healthwatch Redbridge

Whipps Cross Care of the Elderly Report

April 2026

Project Details

Service Provider	Sage, Syringa and Sycamore wards Whipps Cross Hospital Whipps Cross Road, London E11 1NR
Contact Details	Hanan L'Estrange-Snowden
Date/Time of visit	17th November 2025, 2.00-5.00PM 19th November 2025, 2.00-5.00PM
Type of visit	Announced
Representatives undertaking the visit	Miranda Peers Rafat Kiani Roxana Solis Margaret Igglesden Sally Curtis
Contact details	Healthwatch Redbridge Redbridge Institute of Adult Education, Gaysham Avenue, IG2 6TD 020 4635 4616

Disclaimer

Please note that this report relates to findings observed during our visit made on 17th and 19th November.

Our report is not a representative portrayal of the experiences of all service users and staff, only an account of what was observed and contributed at the time of the visits.

Contents

Acknowledgements

Healthwatch Redbridge would like to thank the patients, relatives and carers who engaged with our Representatives and took part in the face-to-face interviews.

We were also grateful for the support received from the Whipps Cross Patient Engagement Team, and to the staff on Sage, Syringa and Sycamore wards for their welcome and support on the day.

Executive Summary

This report is in two parts. The first part reflects our Care of the Elderly ward visits, and the second part reflects the patient journey following hospital discharge.

During part one, Healthwatch Redbridge carried out visits to Care of the Elderly wards at Whipps Cross Hospital. The visits aimed to understand patient, relative and carer experiences on these wards, following concerns raised through community outreach and the Whipps Cross Patient Panel.

We spoke to 28 people, finding that patients frequently described staff as kind and caring, and cleanliness standards were consistently rated highly. However, the visits also identified several areas requiring improvement, including hydration support, call bell access, communication, personal care, mobility, medication understanding and discharge planning.

Two serious concerns were escalated immediately: rough handling during personal care and a call bell being silenced without engagement. The Patient Experience Team responded promptly, initiating safeguarding processes, staff debriefs, reflective practice and comfort rounding. Additional actions included reinforcing hydration reviews and launching a Pyjama Paralysis pilot.

During part two, Healthwatch Redbridge conducted telephone interviews over a four-month period with two patients/family members to understand the strengths and limitations of the hospital discharge process and the challenges patients face as they transition into community and social care.

Both experiences were very different. One patient experienced a positive and speedy experience in the discharge lounge, but inconvenient post-discharge support and a lack of orthopaedic follow-up. The family of the other patient experienced repeated discharge delays, poor communication, a lack of care coordination and limited family involvement in key care decisions.

Introduction

Healthwatch Redbridge had received anecdotal evidence regarding the Care of the Elderly wards through our community outreach visits, information and signposting service and the Whipps Cross Patient Panel. The concerns raised regarded medication management, access, and confusion regarding the reablement service, hospital discharge/continuity of care, confusion regarding cost and care hours and people not being provided with their full allocation of carer visits/hours. We wanted to gather further insight to understand these concerns.

Healthwatch Redbridge wanted to speak to patients, relatives, and carers about their experiences of the Care of the Elderly wards and to make their own observations about the patient experience.

We wanted to follow up with some patients once they had been discharged from hospital to understand their experience of care. To gain further insight into patient's experience of community health and social care services, we have also conducted engagement visits to key community organisations, inviting attendees to complete our survey.

Aim & Objectives

Aims:

To speak with patients, relatives, and carers on the Care of the Elderly wards, to understand what works well within the wards and what improvements could be made to improve patient experience.

To identify any patients, relatives and carers who would be willing to be contacted to share their experience of health and social care services with us once they have been discharged from hospital.

Objectives:

- To identify what patients, relatives and carers feel is working well on the Care of the Elderly wards
- To identify what could improve patient experience
- To make recommendations based on feedback received from patients, relatives, and carers
- To make recommendations based on observations made by Representatives during the visits

Methodology

Prior to the ward visits, we conducted desk-based research. This consisted of analysing six-months of PALS data (Appendix 2) and a meeting with the Complex Discharge Team (Appendix 3). The insight gained from this assisted us with our development of our patient questionnaire.

The ward visits were conducted by Healthwatch Redbridge Representatives; including two members of staff and three volunteers. In some cases, Representatives spoke to relatives or carers who answered questions on behalf of their family member/charge. All responses have been anonymised.

Representatives spoke with patients, relatives and carers using a standard set of questions. Representatives took the time to explain who they were and why they were there. They confirmed with individuals that they were happy to speak with them and that their responses would be confidential and anonymised before publication. Representatives additionally explained that they would like the opportunity to follow a patient's journey once they have been discharged from hospital. This would involve a fortnightly telephone call over a three-month period. Any patient who was happy to be contacted shared their contact details with the Representative.

Information leaflets explaining both the role of Healthwatch and the follow-up discharge journey work were left with each person. The report was sent to the provider, giving them the opportunity to request any factual inaccuracies be corrected prior to publication.

Pre & post meeting

We advised the Whipps Cross Patient Experience Team of the visits. The dates and times of the visits were agreed with the ward matrons. The Head of the Patient Experience Team took us to the wards and introduced us to each ward matron.

During the visit we were shown the e-whiteboard system that is being rolled-out across the Trust. These will replace physical boards during ward rounds. Anyone working with a patient can upload information to the system, including hospital transport and the pharmacy. All updates are logged digitally, and the system shows real time requests (e.g. bloods and diagnostics) and updates. We identified one current glitch with the system whereby when a "Discharge Ready Date" is entered, if the discharge does not occur, the date remains visible. We followed up with the Strategy Manager for Unplanned Care & Frailty who informed us that the system will be changed to include both the original discharge date and new planned discharge date, enabling them to calculate how many days beyond original discharge the patient is expected to be discharged. "This data will help quantify delays caused by external factors (e.g., care packages, specialist equipment) and internal process inefficiencies." After each visit, we held a short de-briefing meeting with the Head of the Patient Experience Team to highlight the key issues we identified. We were made welcome by all staff we engaged with.

