healthwatch
Redbridge

Care of the Elderly Project: Community Engagement Report

April 2026

Project Details

Item	Details
Project Name	*Care of the Elderly – Community Engagement*
Purpose	To understand older residents' experiences of hospital care, discharge processes, and post-hospital support across Redbridge.
Engagement Period	September 2025 – March 2026
Methods Used	• Online and paper surveys • In-person engagement at community events • Outreach via GP practices, community organisations, cultural and faith groups • Targeted engagement with sensory-impaired residents • Email and newsletter distribution through partner networks
Project Leads	Rafat Kiani - Research and Engagement Coordinator Miranda Peers - Volunteer Coordinator

Disclaimer

This report reflects the experiences shared with Healthwatch Redbridge during the period of engagement. It is based on the views of the 50 older residents who completed the survey and the insights gathered through community outreach. While the findings highlight important themes, they do not represent the full range of experiences of all patients using local health and social care services.

The report should therefore be interpreted as a snapshot of what people told us at the time, rather than a comprehensive assessment of all care provided.

Acknowledgements

We would like to express our sincere thanks to the 50 older residents who took part in this project by completing the survey or sharing their experiences during community conversations. Their insight has been invaluable in helping us understand how hospital and community services are working for older people in Redbridge.

We are grateful to the GP practices, hospital contacts, and the many community, cultural, faith based, and voluntary organisations who supported the circulation of the survey.

We thank Age UK RBH, Pensioners Forum, Albert Road Mosque, Redbridge Carers Support Service, Redbridge Rainbow Community, Shopmobility, Redbridge Respite Care, Redbridge Disabled Women's Welfare Association, Sensory Specialists, and Redbridge Forum for their active engagement through newsletters, event hosting, and direct outreach to their members.

We would like to add a special thank you to The Macular Group/Sensory Specialists who invited us into their group to share their insights about barriers faced by individuals with sensory disabilities.

Finally, we extend our thanks to volunteers who shared the survey within their churches, reading groups, and keep-fit groups. Their support ensured that a diverse range of voices were represented in this work.

Contents

Executive Summary

Healthwatch Redbridge engaged with older residents to understand their experiences of local hospital care, hospital discharge, and post hospital support. This work was undertaken to assess how effectively the hospital to home pathway functions for an increasingly complex older population, and to identify where coordination between health and social care services is working well or breaking down.

Feedback indicates that, while individual services deliver diligent care in places, the overall pathway is often inconsistent and fragmented. Older people described difficulties navigating their care, limited communication, variable personal care, long and unpredictable discharge waits, and mixed access to community-based support. A dedicated focus group with blind, visually impaired, and deaf residents highlighted additional barriers linked to disability awareness, accessibility, and staff understanding of sensory needs.

These issues point to systemwide pressures rather than isolated service failures. The cumulative impact is a pathway that does not always provide older residents with the clarity, continuity, or safety they need as they move between hospital, community, and social care services.

Key Findings

- Basic care was unreliable, with 44% reporting poor support with washing, dressing, and toileting, and half rating access to clean clothing and gowns as average or below. Noise levels were a major concern, with 60% describing the ward environment as poor or very poor.

- Patient safety processes showed weaknesses, including poor medication management (36% poor/very poor) and difficulty accessing call bells (32%).

- Communication and involvement were major concerns, with many patients reporting unclear explanations, not feeling listened to, and lacking confidence to ask questions.

- Access to therapy and community services was mixed, with district nursing and reablement rated positively, but physiotherapy, occupational therapy, mental health support, and care packages showing variable or negative experiences.

- Discharge processes were delayed and unpredictable, with most patients waiting 4–12+ hours on the day of discharge. Medication and paperwork were the main causes of delay, and early discharge planning was inconsistent.

- Post hospital discharge support varied, with strong feedback for carers and district nursing but inconsistent experiences with therapy follow-up and equipment provision.

- Sensory impaired patients faced significant accessibility and dignity issues, including insensitive staff interactions, lack of awareness of visual/hearing needs, and practical barriers such as missed meals and poor navigation support.

Executive Summary

Recommendations

Improve communication and patient involvement through consistent communication standards, clearer care plans, and time provided for meaningful conversations.

