Health care professionals: please try to determine if access has changed post covid pandemic.

Notes about visiting arrangements – check any notices displayed/ask residents or relatives.

Please note any positive aspects of visit:

Information gained from: (please do not use names just indicate staff/resident/visitor)

Did you raise any concerns? If so, who did you report back to? (Please indicate full name and position in CH and type of concern)

Names of volunteers completing visit

Signature & date:

Appendix

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NAME OF CARE HOME _____ DATE OF VISIT _____

RISK ASSESSMENT

Completed by

Name	Job Title	Date

Activity

Description	Location	Date
Engagement activity by means of non-enter and view.		

Risk Assessment

HAZARD	RISK	LIKELIHOOD	MITIGATING ACTION
Covid 19	Volunteers bringing covid 19 into the home.	LOW	All volunteers to carry out lateral flow test prior to the visit. Any symptoms of covid 19 to be reported immediately to staff at HWWL and visit cancelled.
Covid 19	Volunteers contracting Covid 19 from either residents or staff in the home.	LOW	Lead volunteer to contact home manager on the day of the visit to establish the current covid and infection control status of the home. All volunteers to strictly adhere to the homes/local infection control or covid policy and wear masks as requested by home manager, resident or relative. Always use hand sanitiser before contact and between contact with individuals.
Volunteer safety due to potential hostility from family, residents or staff during the visit.	Hostile and non-cooperative reactions.	LOW	As this is to be a supportive exercise this is not deemed to be a risk. However, volunteers should always remain observant and be prepared either to summon help or remove themselves from a situation where they feel uncomfortable or unsafe. If deemed necessary, terminate the visit.
Being invited into a residents' bedrooms to talk.	Vulnerability to both resident and volunteer	LOW	Volunteers should if at all possible, remain in communal areas and within sight of fellow volunteers. Should a resident invite you into their room, politely decline and suggest the quiet lounge. If the weather permits, an outside seating area is another option.

Appendix

			Ensure that the volunteer/HWWL staff you are paired with are aware of your whereabouts.
Being offered gifts or money by residents.	Vulnerable residents may offer you gifts or cash as they may see you as a friend come to visit.	MEDIUM	Volunteers should never accept any gifts of money from any party when carrying out either supportive or enter and view visits. Should any gifts or money be offered, politely decline and inform the volunteer you are partnered with and if necessary, the home manager.
Disclosure by resident or staff	Potential cause of distress to volunteer following a disclosure or witnessing and incident whilst in the setting.	LOW	Volunteers have undergone training prior to commencement of visits. Volunteers have been made aware that any disclosures should be recorded and reported to the home manager. Then discussed with HWWL staff who will act accordingly. All volunteers to ensure they have accurate and up to date contact details of HWWL.

Have all relevant staff and volunteers been provided with a risk assessment?

YES	

Authorised by

Name	Date	Signature

References

- Department of Health & Social Care. Infection prevention and control: resource for adult social care. Published 31 March 2022. www.gov.uk

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