Introduction

Starting in January this year Healthwatch Wandsworth has been visiting sheltered schemes in Wandsworth. This work was done in partnership with the Older Peoples Forum who received funding from The Charles Hayward Foundation, The Seldom Heard Groups initiative funded by Wandsworth CCG, and Sanctuary Housing to carry out a number of 'Getting to know you' and 'Reminiscence Sessions'. The schemes visited have been a mixture of council funded schemes and Sanctuary Housing schemes. The issues and stories that have been used to compile this report have been taken from sessions with the following sheltered Schemes:

Wandsworth Borough Council run sheltered schemes:
Alton Manresa
Ashburton
Grosse & Hepplestone
Lennox
Minstead Gardens
Francis Snary

Sanctuary run schemes:
Shaftesbury & Cooper House
Joshua Oldfield House
John Kirk House
Tailors Court

In total, 10 schemes have been visited so far, with more planned to take place in the next few months. Healthwatch has engaged with 68 residents and to date the whole project has met with 117 residents.

The issues identified in these sessions have been grouped thematically for ease of reference and response.

Methodology

Previous work with sheltered schemes showed Healthwatch Wandsworth the importance of establishing a relationship with this group to ensure they feel comfortable talking about their experience of health and social care services. To enable us to do this it was agreed and planned that HWW would attend 2 sessions; the first one to get to know the residents, learn about their experience of accessing health and social care services and identify any requests for information and signposting. The second session was used to identify any further issues, answer questions raised in the previous meeting and deliver an information session on how to complain and feedback about healthcare services.

Summary

The core issues that were identified in the sessions can be grouped around the following themes:

- **GP's**
- **Older People as Carers**
- **Quality of Home Care**
- **Consistency/continuity of home care staff**
- **Communication between SHO's, Care Agencies, families and health service providers**

- **Persistent lack of understanding of the SHO's role & huge demands on them**

GP's and other Health Care Services

GP's: Many of the residents reported being happy with their GP service and many of the stories recorded by Healthwatch were positive.

The following surgeries were mentioned:
Falcon Road
Trinity Road Surgery
Grafton Medical Surgery
Brocklebank Surgery and Home Dental Service
Alton Road Surgery
Charlton Practice, Cortis Road
Trevellyan House practice

A common theme amongst many of the schemes that we visited was difficulty with booking appointments. The majority access appointments through walk-ins or phoning in. Many found that the only way they can book an emergency appointment is to turn up at the surgery very early and wait for the surgery to open. The telephone lines are very busy in the mornings and even if they get through, often the emergency appointments are taken. What happens to those that are too ill to walk-in or even make the telephone call themselves? Some SHO's have found themselves calling GP's for residents that are too vulnerable to make appointments, request home visits or even visit GP's directly on their behalf.

There was also inconsistency in the roll out of the named GP for the 75+. Some said that they had one but rarely got to see them and others had not been given a named GP yet and did not know they were entitled to one.

District Nursing: For the most part district nurses were praised for the care that they provide. However communication was felt to be an issue for some SHO's who felt that the district nurses did not always understand the SHO's role or else they did not listen when they made suggestions or gave feedback on the health needs of the patient.

One SHO spoke about a resident suffering with Oedema who has nurses coming in only once a week to change the stockings. Because she is wrapped up tight and has open wounds, she can barely walk. Keeping the wounds closed all the time also means that they are not healing. The woman used to be able to walk but can no longer do so. This has been going on for 8 months. The nurses will not leave her legs open because she is at risk of infection, which means that she ends up wearing the same bandages for the whole week which does not help wound/infections.

Another SHO has been asking for a replacement of a very old catheter for a resident that suffers with arthritis. The arthritis makes it difficult for the resident to open and drain her catheter without help, but she has not been listened to.

Following the first report into Sheltered Schemes that Healthwatch produced, the CCG expressed an interest in providing training for GPs and other health professionals regarding the SHO's role and what they can/cannot do for residents. District Nurses and SHO's play vital roles in safeguarding the health and wellbeing of Sheltered Schemes and Healthwatch feels that this awareness raising

training is still required and will help facilitate closer working and understanding between district nurses and SHO's.

Discharge: One resident admitted into St George's Hospital suffering from a Stroke spoke about her experience of the discharge process. Morning nurses had wanted to move her to Kingston Hospital but decided against it as there is no stroke unit there and it would therefore not be suitable. However, the night shift decided at 11.30pm to proceed with the transfer to Kingston Hospital where the patient was told that they could do nothing for her and was then discharged at 1.30am.

Another elderly patient at St George's was kept waiting on a stretcher for 8 hours to be taken home. The man needed a specialist ambulance to take him home. One admin member of staff took it on herself to keep calling about his transport arrangements but was continually told that it was being arranged. When she called up after the shifts had changed it turned out he had been forgotten about, which delayed his pickup as the new staff didn't know about him. The receptionist then took it upon herself to make sure he was okay and eventually she had to go to get the gentleman something to eat and drink. The patient was finally taken home at 9:45pm, having been waiting from midday.