Strengthen personal care and ward experience by improving staffing approaches, ensuring access to clean clothing, reducing ward noise, and making call bells reliably reachable.

Reduce ward noise and support rest by providing ear plugs and actively managing ward noise to improve comfort and recovery for patients affected by loud and disruptive environments.

Improve accessibility and disability awareness by ensuring all staff receive mandatory sensory-impairment training, that patient needs are clearly recorded and acted on, that Accessible Information Standard (AIS)[1] communication methods are consistently used, and that patients receive reliable support to navigate the hospital environment.

Streamline discharge planning and coordination by starting planning earlier in a patient's stay, reducing delays caused by medication, transport and paperwork, and introducing a simple real-time tracking approach, building on, but distinct from, the existing EPR (Electronic Patient Record) system, to give teams clearer oversight of each patient's progress and resolve pressure points sooner.

Improve post discharge support and continuity through stronger coordination between services, reviewing care package quality, offering early follow-up contact, and ensuring equipment is delivered and explained promptly.

Promote systemwide integration and learning by establishing a cross-sector forum, improving signposting, strengthening shared responsibility across health and social care, and involving community voices in ongoing service development.

Background & Context

Redbridge has a significant and growing older population, which shapes demand for hospital care, discharge support, and community services. According to the 2021 Census, 37,960 residents were aged 65 and over, including 10,404 aged 80+.[2] The distribution of older adults varies across the borough, with areas such as Wanstead & Woodford having a higher proportion of older residents compared with wards like Loxford.[3]

Long-term conditions are a major driver of health and care demand. Redbridge has a high prevalence of diabetes, with rates above the national average.[4] Cardiovascular disease also remains a significant burden, with Redbridge showing higher than average hospital admissions for heart failure and coronary heart disease.[5]

Healthy ageing indicators show further pressures. Healthy life expectancy at age 65 is lower than the London average, meaning many older residents live with illness or disability for longer.[6] Redbridge also has a 17.1% emergency readmission rate, higher than both London and England.[7]

Reablement availability has declined, with only 3% of older residents receiving support on discharge, although outcomes for those who do receive it remain strong.

Frailty and falls are key contributors to hospital activity. Nationally, around half of people aged 80+ experience a fall each year, increasing the likelihood of hospital admission and the need for coordinated discharge planning.

Sensory impairment is another key factor. The Joint Strategic Needs Assessment (JSNA) highlights hearing loss, visual impairment and communication barriers as key issues affecting older residents.

Together, these demographic and health pressures highlight why understanding older resident's experiences of hospital care, discharge and community support is so important in Redbridge, and they directly informed the approach we took in the next stage of our engagement.

Introduction

Healthwatch Redbridge received anecdotal evidence from residents, carers, and community partners regarding the experiences of older people on the Care of the Elderly wards across Whipps Cross, Queen's, and King George Hospitals. Concerns raised included medication management, communication around reablement services, confusion about care package hours and costs, and challenges with hospital discharge and continuity of care. These issues were echoed by the Whipps Cross Patient Panel and through our wider signposting and outreach work, highlighting the need for a deeper understanding of the patient journey.

To build a comprehensive picture of care of the elderly services, Healthwatch Redbridge is undertaking a phased approach to gathering insights:

Phase 1: Ward based engagement: Speaking directly with patients, relatives, and carers on the Care of the Elderly wards at Whipps Cross hospital.

Phase 2: Community based engagement: Gathering insights from older residents who have engaged with health and social care services before, during, or after a hospital stay.

This report focuses on the second element, the community engagement which forms a crucial part of understanding the full care journey. By speaking with older people in familiar community settings, we were able to gather insight from individuals who may not be reached through hospital based engagement alone.

The aim of this stage of the project was to gather feedback from older residents within community settings to better understand their experiences of hospital care, discharge processes, reablement, and social care support. Through this work, we sought to:

- Capture the experience of individuals who had recently been in hospital.
- Explore challenges related to communication, continuity of care, and access to reablement or care packages.
- Identify gaps in information, signposting, and support for older people and their families.
- Strengthen our understanding of how health and social care services work together from the viewpoint of service users.

We are planning to carry out future engagement at care of the elderly wards within Queen's, and King George Hospital's during 2026.