Key Findings

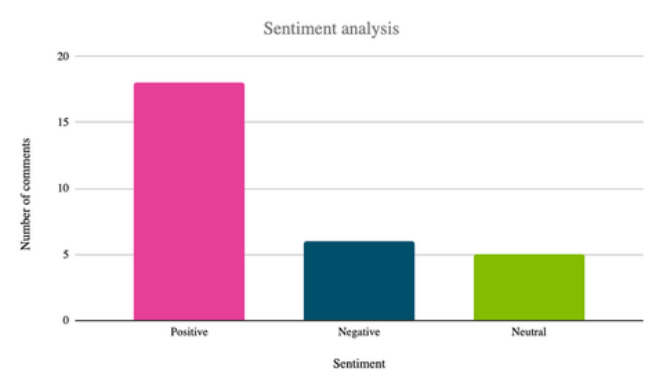
Healthwatch Redbridge visited Sage, Syringa and Sycamore wards on Monday 17th and Wednesday 19th November 2025. These wards are Care of the Elderly wards. During our visits, we spoke with 17 patients, seven relatives and four carers: 28 people in total. We completed 23 questionnaires with some questionnaires completed jointly by a patient and their relative or their carer.

The findings below are a combination of patient experience feedback and observations made by our Representatives during the visits. We have used the word patient throughout, rather than specifying whether comments were made by patients, relatives, or carers.

Findings:

What do you think about the ward?

We asked a general, open-ended question to start the conversation. The overall sentiment of comments was far more positive, than negative or neutral.



Five patients commented on the "kind and caring" staff.

"Nurse & doctors are very kind, considerate to the patient."

Four patients described the ward as excellent, with three describing it as nice and another two calling it very good.

The negative comments pointed to several distinct challenges including limited staff capacity, gaps in understanding and insufficient communication.

"I don't think the staff have time to be pushing fluids. If you can't eat and drink independently, you're in trouble."

"…I feel she has been overall ignored. Dementia is her main and only problem, (according to the Doctor). I feel she has been dismissed as a nuisance."

"Nothing is really followed through until the end. Been here nearly a fortnight and I'm no further on and I'm not sure what's happening."

Key Findings

Findings:

Is there anything you would change about the ward?

Eight patients felt that everything was ok on the ward and did not identify any areas that they felt needed changing.

The area with the most comments regarding change was food, with four comments. Three of these related to improving the quality of the food. Additionally, one patient told us that they did not receive their meal one evening and when they asked were told that the food had run out. They also said that sometimes their food is given to other patients.

Improved communication and listening to the patient's needs was mentioned by three patients.

"Communication is hit and miss. We were getting regular updates from the doctors. It's more hit and miss with nursing. It does feel at times like you're bothering them and they wish you'd go away."

Three patient's mentioned noise on the wards from other patient's or staff.

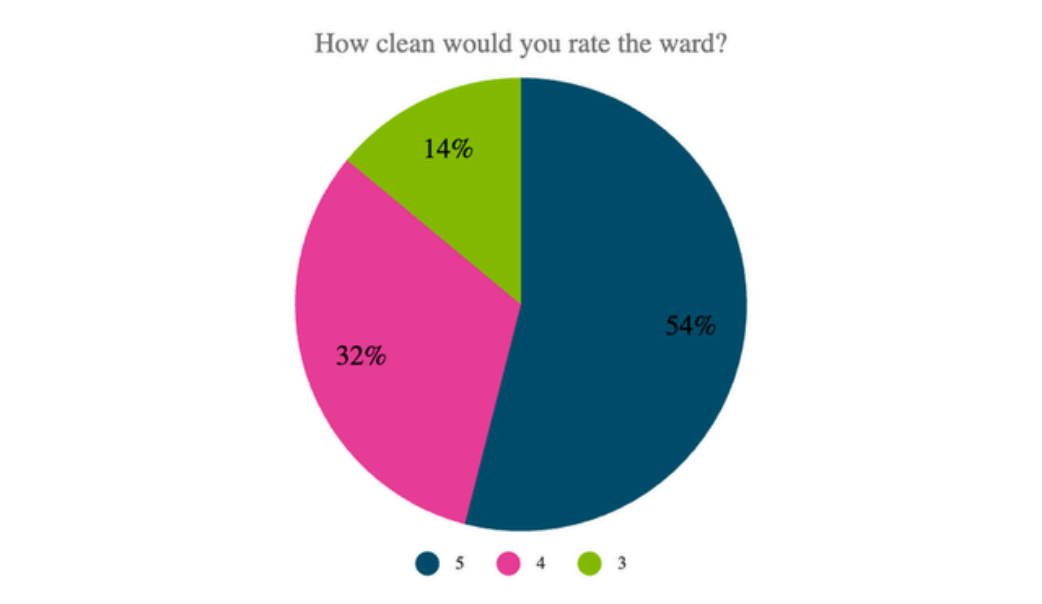
Two patients also wished that the staff had a greater understanding of their particularly health needs.

Key Findings

Findings:

Cleanliness

We asked patients how clean they felt the ward was on a scale of 1-5. Patients were very positive about cleanliness across all the three wards that we visited.



Over half (54%) rated the ward 5/5 in terms of cleanliness, with a further 32% rating it 4/5 for cleanliness.

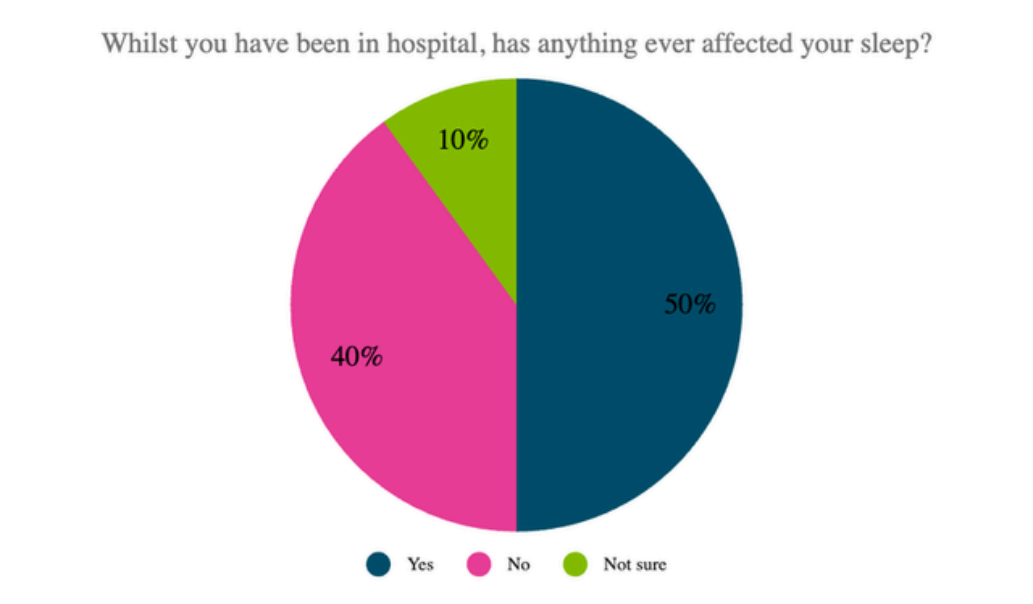
"There was a spillage the other day, it was mopped up within five minutes."