These cases point towards an issue of communication when staff change-overs happen, leaving vulnerable patients at risk of being forgotten or discharged at unsuitable times.

Some residents questioned what the transport arrangements would be after being taken to hospital after a 999 call. If discharged on that day, patients are expected to make their own transport arrangements to get home. Often many elderly people arrive at hospital unaccompanied and with no money. Transport can be arranged (via PALs) during normal office hours otherwise patients have had to sort themselves out. Would this also apply to elderly vulnerable people?

Communication: One resident spoke about his frustrations communicating with health professionals. He is going deaf and is waiting for his hearing aid to be fitted. He is currently working with 5 hospitals for his general healthcare needs and the delay is causing isolation. Despite his being deaf, health professionals keep calling him instead of emailing him and this causes him to miss appointments. Is there a system where a patient can have added to their medical notes that their preferred method of communication is emails or letters? This particular patient currently has to wait for his daughter (who works full time) to come and check his emails once a week.

Concern was also raised about residents that have, or are being diagnosed with, dementia missing appointments because they forget to open and read mail or because they forget about their appointments. If the resident does not have family or friends to check up on them it could be months again before it is realised that they did not show up for an appointment. Suggestions were made that the relative or SHO be copied into appointment letters so that they can remind them. Is this something that can be looked into?

Communication between Hospitals, GPs, SHO's and care agencies was one of the most pressing concerns highlighted by both residents and SHO's. Communication plays an important role in preventing wastage of time and services. There is often not enough communication between hospitals and the carers' agency to prevent carers attending a client's home when the client is not there, thus wasting time. Who is responsible for informing the care agency that a resident is no longer in their home and has been admitted to hospital so that they can then inform the carer?

Residents also questioned who is responsible for informing GP's that their patient has been taken to hospital or a care home? *One resident reported that although he had been receiving an injection*

from a district nurse for 19 weeks, he discovered in his medical notes used by the nurses, there was no record of his GP details or if his GP had been informed.

Pharmacist: Lots of pharmacies were praised as providing a good service, with chemists praised for providing services that are useful, for being knowledgeable and helpful.

However when it came to the new automated electronic prescription system some residents commented that it was causing them trouble. Some reported their chemist not being able to find their name on the system, others have experienced problems getting repeat prescriptions and not understanding how the system works. An introduction leaflet about the new automated system was felt would be very useful.

Conclusions and recommendations:

There were lots of questions raised throughout Healthwatch's visit to the schemes and as part of our duty to report back to the communities we have consulted, we will be returning to these schemes to report back the answers to the questions asked and the responses to the issues highlighted. Although many issues were raised, we feel that the main issues are:

Inter-agency communication - not just between care system and health system but between e.g. GP/ Hospital/Pharmacy

Variable experiences and systems in place when booking GP appointments

More information needed about the new electronic prescription system

SHO's and Social Care Service

Role of the Sheltered Housing Officer (SHO): There are still misunderstandings about the role of the SHO by health and social care professionals and to a certain extent, residents too. Some feel that although their role has changed, their title is the same and this can often cause confusion. Misunderstandings with healthcare professionals usually result in the professional expecting the SHO to carry out the activities and role of a carer. *One SHO spoke about her experience of being shouted at by a Community Matron because the home of a resident was not kept clean.*

Similar to the awareness raising activity carried out to inform social workers about the role of the SHO, a similar exercise to inform healthcare professionals would be useful in tackling misunderstandings.

SHO's spoke about how their role can vary drastically – *"…one day a nurse, the next an electrician, then a handyman, then an events organiser..."* But all this is to be done in reduced hours. Some commented that they struggle to support all the residents as a large majority of their time, which has been reduced, is taken up with the administrative elements of their role, often 'stuck behind a computer screen'. Their reduced availability on the scheme can often mean that they do not always provide the support that the residents may need.

Despite this though many SHO's go above and beyond their role to provide some amazing services such as:

- Producing list of local GP's for new residents or those that need help identifying a GP
- Liaising with care agencies when carers do not arrive on time
- Calling GPs on behalf of residents for appointments/home visits

- Supporting residents to set up Residents Associations
- Organising social activities to bring residents together

SHO's are seen as a source of information and one resident commented *"they are much more important, a lifeline, helping and signposting us. They make a huge difference to the quality of our lives."*

Quality of Home Care: SHO's often find that they are keeping tabs on carers to make sure they are turning up on time and doing what they are supposed to. If a carer is late they will often have to chase up the agency to check what alternatives are being put in place. A carer not showing up or being late often has repercussions for residents who have medication that they need to take by a particular time. Where a resident has to have breakfast before taking medication and a carer is late or does not show up some SHO's have said that they would step in and make sure vulnerable residents have breakfast.