Methodology

Before beginning our engagement work, we carried out desk-based research to ensure our approach was informed and supported by existing evidence. This included:

Analysis of six months of PALS data from Whipps Cross (Appendix 1), focusing on themes relating to the Care of the Elderly wards, hospital discharge, communication, medication management, and social care support.

A meeting with the Complex Whipps Cross Discharge Team (Appendix 2), which provided insight into discharge pathways, familiar challenges, and areas where patients often experience delays or confusion.

This preparatory work directly shaped the development of our patient questionnaire and informed the areas of focus for both the ward visits and the community survey.

Community Engagement - To capture the experiences of older residents across Redbridge, Healthwatch Redbridge carried out a wide-ranging community engagement programme. This included distributing the survey through GP practices, contacting local community organisations, and attending in person events to support individuals to complete the survey.

Survey Distribution - Survey links and flyers were shared with 11 GP practices, all of which were contacted directly via their Practice Managers and asked to circulate the survey to patients and carers. Flyers promoting the survey were displayed at various locations across Whipps Cross hospital.

Community Outreach - We contacted more than 20 community organisations, including Age UK RBH, Pensioners Forum, Redbridge Rainbow Community, Shopmobility, Redbridge Carers Support Service, Jewish community, and several cultural, faith based, and voluntary groups. Outreach involved email communication, follow-up calls, and requests for organisations to share the survey through newsletters or internal networks.

Engagement Visits - Where possible, we attended community sessions to speak directly with older people and support them to complete the survey. Events were held at groups such as Pensioners Forum, Albert Road Mosque, Redbridge Disabled Women's Welfare Association, Redbridge Forum, and Sensory Specialists.

Accessibility and Data Collection - To ensure the survey was accessible to all older residents, we offered multiple formats including large-print paper surveys, digital surveys, and in-person support for individuals who required assistance. We also engaged with culturally diverse groups and ensured our approach was inclusive of sensory-sensitive individuals, including blind and deaf residents, by providing tailored support where needed. Feedback was collected through online and paper surveys, as well as through conversations during community visits.

Key Findings

This section presents the key findings from our community engagement and survey work. Drawing on 50 completed online and paper surveys, community conversations, and engagement with local organisations, the findings reflect the experiences of older residents across Redbridge. The themes below highlight what is working well, where challenges persist, and how hospital and social care services are experienced by those who rely on them.

Findings:

THospital Sites and Ward Locations of Care

Most respondents had recently stayed at King George Hospital (76%), with smaller numbers attending Queen's Hospital (12%) and Whipps Cross Hospital (12%). Ward level feedback was concentrated at King George, particularly from Gentian, Holly, and Beech wards. A smaller cohort related to Whipps Cross wards such as Acacia, Elizabeth, Sycamore. Although some respondents reported attending Queen's Hospital, none specified the ward, limiting ward level insight for that site. Four respondents described being treated in corridors, raising concerns about dignity and privacy. One person shared:

> **"I was in a corridor; it was very difficult and there was no privacy."**

Care and Treatment

Feedback on care and treatment highlighted several areas where patients experienced inconsistent or insufficient support during their stay. Personal care was a notable concern, with 44% reporting poor or very poor support with essential tasks such as washing, dressing, and using the toilet. Several quotes illustrated the emotional and physical impact:

> **"The nurses just ignore and do not talk to you when you are asking for help… I have wet myself waiting for them to come."**

> **"They were very rough while washing me and used to delay helping me to use the commode, I was very scared of them."**

Family members also described distressing experiences:

> **"When they were dressing him, it was hurting. When he told the nurse, she just ignored him and kept going."**

Key Findings

Findings:

Cleanliness of the ward was viewed more positively, with most patients rating standards as average or better and only 6% reporting poor cleanliness.

"They are not giving importance when cleaning the ward... his commode was not properly cleaned."

Noise levels, however, stood out as a significant issue. Sixty per cent of respondents described the ward environment as poor or very poor in terms of noise, indicating that rest and recovery were often disrupted by a consistently loud atmosphere.

Access to communication support, such as interpreters or hearing loops, was mixed among those who needed it. While most did not require this service, 12% of those who did report poor or very poor access, highlighting gaps in meeting accessibility needs.