Key Findings

Findings:

Sleep

We asked patients whether anything had affected their sleep whilst in hospital.



Half of patients (50%) said their sleep had been affected. However, just over 40% said their sleep was unaffected.

Nine comments on sleep disturbances were related to noise made by staff treating patients or noise from other patients.

"Noise from other patients, don't get much rest."

However, one third of these patients were quite reflective on the reasons for this noise.

"Noisy patients, but you can't hold that against them."

"No worse than at home. Patient shouting, talking. Nurses have to make some noise doing their job."

Key Findings

Findings:

Patient Safety

We asked patients what they do if they need assistance. There was a fairly even spilt between "press the button" (nine patients) and "call out" (eight patients).

We asked patients if they could access the call bell. 13 patients said they could access it, with five patients being unsure and four telling us they could not access it.

"The button is put back on the wall. She [the interviewee's mother] can't reach it. She has pushed it and waited for over an hour when needed a wee."

Representatives conducting the visits, observed that in some of the bays, most call bells were mounted on the wall, out of the reach of patients. We raised this with the Head of Patient Experience at the end of our visit.

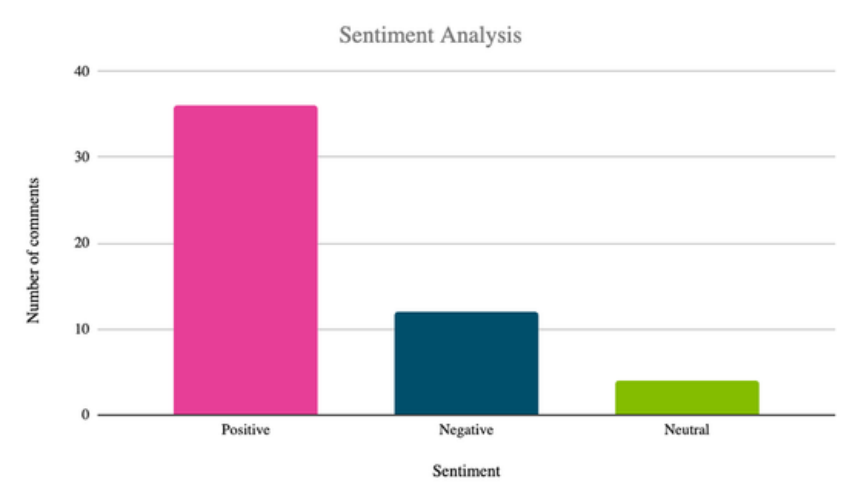
We wanted to know how long it took patients to receive support once they have pushed the call bell. Of the 13 patients who could access the call bell, seven told us they received support in less than 30 minutes, with three telling us it took more than 30 minutes and three patients not being sure of how long it took.

Key Findings

Findings:

Staff

Patients shared multiple comments on how they felt they had been treated by the doctors during their stay. The overall sentiment of comments was far more positive, than negative or neutral.



Patients commented on communication, demeanour, support and whether they felt they had the information they needed about their treatment and understood it. There were nearly double the number of positive comments relating to communication (11 comments) than negative comments (five comments).

"When we've been contacted, the level of communication is excellent. It's very member of staff dependent. And at times we've really had to hunt out information."

There were three times as many positive comments (six) on the doctor's demeanour, than negative comments (two):

"The doctors are pleasant and friendly."

It is worth noting that one relative told us, that, **"Some [doctors] have been very nice and spoken nicely to my sister. Some have shouted at her."**

Key Findings

Findings:

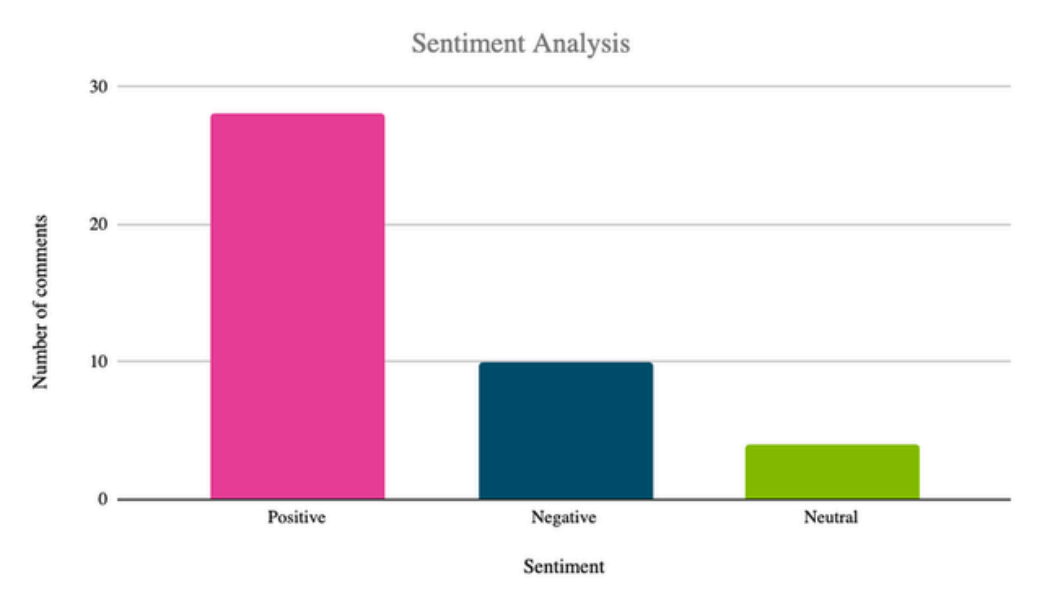
Staff

The theme which showed nearly an equal number of positive (five) comments and negative (four) comments was on the patient's level of access to information about their treatment and their understanding of this.