Other examples of poor quality home care include:

- *It was discovered that a carer was not completing paper work to say what had been done for the client. When the SHO reported this, the carer came in and backdated the information that should have been written up already. The SHO had however taken photographic evidence of the paperwork that was missing.*
- *There was one day when the warden went to a resident's apartment with a doctor because of concern about their care. When they arrived the carer was there and the resident was on the floor but the carer had not picked them up. The doctor and the SHO had to pick up the resident.*
- *One carer would come to visit a resident but instead of working would sometimes lie down on the sofa and have a rest. Other times he would make tea for the resident and maybe do the dishes.*
- *One resident spoke about how his carer would come in too late in the morning, once he was already dressed, had had his breakfast and had made his bed because he was in the habit of getting up really early in the morning (4am) and doing these things. The carer would not come till 10/10.30. The resident could have done with the help but by the time it got to him it was of little use.*

Some SHO's felt that it would help them if they knew which residents had carers coming in. Although it was felt that this would add to their large workload, knowing the care plans of vulnerable residents, with their consent, would help them to ensure that these residents are getting the care that they are supposed to. Lots of vulnerable residents will not speak up for themselves and often poor care can be missed unless it is noticed by other residents or the SHO.

There used to be a system in place where carers used a special telephone to call in when they arrived at a home and left. The SHO's want to know if this is still an active procedure and if so who is enforcing it?

Consistency/Continuity of Care: Many residents spoke about their frustration organising care for themselves or a loved one. There can be wide variations in the experiences of residents living in the same scheme organising their care. In one scheme, two residents can have a very different experience.

For one resident, carers were put in place very quickly but it took a long time to get assessments organised. In another case at the same scheme, the SHO had to visit the GP of a vulnerable resident

as it was taking too long to organise an assessment and care. The GP was on the phone straight away and got the ball rolling for the resident.

Some said that they struggle to get the carer of their choice. Vulnerable residents especially get comfortable with one carer and when this is changed without any consultation with them it often causes distress.

One resident trying to organise care for her husband spoke about her struggle to get the carer that works best with her husband. Although the particular carer is available and willing to work with her husband, the carer has been taken off working with that particular client. The couple were not told why or given any warning.

Residents also spoke about their differing experiences with the organisation of aftercare after being released from hospital. Two residents, who both used Epsom hospital for the same treatment had hugely varying experiences with aftercare, with one receiving absolutely none and the other receiving the aftercare that he needed.

Residents and SHO's wanted to understand why there is such inconsistency and who is responsible for ensuring that after care is organised for a patient when they leave hospital?

Communication with Care Services: A large majority of SHOs and residents expressed concern that there is no communication between the Care Agency, the carer and the SHO. This is an area of concern as poor communication can mean that residents are not getting the care that they deserve and that this goes unnoticed until too late.

Many of the SHO's that we spoke to had suggestions to improve the quality of care received by residents.

In some schemes, the SHO is not aware of which residents get carers and which do not. In order to look out for vulnerable residents, SHO's felt that it may be useful for them to know which residents have carers.

There is not enough communication between Agencies and the carers to prevent a carer from attending a client's home when the client is not there. This wastes the carer's time. SHO's want to know who is responsible for informing the carer that a client is no longer in their home.

In one example a resident had died in her home. It turned out the carer had visited twice, not received a response but then had not reported it to the SHO or the Agency either. The woman was found by emergency response officer a few days later.

Does the Carer have a duty to report not being able to access the property or client?

SHO's are also concerned if it is not communicated to them that a resident has been sent to a care home or moved elsewhere for more care.

SHO's felt that they can end up relying on 'concerned neighbours' informing that they have not seen a particular resident , as often no one communicates with the SHO about what is happening with residents.

Elderly Residents becoming carers: In two of the schemes we visited we were made aware of elderly residents that have ended up becoming carers for their relatives. In both cases they had tried to get help but due to the poor quality of care received or due to the resistance of the person being cared for, they had to take on the mantle of being a carer. Being elderly and vulnerable themselves, taking on this extra role caused anxiety and stress.

One resident ended up becoming a carer for a sibling because she had refused to accept help. He wanted to know what happens if someone needs help but doesn't want the support. Another resident was unhappy with the work of the carer and despite complaining, which did not help, decided to step in and take on the caring role herself.

There is an issue here about access to information about what options are available to them.

Conclusions and recommendations:

There were lots of questions raised throughout Healthwatch's visit to the schemes and as part of our duty to report back to the communities we have consulted, we will be returning to these schemes to feedback answers to the questions asked and the responses to the issues highlighted. Although there were many issues raised, we feel that the main issues are:

- *Misunderstood role of SHO (AKA Scheme Manager for non- council schemes) EITHER- Too much is expected of them OR information is not passed to them about residents- latter is particularly important for larger 'detached' schemes.*
- *Special support systems should be in place if an elderly person becomes the carer for a loved one- especially with regard to support completing paperwork and retaining the additional support from a trusted carer*
- *Clarification of transport services to and from hospital - especially for vulnerable older people who may have no one to meet them at home.*
- *Communication between the SHO and the Care Agency*
- *Who is responsible for informing an SHO that a resident is not home and/or has not been seen for a while?*