Access to clothing and clean gowns was also inconsistent, with half of respondents rating this as average or below. This suggests that patients were not always able to maintain comfort or dignity through appropriate clothing.

Medication management showed further variability, 36% rated their experience as poor or very poor, indicating issues with timeliness, accuracy, or communication around medication. Lived experience echoed this:

"Gave wrong medication, when I asked their name, they hid their badges and ignored me."

Access to the call bell was another area of concern, with 32% reporting difficulty using or reaching it when they needed assistance. Some described more concerning practices:

"They will remove the call bell, so I don't press it."

Dietary support was adequate, with 32% rating it as average and 22% as good, though 8% reported poor or very poor experiences, indicating that some dietary needs were not fully met.

Assistance with eating was a challenge for many who required help. Among those who needed support, 36% rated it as poor or very poor, suggesting that some patients struggled to receive timely or appropriate help at mealtimes.

"They just put the food on the table, never helped or asked if I needed any help."

Key Findings

Findings:

Experience of Communication and Care from Clinical Staff

Patient feedback revealed consistent challenges in communication, involvement, and interpersonal care across both nursing and medical staff. Many patients struggled to feel informed, listened to, or confident engaging with clinicians during their hospital stay.

Communication was a prominent concern. Nearly half of respondents felt that nurses did not explain health checks clearly (48%), and a similar proportion reported unclear explanations from doctors, with only 34% agreeing that their treatment was explained well and 34% disagreeing. This lack of clarity contributed to uncertainty about treatment plans, with just 36% feeling their plan was explained and 34% disagreeing.

"Staff were very rude… they never used to help… I was very scared of them."

Over half of patients (52%) said they did not feel listened to by nursing staff, and many described interactions that left them feeling overlooked or not fully acknowledged. Confidence in asking questions was low across both staff groups: 54% did not feel able to ask nurses questions about their care, and 48% did not feel able to ask doctors.

"My family tried to explain my care needs, but the nurses were not prepared to listen, we had to get the lead matron involved."

The emotional and relational aspects of care showed similar inconsistencies. Nearly half of respondents (48%) did not feel adequately cared for by nurses, while only 26% reported positive experiences. Although fewer specific figures were reported for doctors, the overall pattern indicates that many patients did not feel supported or involved in decisions about their care.

"They were rude… heavy-handed… they hid their badges."

Key Findings

Findings:

Access to Support Services

Patients reported a wide range of needs for therapy, community and specialist services during their hospital stay and as part of their discharge planning. The most required therapies were physiotherapy (44%) and occupational therapy (34%), reflecting the prominent level of rehabilitation needs among older patients.

Demand for post-hospital support was also substantial: 50% required a care package and 48% needed district or community nursing. Specialist long-term condition services were needed by 34% of respondents, including neurological, cardiac, continence and brain-injury support, with 18% also requiring mental health support.

> **"Incontinence service is appalling… they make you jump through lots of hoops and there is no follow-up."**

Among those who accessed these services, experiences of helpfulness varied considerably. District or community nursing received the strongest feedback, with 75% of users finding it helpful and only 13% reporting negative experiences. Reablement services also performed well, with most users rating them positively.

Other services showed more mixed results. Physiotherapy was helpful for 54%, though 36% did not find it helpful. Occupational therapy received similarly varied feedback, with 41% finding it helpful and 24% not.

Experiences of care packages were more negative; with 44% reporting they were unhelpful and only 24% finding them helpful to any degree. Feedback on mental health support was limited and mixed: 11% found it helpful, 22% did not, and many had not accessed it. For specialist long term services, nearly half (47%) found the support helpful, while 35% did not.

Key Findings

Findings:

Discharge Experience

Patient feedback highlighted several challenges throughout the discharge process, from the timing of initial conversations to the practicalities of leaving hospital. Many respondents reported delays at multiple stages, indicating that the discharge pathway is not always streamlined or predictable.

Nearly two thirds (60%) of respondents stated that the first discussion about discharge did not occur until three or more days after admission, with over a quarter (28%) waiting more than five days. Only a small number (4%) were spoken to about discharge on the day they arrived, suggesting that early planning was inconsistent.