"Alright, a bit low on information. Hard to find out a plan…"

"I have no understanding of my treatment plan or my family having been told what the next steps are…"

Patients also shared multiple comments on how they felt they had been treated by the nurses during their stay. The overall sentiment of comments was again far more positive, than negative or neutral.



Patients commented on care and support, communication, and demeanour. There were double the number of positive comments (eight) relating to care and support as there were negative comments (four).

"I'm generally very well treated. They helped me with washing and personal care. They regularly change my clothes."

Key Findings

Findings:

Staff

The negative comments regarding patient care were concerning, and we raised some of these with the Head of Patient Experience at the end of our visit. One patient reported being handled in an overly rough or aggressive manner.

"…the nurses are not helpful, using extreme force to handle me. I have been treated very badly. I was hurt extremely."

Another patient reported to us that she was being ignored by nursing staff.

"Sometimes they ignore me when I need assistance… I press the button continuously, but they ignore me."

We witnessed the call bell she had pressed being switched off, with no interaction given to the patient.

There were two further concerning comments regarding patient care and toileting, with two patients being left to go to the toilet in their incontinence pads. This is concerning because if patients are left wearing soiled incontinence pads, it could lead to risk of infection.

"Support with commode - Told to "do it in my pants" and they will clean me."

"She would have used a commode prior to coming to the hospital, but she's been padded up and left in bed."

The comments regarding communication were all positive (eight), with most of these describing the nurses speaking nicely and listening to the patients.

"The nurses talk to me and listen to me."

The one negative comment regarding communication, described listening as being variable.

There were three times as many positive comments (six) about demeanour as there were negative comments (two).

"…are very kind."

Key Findings

Findings:

Support Needs

We wanted to understand if the patient's individual support needs were being met. We asked questions relating to food and communication needs. We asked patients if they were being provided with food that matched their dietary requirements or preferences. Five relatives told us that their family members were not eating well. It was not clear if this was due to the food not meeting their specific requirements or if it was due to personal preferences.

"It's not the food my sister is used to, and she has lost her appetite since being here."

"She's not eating food. She's been getting supplements - they've been prescribed, but I'm not sure if she's taking them and I'm not sure if it's being monitored."

An equal number of patients (five) shared that they need support with eating and that they receive support, as who told us that they need support, but do not receive it (five).

"I need support to open boxes as my right hand is not working, apart from that I can eat myself."

"I have had a stroke and ask for help, no one helps. My neighbour at the hospital has had to feed me."

Three patients told us they have communication support needs. Two patients told us they are D/deaf. One patient's relative had to take their hearing aid home as one got lost on the ward, and they could not risk another one being lost. Another told us that their hearing aid was broken on a previous ward after being removed roughly for a temperature check. This patient is no longer able to express what she needs due to this. The other relative told us the staff communicate by speaking loudly to the patient or that the patient can lip read.

Not having hearing aids is a major communication barrier in accessing health care services. This can lead to the patient not being able to describe their pain, not being able to ask for support to access the bathroom, not being able to give consent to treatment, and being left without a sense of dignity.

When we subsequently clarified the BARTS Health policy on replacing lost patient property, we were advised "that if they bring valuable personal items (such as hearing aids) into hospital, they should ensure these are appropriately insured to cover loss or damage. This position has not been applied to emergency admissions, where patients often have little or no choice about what they bring with them."

Key Findings

Findings:

Support Needs

We heard from the majority of patients, 86%, that water was readily available.

However, we heard from six relatives that their family members could not manage this themselves. Some of these patients have dementia and therefore do not remember to drink, while others are unable to manage to lift the jug of water, some of whom have had a stroke and therefore have muscle weakness. They are reliant on relatives and carers to provide support with drinking, but this is limited to visiting hours. Our Representatives noted that a patient in a side room did not have the table close enough for her to be able to access her water.

"She's not drinking enough as wee is very dark."

"I have had a stroke, no one provides me any assistance to give me water, I call out to them, but they take so long to come."

We raised this with the Head of Patient Experience at the end of our visit.

One patient additionally raised that they need warm water to drink due to their hiatus hernia. They commented that this was not always provided, but nurses will bring it when asked.

Clothes

We wanted to understand whether patients were encouraged to get dressed during their hospital stay. This is in line with the NHS End PJ Paralysis model, that aims to reduce immobility, muscle deconditioning, and dependency at the same time as protecting cognitive function, social interaction and dignity by encouraging people to get dressed by themselves. Only two patients told us they could. One relative pointed out that it was easier for their family member to wear a hospital gown.

Our Representatives noted that, apart from the odd patient, everyone was wearing hospital gowns. We observed that the hospital gowns were clean. We raised this with the Head of Patient Experience at the end of our visit.

Key Findings

Findings:

Medication

Prior to our visits, one of the areas we had heard some anecdotal information was on medication management. Therefore, we asked several questions to try to understand the patient's experience of this aspect of hospital care.

During the two visits, we identified two specific concerns. There was some uncertainty from patients regarding their medication. Seven patients told us they had been prescribed new medication since being on the ward, with three of these expressing a lack of understanding regarding their new medication.

"No one has explained to me why my meds have been changed around."

"Been given medication not got a clue what they are."

One additional concern we noted was regarding how a patient's medicine was being managed. One relative told us:

"My sister has been taking her medication for the first few weeks, but as of late she has refused and they have not made any effort to encourage her or liquify it."

Additional Support

We asked whether patients had been referred for additional support to services such as occupational therapy. Eight patients told us that they had. Four have been referred to occupational therapy, with two describing this as "extremely helpful", one as "helpful" and one as "prefer not to say".

"Mum was under occupational therapy at home. She's seen occupational therapy whilst in hospital. They've had mum walking and doing stairs."

Three patients were referred to physiotherapy, with one describing this as "helpful", one "not at all helpful" and one "prefer not to say".

"There was a physio referral made and I was told that she didn't engage with them as she was too weak and feeble. She's now immobile. She wasn't immobile before she came in."

Key Findings

Findings:

Additional Support

One patient told us that no support has been offered.

"No support has been provided, never ever been asked, no palliative support."

Another family member told us that their relative did not want to engage with the support offered:

"Physio was offered but refused by my sister."

Our findings show that two patients became immobile whilst on the wards.

"My sister can't voice her opinion, but I can. She has really deteriorated. She is not eating, not drinking and not walking."

Key Findings

Findings:

Hospital Discharge

Prior to our visits, one of the areas we had heard some anecdotal information was on hospital discharge. Therefore, we asked several questions to try to understand the patient's experience. We met with the Lead of the Complex Discharge Team prior to our visits to understand the systems and processes and any challenges they face.

NHS England's statutory guidance states that patients should be informed of discharge plans upon admittance. 45% of patients had been told when they were likely to be discharged from hospital. With a similar percentage, 41%, did not know when they were likely to be discharged, with the remaining percentage unsure. (It is worth noting that two of the 23 patients we spoke to had very recently been admitted to the wards and therefore had yet to speak to a doctor.)

Only 32% of patients knew what care they were likely to receive once they were discharged.

"Care times 4 daily."

Only 27% of patients knew about any new medication they may need to take once they were discharged.

"I'm going home tomorrow. A Redbridge person explained things. They told me to take folic acid, vitamin D & meds."

Only 18% of patients knew how it would work once their GP takes over prescribing any new medication.

"Daughter and son spoken to by pharmacist. Said arranging it but don't know exactly."

A higher percentage, 55%, knew how they were going to get home from the hospital. The comments about hospital discharge showed that 36% of patients were unclear about what their discharge plan was. In half of these patients, this was due to the discharge plan changing.

Key Findings

Findings:

Hospital Discharge

"We've had two failed hospital discharges. She should have been discharged last Friday, but a lack of an ambulance meant it didn't happen. Then it was supposed to be today, and it's been changed, and she has to have a period without a urinary catheter. I'm here today trying to get her to drink to see if she'll voluntarily pass urine. It's a ramshackle discharge when you clearly need beds."

"They have told me continuously that I will be discharged. It's been going on for five weeks. They keep changing my discharge date. I just don't know when I can go home, the date keeps changing. They never give me a clear date."

In the other half of patients, there appeared to be uncertainty due to a lack of communication from staff.

"No one has communicated with me about…discharge."

"Only heard today, my family didn't know [about hospital discharge]. No communication to care agency about changes of medication."

"They have said they can't send me to my care home as a social worker hasn't sorted this, although my daughter and son in law checked that the care home is still awaiting my arrival and my place still exists there."

Key Findings

Findings:

Other issues or concerns

Two family members highlighted an issue with not being involved in their family members' care despite wishing to be.

"We've been told that she can't be discharged until she can pass urine without a catheter, but her care home is able to support her with a catheter. Our views are noted, but nothing happens."

"There is not much communication or involvement from the doctor or staff on important issues. I asked for a medical assessment. They assisted her without me being there."

The same family members also raised an issue with not being able to contact the ward and with not being able to speak to the most appropriate doctor or nurse about their family member's care.

"It would be helpful to give out an A4 sheet with the main contact numbers on. There is no consultant or named nurse on her bed board. The discharge coordinator is incredibly difficult to get hold of."

"It is very difficult to contact the ward via the switchboard."

Post visit debrief meetings and subsequent actions

Following both visits, we met with the Head of Patient Experience to share our immediate findings and raise any urgent areas of concern. These were:

- Staff raised a Safeguarding/s during the first visit (patient/s being roughly handled by HCAs whilst being washed) and patient incident during the second visit (call bell of blind patient ignored and silenced) with Head of Patient Experience.

- Raised other issues with Head of Patient Experience – patients on one bay who were dehydrated, call bells being out of reach, lack of patients being dressed.

The Head of Patient Experience immediately started to act on these issues. We were kept informed of new processes that were put into place due to our reporting of the issues. These are detailed below.

Safeguarding concern raised during the first visit (patients being roughly handled during personal care)

The concern was fully reviewed, and a report was compiled following discussions with the patient and next of kin in the adjacent bed. Despite multiple attempts, we have been unable to contact the patient and/or relevant next of kin, but two letters have been sent inviting them to contact the Patient Experience Team.

The incident was also reviewed with staff, including reflective discussions, remedial training, and follow-up. The Patient Experience Team carried out regular comfort-rounds on the ward from December – February. In addition, learning from the incident has been incorporated into safeguarding training as part of ongoing staff development.

Patient incident during the second visit (call bell silenced and not responded to)

The staff member involved was identified and debriefed, with discussion focusing on appropriate patient responses, professionalism, and managing frustration. The scenario has also been included in the Development Day programme to support learning and reflection.

Concerns raised regarding dehydration, call bells out of reach, and patients not being dressed

- Regular nutrition and hydration reviews have been reinforced, with added emphasis during handovers to ensure consistent practice.

- Call bells: We were unable to identify this as a wider systemic issue. As previously communicated following your visit, the Matron attended the ward immediately and then carried out daily unannounced audits over a two-week period, without staff being made aware of the specific concerns. These audits demonstrated that most patients had access to their call bells. In cases where this was not possible, a clear and documented clinical rationale was in place. While the importance of call bell access has been reinforced at handover, no further action is required at this time.

- Patients not being dressed: We are launching the Pyjama Paralysis programme on Sage Ward as a pilot, with the involvement and support of patients next of kin. Subject to evaluation and feedback, we will consider extending this initiative across all three wards.

Recommendations

Further Recommendations following Patient Experience Team's subsequent actions

- We are pleased that the Safeguarding concern was taken seriously and acted upon swiftly. We recommend that the "comfort rounding" should continue after February and be done sporadically to pick up on any concerns. These could be run by individuals who can deliver independent observations.

- A mandatory response timeframe for patient call bells could be introduced and adhered to across all Care of the Elderly wards. Setting a clear expectation for response times, supported by monitoring and staff training, will improve patient experience and ensure that essential care is not postponed.

- The HCA/ward assistant should update the nursing staff when they see that a patient is not drinking their water. This is easily identifiable by how much remains in the jug and by the colour of a patient's urine. This can feed into the review at handover. We recommend that a hydration champion be allocated per ward who can then be tasked with supporting those patients to increase their water uptake.

- We acknowledge and applaud the recent call bell audit. We recommend that sporadic call bell audits are conducted. Obviously, there will be staff changes on the S wards, and we want to ensure that all staff working with patients are complying with the protocol of call bells being within reach, unless for a specific reason.

- We applaud the introduction of the End Pyjama Paralysis Programme and look forward to receiving updates into how this is working on Sage ward and whether it is rolled out to the other wards.