The discharge process itself was often lengthy. Half of respondents (50%) waited 4 - 8 hours on the day they left hospital, and a further 20% waited 8 - 12 hours. Rapid discharge was uncommon, with only 4% leaving within four hours. Additionally, 12% experienced exceptionally long waits of 12 hours or more, including some who waited over 24 hours.

“It took so long, I was getting stressed and agitated waiting.”

Medication was the most common cause of delay, with 74% waiting for prescriptions to be prepared. Delays in paperwork also contributed significantly (62%), while transport delays affected 24% of respondents. Only a small proportion (6%) required time for a care package or equipment to be arranged. These findings contrast with national expectations set out in the Hospital Discharge and Community Support Guidance, which emphasises early discharge planning, timely preparation of medication and paperwork, and coordinated communication between hospital and community teams.

“Half the medication was not complete, and they asked us to come tomorrow.”

“Hospital transport is really bad, they take so long and you just have to wait.”

Over half (58%) of respondents reported they were discharged in the afternoon, with fewer leaving in the morning (14%) or evening (18%). When leaving hospital, most respondents relied on informal support. Two thirds (66%) were taken home by a family member or friend, while 28% used hospital transport. No respondents reported using public transport or other means.

A small but notable proportion of patients experienced early readmission. Around 18% returned to hospital within three days of discharge.

Key Findings

Findings:

Experience of Post-Discharge Support Services

Among those who responded, experiences varied considerably. Short term stays in nursing or care homes received an even split of positive and negative ratings, indicating inconsistent quality. Help at home from a carer was viewed more favourably, with 68% of respondents rating the service as good.

> **“Since the last hospital stay, carers have been put in place… we are very grateful.”**

Reablement services were well-received, with 60% reporting positive experiences, while district nursing support also performed strongly, with 63% rating it as good. However, physiotherapy and occupational therapy showed more variation.

Physiotherapy received a mix of positive, neutral, and negative ratings, suggesting uneven access or quality. Occupational therapy also showed a broad spread of experiences, with 40% rating it positively and 30% negatively.

Feedback on additional equipment provision was similarly mixed, with equal proportions (22%) reporting good and poor experiences.

Experiences of Sensory Impaired Patients (Blind and Deaf Participants)

As part of our community engagement, we held a dedicated focus group for sensory impaired individuals, including blind, visually impaired, and D/deaf participants. The group highlighted significant concerns regarding staff awareness, communication, and the handling of disability related needs within hospital settings.

Participants reported that some staff lacked basic understanding of sensory impairments, leading to interactions that were described as insensitive, inappropriate, or dismissive. One participant expressed shock at the nature of questions asked by a night-shift staff member, including comments such as ***“How do blind people know where the toilet bowl is?”*** and ***“How do you do things at home without help?”*** These questions were perceived as intrusive and demonstrated a lack of disability awareness.

Key Findings

Findings:

A consistent theme was the need for improved staff training. Participants felt strongly that all NHS staff should receive mandatory sensitivity and disability awareness training, particularly regarding visual and hearing impairments.

They emphasised that disabilities should be clearly recorded on patient files, including the level of visual impairment and the type of support required. Staff should read patient records before interacting with patients, especially when calling individuals for appointments, tests, or procedures.

Staff should avoid vague instructions such as “this way” or “I’m over here,” as visually impaired patients cannot follow directional cues without guidance. The use of a white cane should be universally recognised by staff as an indicator of blindness or visual impairment.

Participants also reported practical issues affecting dignity and independence, some patients were not informed when their food trays had arrived, resulting in meals being removed untouched. Others described being left without assistance to navigate corridors or locate clinical areas.

Discussion

The findings reveal a hospital-to-home pathway that is inconsistent, difficult to navigate, and often poorly coordinated for older patients. System-level issues were evident throughout: unclear communication, variable personal care, long and unpredictable discharge processes, and mixed access to post-hospital support. These gaps left many older residents feeling uncertain, frustrated, and, at times, unsafe.

Communication was a major weakness. Many patients did not feel informed about their treatment, listened to by staff, or confident asking questions. For older people managing multiple conditions, these gaps significantly undermine understanding and involvement in decisions.

Personal care and the ward environment were similarly inconsistent. While cleanliness was generally positive, many patients reported poor support with washing, toileting, eating, and reaching the call bell. Noise levels were frequently described as disruptive, suggesting that ward environments do not always support rest or recovery.