Recommendations

Based on the analysis of all feedback obtained, Healthwatch Redbridge would like to make the following recommendations:

- **Hearing aids should not be classed as personal valuable items, such as a ring.** A hearing aid is an essential communication support device and should be treated as such. Regarding a hearing aid as a personal item, rather than as a communication tool, could be seen to creating a barrier in direct contravention of the Accessible Information Standard and The Equality Act 2010 and the NHS Constitution. The Trust should treat each case individually where a hearing aid is lost or broken in the hospital.

- **Carers Information Packs could be introduced** providing relatives and carers with: Hospital Discharge Leaflets, Welcome to the ward leaflets, Hospital communication book, other patient leaflets that are appropriate to the clinical area, Matron/Senior Sister or other key staff contact details, PALS leaflet, Deaf Awareness Pack, Carers Policy, Carers Cards and Parking Concession forms.

- **Patients where possible should be encouraged to use the commode**, rather than left to toilet in their incontinence pads which may not be changed promptly and which can lead to infection.

- **Introduce a system to ensure relatives are regularly kept-up-date regarding care,** treatment and discharge planning. Some patients are unable to communicate and therefore cannot provide their relatives with these updates. Doctors' visits are in the morning and visiting hours in the afternoon. This means that some family members were not kept informed and struggled to find out what care and treatment was planned for their relative.

- **Elderly patients should be encouraged to mobilise safely and regularly**, with activities tailored to their clinical needs. Staff should encourage movement using physiotherapy guidance and risk assessments, as patients can quickly become frail during hospital stays. Mobility plans should be clearly documented and communicated at handover to ensure continuity of care.

- **All internal hospital referrals should be followed up and actioned within an agreed timeframe** to prevent delays in patient care. Clear standards for referral response times should be established, communicated to staff, and routinely monitored. Where referrals are not acknowledged or progressed promptly, a structured escalation process should be used to ensure patients receive the required assessment or intervention without unnecessary delay.

Recommendations

- **Stroke patients who have communication or movement issues should be provided with care appropriate to the individual patient's needs**. For example, if a patient cannot manage their water jug, then a hands-free drinking system (such as the example given here), could be implemented.

- **All patients should be informed of their discharge plan** on admission to the ward. Planning discharge at an early stage will help staff members to anticipate any problems and put appropriate support in place. Whipps Cross Hospital should endeavour to provide patients with a summary of the discharge plan. NHS guidance states:

"Planning for discharge should begin on admission. Where people are undergoing elective procedures, this planning should start pre-admission, with plans reviewed before discharge. This will enable the person and their family members or unpaid carers to ask questions, explore choices and receive timely information to make informed choices about the discharge pathway that best meets the person's needs."

Project Details

Project name	Care of the Elderly: Patient Discharge Follow-up Report
Project period	December 2025 – March 2026
Method	Telephone interviews
Number of respondents	2
Led by	Healthwatch Redbridge

Acknowledgments

Healthwatch Redbridge would like to thank the patient and relative who shared their hospital discharge experiences with us. We are deeply grateful for your support, without which this project and report could not have been completed.

Disclaimer

Please note that this report relates to findings over a four-month period (December 2025 – March 2026) with two individuals.

Our report is not a representative portrayal of the experiences of all service users, only an account of what was contributed at the time.

Objectives

- Explore the process of hospital discharge for elderly patients, highlighting strengths and areas for improvement.
- Assess the quality and effectiveness of community health care and social care packages provided after discharge from hospital.
- Understand the challenges faced by patients and their families as they transition from hospital to adult social care services.
- Examine the coordination and communication between hospital teams and social care providers to ensure seamless care delivery.
- Gather insights to inform recommendations for enhancing patient-centred care and improving service delivery across the care continuum.

Introduction

During our Care of the Elderly ward visits in November 2025, we invited patient's and/or their family members to share their hospital discharge experience with us, including any social care support they received following discharge. This report focuses on the insight we gathered from two patients/family members once they had been discharged from Whipps Cross Hospital. This forms part of our Care of the Elderly Project.

Methodology

During our ward visits, we asked patients/family members if they would consent to be involved in the next phase of our project: being contacted by telephone to monitor the patient's discharge journey. We planned to conduct a few telephone calls per patient/family member over a four-month period. We achieved this with one of the patients.

Very sadly, two patients died shortly after being discharged. We conducted one in-depth telephone conversation with a family member from one of those families. We were unable to speak to the other family member at the time of writing this report, but we have left the door open if they would like to speak to us in the future to discuss their experiences.

Patient One

Summary of Key Issues

Delays and Disruptions in the Discharge Process
The patient's return to the care home was delayed multiple times due to ambulance unavailability and a late clinical decision to trial catheter removal. These delays caused significant distress for the family and contributed to a poorly coordinated end of life experience.

Poor Communication and Limited Family Involvement
The family reported feeling excluded from decision making, particularly regarding catheter management and bowel interventions. There was limited access to doctors which was partly due to strikes and partly due to nursing staff who were perceived as restricting contact with doctors. As a result, the family struggled to obtain timely updates or contribute meaningfully to care planning.

Fragmented Care Coordination
The NHS teams involved (ward staff, community urology, palliative care, Fast Track) appeared to operate in silos. Their decisions were not aligned or communicated clearly, resulting in unnecessary delays, duplicated efforts, and unnecessary stress.

Lack of Transparency in Fast Track Funding Decisions
The family felt the Fast Track Team's decision not to fund end-of-life care was unclear and unexplained. The family reported a perception that securing Fast Track funding in Redbridge is unusually difficult, even for people who appear to meet the criteria and there is no structured route to query or understand the rationale.

Inconsistency in Staff Engagement and Support
Experiences varied significantly depending on which staff were on shift. While some nurses were supportive and communicative, others acted as gatekeepers or provided minimal engagement. This inconsistency impacted trust and the overall quality of experience.

Recommendations

Establish Clear Communication Pathways
Provide families with a named clinical contact, direct telephone access or scheduled updates, and written guidance on who to contact—reducing barriers and keeping them informed.

Implement Consistent Discharge Planning
Avoid last-minute interventions unless essential, ensure multidisciplinary agreement before discharge, and book transport early with backup plans.

Improve Hospital–Community Integration
Use a shared digital handover system for ward teams, GPs, community services, care homes, and palliative care to prevent duplication and conflicting decisions.

Increase Transparency in Fast-Track Funding
Offer written explanations, clear routes for queries or appeals, and ensure staff understand and can explain the criteria.

Strengthen Staff Training in Communication
Provide refresher training on compassionate communication, emphasise family involvement, and promote proactive rather than gatekeeping behaviours.

Patient Two

Summary of Key Issues

Emotional Stress Related to being on a ward with patients with Dementia

The patient reported distress with being on a ward with dementia patients who were calling out. But she thought the nurses were caring and kind and doing their best with the limited resources they've got.

Positive experience in the discharge lounge

The patient shared that staff were friendly and chatted with her. She was given food and drink. She was discharged quickly after one and a half hours.

Unnecessary and poorly coordinated post discharge support and equipment

The patient received equipment she did not need, such as a commode and unwanted early morning carer visits, creating inconvenience rather than support as she had to get up early to answer the door, simply to turn the carers away, when she really wanted to rest after her hospital stay. She felt the hospital physio was proactive, but some equipment was provided in a standardised rather than personalised way, leading to unnecessary items that did not reflect her actual needs.

Lack of Orthopaedic follow-up

The patient had some mobility issues for several weeks following discharge with swelling and some pain in her foot and ankle. Prior to being discharged, she went to have an X-ray, but this was unable to take place as she could not stand in the right position for the X-ray to be taken. Upon discharge, she was using a mobility frame and door handles to navigate around her flat. Although she was told Orthopaedics would contact her after discharge, no communication ever occurred, leaving her without a clear clinical plan or understanding of her treatment pathway. The patient ended up purchasing a pair of supportive boots to aid her movement. During our final telephone-call, four months after discharge, the patient reported that her foot had improved – the swelling had gone down and she was no longer in pain.

Limited Access to Patient Resources in Hospital (e.g., Books)

The patient wanted access to books during her hospital stay to help with the boredom of being in hospital. Some members of staff or visitors brought her the odd book. She suggested introducing a mobile library service to help with boredom. We contacted the Head of Patient Experience to raise this suggestion and were informed that they do have a trolley library service. This suggests that the service could benefit from increased promotion across the hospital wards.

Patient Two

Recommendations

Strengthen and Coordinate Post Discharge Follow-Up

Ensure all promised follow-up appointments (e.g., Orthopaedics, ward reviews, therapy) are booked before discharge and clearly communicated in writing. Use automated alerts or a named coordinator to prevent missed or delayed follow-ups and provide patients with a clear route to escalate concerns if appointments do not occur.

Assign a Named Care Coordinator for Continuity and Communication

Provide each patient with one dedicated contact responsible for verifying appointments, monitoring symptoms, liaising with hospital teams, and offering guidance on what to do if their condition worsens. This reduces confusion, repetition, and the burden on patients to chase information.

Improve Integration and Information Sharing Across Hospital and Community Services

Develop a shared digital record accessible to ward staff, outpatient teams, GPs, community services, and equipment providers. This prevents duplicated assessments, conflicting decisions, and gaps in communication—including in urgent escalation scenarios.

Personalise Post-Discharge Care, Equipment, and Home Support

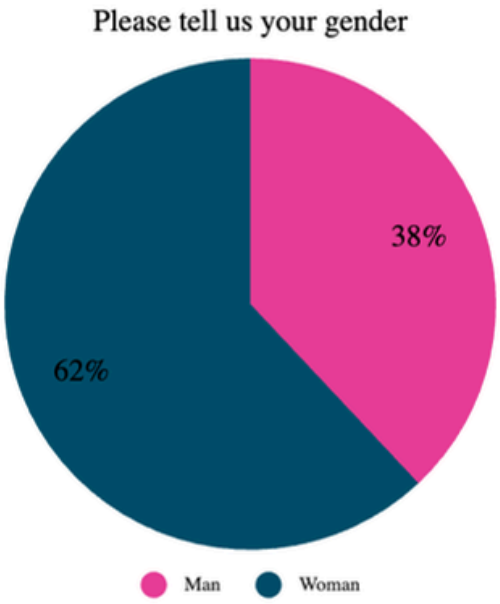
Introduce a simple verification step before equipment or care services are issued to ensure they reflect the patient's actual needs and preferences. Allow patient selected carer visit times, provide rapid access to appropriate clinical reviews (including adapted imaging), and ensure home safety measures (e.g., key safe installation) are put in place promptly.

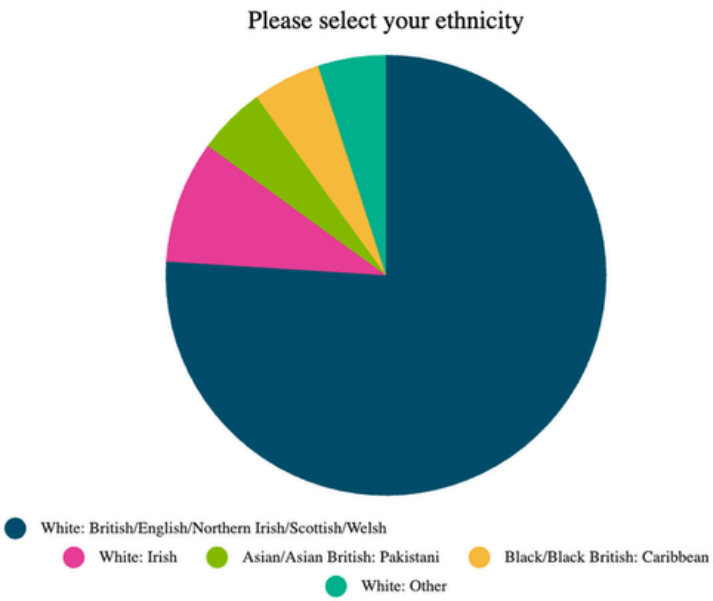
Enhance Patient Wellbeing and Monitoring After Discharge

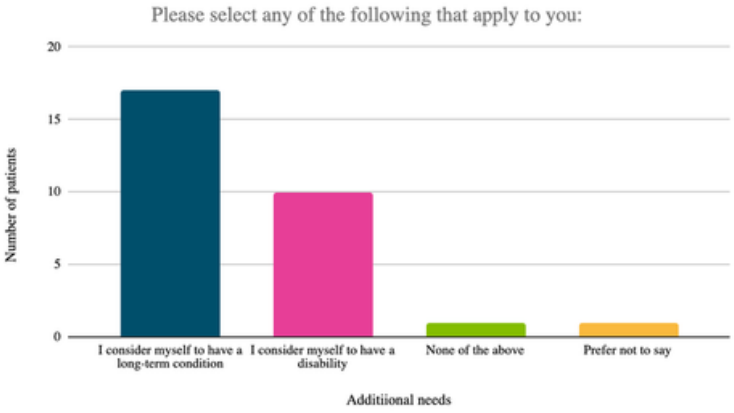
Provide patients with clear written instructions for urgent concerns, including direct numbers and expected response times. Additionally, enhance inpatient experience through wellbeing initiatives such as access to books or digital entertainment.