Discharge was a significant pressure point. Planning often began late, and many patients experienced long waits due to delays in medication and paperwork. These experiences contrast with national expectations set out in the Hospital Discharge and Community Support Guidance, which emphasises early planning, timely preparation of medication and documentation, and coordinated communication between hospital and community teams. Most patients relied on family or friends for transport home, and a notable proportion (18%) were readmitted within three days, indicating gaps in discharge readiness and follow-up support. Post-discharge services also varied: district nursing and reablement were viewed positively, but care packages, equipment provision, and therapy services were inconsistent or unhelpful.

Sensory-impaired patients faced additional barriers linked to poor disability awareness, insensitive interactions, and a lack of practical support. These experiences show how existing system weaknesses disproportionately affect people with visual or hearing impairments, raising concerns about accessibility and equity.

Conclusion

This engagement provides a clear view of how older residents experience the journey through hospital and back into the community. Given that most respondents were patients from King George Hospital, the patterns described here are especially reflective of experiences on those wards.

While the specific issues raised vary, the overall picture is one of a system that does not always operate with the consistency, coordination, or accessibility that older people need. The findings show that the challenges are not confined to one part of the pathway but emerge at multiple points, shaping how people understand their care, how supported they feel, and how smoothly they transition home.

What stands out most is the cumulative effect of these experiences. Small gaps in communication, delays in processes, or missed opportunities for support can, when combined, create a journey that feels fragmented and difficult to navigate. For those with sensory impairments or limited informal support, these pressures are amplified, highlighting the importance of designing services that work well for everyone, not just those who can advocate for themselves.

The insights gathered through this work underline the need for a more joined-up approach across hospital, community, and social care services. Strengthening coordination, improving accessibility, and ensuring that staff have the tools and awareness to meet diverse needs will be essential to creating a more reliable and person-centred pathway.

Recommendations

The recommendations focus on strengthening the hospital-to-home journey for older residents by improving communication, personal care, accessibility, discharge processes, post discharge support and systemwide coordination.

Communication and Patient Involvement - Improve how information is shared with patients and families by introducing consistent communication standards. This requires ward staff, clinicians, and discharge teams to explain care plans in plain language, check understanding, and provide written or visual information that patients can understand.

Personal Care and Ward Experience - Enhance the quality and reliability of essential personal care by auditing staffing approaches, ensuring call bells are accessible and improving access to clean clothing and gowns.

Ward Noise Management - Reduce noise levels on wards to support rest and recovery by ensuring patients have access to simple noise-reduction measures such as ear plugs, alongside wider efforts to minimise unnecessary noise during both day and night.

Accessibility and Disability Awareness - Strengthen disability inclusive practice through mandatory sensory impairment training, clearer recording of patient needs, more Accessible Information Standard (AIS) methods are utilised, and better navigation support for visually impaired patients is provided.

Discharge Planning and Coordination – Planning earlier in a patient's stay, reducing delays caused by medication, transport, and paperwork. Using a simple, real-time discharge-tracking approach, building on, but separate from, the existing EPR (Electronic Patient Record) system to give teams clearer oversight of each patient's progress and resolve issues sooner. This approach aligns with national expectations set out in the Hospital Discharge and Community Support Guidance, which emphasises early planning and coordinated communication.

Post Discharge Support and Continuity - Services should focus on more reliable coordination between hospital and community teams, ensuring care packages start on time, patients receive an early follow-up after discharge, and any equipment is delivered and explained promptly. Tracking how quickly information is shared, how consistently care packages begin, whether follow-up contact happens within the first few days, and whether equipment arrives on time will help demonstrate improvement and ensure older residents experience smoother transitions home.

System Wide Integration and Learning - Promote shared responsibility across health, social care, and community partners by establishing a cross-sector forum, using patient experience data to drive improvement, enhancing signposting, and involving community voices in ongoing service development.