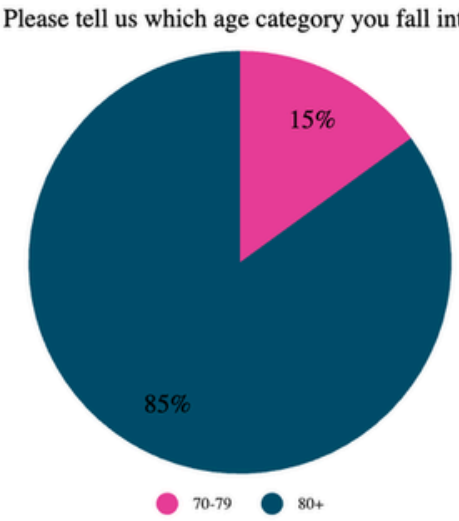
Appendix

Demographics









Appendix

Whipps Cross PALS data

Older Peoples Service PALS Data Whipps Cross Hospital Jan-Jul 2025
Themed comments
Total number of emails/comments – 60
Total number of issues (people have raised more than one issue within a comment) - 66

Theme	Number of times raised	Issues

Discharge	20 (of these 20, the same email was raised 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

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.

Note: Healthwatch Redbridge will submit a Freedom of Information (FOI) request to obtain clarity on some of the issues raised by the Complex Discharge Team.

ACHA

We sought insight from the Academic Centre for Healthy Ageing (ACHA) who are working with Whipps Cross Hospital to improve discharge pathways for patients.
ACH shared that their current work is focused on normal discharge pathways and fast-track discharge for people receiving palliative care. A significant part of their work also involves ongoing conversations around delayed discharge, particularly:

- Delayed discharge for people in palliative care to care homes, and
- Delayed discharge of medically fit individuals returning to their care homes.

They explained that this work is still very much in the exploratory stage, and that the organisations ACHA is currently engaging with have consistently expressed dissatisfaction with the existing discharge system, with a shared view that it is not working effectively.

ACHA agreed to approach the Head of the Patient Experience Team at Whipps Cross Hospital, with a view to being involved in joint work with Whipps Cross once our report is completed. This would allow Healthwatch Redbridge to later revisit the impact of our report and the implementation of any recommendations made.

Appendix

Questions for patients once discharged from hospital

My name is X and I am ringing from Healthwatch Redbridge. You may remember that we spoke to you whilst you were in hospital to ask you questions about your/your relative's hospital stay. At the time we mentioned that we would like to follow up with patients once they have been discharged to see how they are getting on. Is it ok if I ask you a few questions now? It will take about 20 minutes.

Are you ok with me taking a voice recording of our conversation? To keep this anonymous, please do not use your/your relative's name or any personal or identifying details. Please be assured that if you do mention anything personal, we will change this/not include it in our write up.

You may remember, we mentioned that as a thank you for sharing your/your relative's experience, we would like to offer you a £100 shopping voucher for speaking to us every two weeks from now until end of February. This will really help us to understand your relative's journey following their discharge from hospital.

[Questions on following page]

Appendix

Questions for patients once discharged from hospital

Offer to email/post the above information for individual to refer to.

- How have things been since leaving hospital?
- Did you need further care or treatment after leaving hospital? Tell me more about this. Please name the service you are receiving support from.
- Did you feel you were involved in the decision making around your care or treatment?
- Did you understand what the care or treatment was for?
- How soon after you were discharged, did you hear from any service about the support you would receive?
- How were you contacted?
- Were you able to communicate with the team that was looking after you?
- Did anyone give you any contact information?
- How easy or difficult was it to do so?
- Do you have any comments on the quality of care and treatment you have received?
- To what extent do you feel that the care provided met your specific health and care needs?
- What has worked well?
- What could be improved?
- Do you feel you needed support, care, or treatment after leaving hospital that you did not receive?
- Overall, what went well with the way you left hospital?
- Did you feel safe when you left? Tell me about that.
- Can you suggest any improvements so patients in the future have a better experience of discharge?
- Do you have anything else you would like to comment on?

Barts Health NHS Trust Response

The following response was provided by Shahida Trayling, Director of Nursing & Governance, Barts Health NHS Trust, following receipt of this report.

We thank Healthwatch Redbridge for this report and value our continued partnership in improving the experience of older residents moving through hospital and back into the community. We would like to offer the following clarifications and context.

- Virtual wards: there is a virtual ward for Redbridge, run by Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) rather than Whipps Cross Hospital, which runs the Waltham Forest virtual ward. In line with NHS England guidance, virtual wards are designed to provide hospital-level care at home, not a general follow-up service for all discharges, and there is not currently funded ICB capacity to hold patients within them for extended periods.

- Shared responsibility for discharge: discharge is not the responsibility of Whipps Cross Hospital alone. We work closely with Redbridge local authority and the Integrated Care Board (ICB), and are signed up to the ICB's "Care Closer to Home" programme.

- Information sharing: discharge letters are recorded on the "One London" shared record, through which we can also view notes from community and primary care services. The Universal Care Plan, accessible to patients living in London boroughs via the NHS App, is introducing new frailty and dementia functions to act as a patient and hospital passport rather than being focused solely on end-of-life care. Our End-of-Life Board is supporting wider awareness and completion of the plan.

- Single patient record: we note the discussions currently before Parliament on a single patient record for England, and would welcome Healthwatch Redbridge's support in lobbying for this.

Healthwatch Redbridge

Redbridge Institute of Adult Education
Gaysham Ave, Gants Hill Cres, Ilford IG2 6TD

Website: www.healthwatchredbridge.co.uk

Telephone: 020 8553 1236

Email: info@healthwatchredbridge.co.uk

Facebook: Healthwatch Redbridge

X/Twitter: @hwredbridge

Instagram: @healthwatchredbridge

LinkedIn: Healthwatch Redbridge

Bluesky: @healthwatchredbridge.bsky.social

healthwatch
Redbridge