References

1) NHS England (2024) Accessible Information Standard. Available at: https://www.england.nhs.uk/accessible-information-standard/

2) Office for National Statistics (ONS) (2022) Census 2021: Population change and age structure – Redbridge (E09000026). Available at: Redbridge population change, Census 2021 – ONS

3) Office for National Statistics (ONS) (2022) Census 2021: Population change and age structure – Redbridge (E09000026). Available at: Redbridge population change, Census 2021 – ONS

4) Office for Health Improvement and Disparities (OHID) (2023) Fingertips: Cardiovascular Disease Profile. Available at: Fingertips | Department of Health and Social Care - https://fingertips.phe.org.uk/

5) Office for Health Improvement and Disparities (OHID) (2023) Fingertips: Cardiovascular Disease Profile. Available at: Fingertips | Department of Health and Social Care - https://fingertips.phe.org.uk/

6) London Borough of Redbridge (2024) Joint Strategic Needs Assessment (JSNA): Ageing Well and Adult Social Care. Available at: Redbridge Joint Strategic Needs Assessment - jsna-2024.pdf

7) London Borough of Redbridge (2024) Joint Strategic Needs Assessment (JSNA): Ageing Well and Adult Social Care. Available at: Redbridge Joint Strategic Needs Assessment - jsna-2024.pdf

Appendix 1

Older Peoples Service PALS Data Whipps Cross Hospital Jan-Jul 2025

Theme	Number of times raised	Issues
Discharge	20 (of these 20, the same email was sent on 3 different dates suggesting a lack of response to the issue)	• Delays to discharge (3) • Concerns re discharge plan • concerns re care package/lack of support (2) • care home found too far away (1 – raised 3 times) • inappropriate discharge (wife continuing to suffer incontinence) (1)
Care	17	Lack of care/poor care: • medication (4) • dirty clothing/bedding – not being changed (2) • patient's condition deteriorating/decline in mental health (2) • pressure sores (1) • lack of attempt to feed patient (1)
Communication	15 (one email duplicated on the same date)	Poor/lack of communication: • relative told consultants do not often speak to families • "Little to no communication with clinical staff, leaving the family uninformed about the patient's condition and treatment" • "Procedures and treatments are not communicated beforehand, causing confusion and distress."
Delays	6	Tests (2) Cancelled hospital transfer (happened twice) Treatment (1) Care (1) Fixing blocked toilet (1)
Staff attitude	2	Doctor (1) Hostess? (1)
Other	6	• Housing issues (2) • last rites • care provider trying to locate patient • lost property • daughter asked to leave ward despite being patient's carer
Total	66	

Appendix 2

Insight gathered from meeting with Complex Discharge Team at Whipps Cross

- Patient's referrals to the district nursing team can get missed. If the day shift pattern does not pick up the referral in time, and the shift switches to the night shift, then the patient can get missed.

- Equipment store (equipment provided by Medequip) is often empty

- Lack of a wraparound system - no virtual wards

- Referrals to the reablement service are more declined, than accepted. Reasons given that they will not take someone if a patient has a plaster or has upstairs living.

- If patients are declined for reablement, they are referred to the integrated care hub (ICH). They will have to wait one week for this to be discussed by a panel and then agreed by a manager.

- If a patient is referred for rehab from Whipps to King George Hospital, they can end up staying longer at Whipps waiting for space at King George Hospital.

- If the patient is being referred for an interim placement (nursing/care home) this can take two weeks, with lots of questions from the panel back & forth, even though evidence has been provided in the referral. There is no integration with the social work or mental health team.

- There is no neuro-rehab in Redbridge. Therefore, the caseload is passed onto consultants that are not experts in this area of medical practice, to make decisions regarding the individuals onward treatment plan.

Appendix

Age	
55 - 69 years	11
70 - 79 years	29
80 +	4
Not known	5
Prefer not to say	1
Grand Total	50

Gender	
No answer	2
Man	13
Not known	1
Prefer not to say	1
Woman	33
Grand Total	50

Ethnicity	
No answer	2
Asian/Asian British: Bangladeshi	7
Asian/Asian British: Indian	4
Asian/Asian British: Pakistani	17
Black/Black British: Caribbean	1
Indo Caribbean	1
Not known	1
White: British/English/Northern Irish/Scottish/Welsh	15
White: Other	2
Grand Total	50

Please select any of the following that apply to you?	
I consider myself to have a disability	14
I consider myself to have a long-term condition	28
None of the above	8
Grand Total	50

Healthwatch Redbridge

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