Patient and unpaid carer engagement across South West London community services

By Healthwatch Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth

Contents

Executive summary

The South West London Integrated Care Board commissioned the six independent Healthwatch organisations in Croydon, Kingston, Merton, Richmond, Sutton, and Wandsworth to gather feedback from service users and their unpaid carers across a variety of adult and paediatric community services.

This report presents key insights drawn from **527 responses** in six boroughs, capturing experiences from a diverse range of communities and services.

Across boroughs, patients and unpaid carers valued the generally excellent staff and professionalism and most patients and unpaid carers felt that they had received high-quality, compassionate care. Most participants also said that the services - once they had progressed past often long waits for initial care - were timely and responsive.

In addition, we identified eight areas around which patients and unpaid carers commonly raised concerns. Some services were better at addressing these than others, offering opportunities for collaborative learning. The eight thematic areas were:

- Communication and information sharing between the service and patients or unpaid carers
- Coordination and information sharing between services
- Involvement of patient and unpaid carers in decision-making
- Wait times
- Continuity of care
- Cultural competency and accessibility
- Support for unpaid carers
- End of life care planning
- Patient independence and A&E visits

Based on patient and unpaid carer feedback, we have drawn out specific opportunities for improvement to support the South West London ICB in elevating patient and unpaid carer experiences by enhancing overall care, reducing between-borough disparities, and addressing health inequalities.

About South West London Healthwatch

South West London Healthwatch is a collaborative of six independent Healthwatch organisations (Healthwatch Croydon, Merton, Kingston-upon-Thames, Richmond-upon-Thames, Sutton, and Wandsworth). Since 2022, they have collaborated to gather insights across the Integrated Care Board's footprint in South West London to ensure that people have a voice in NHS decision-making.

Background

Community services provide various out-of-hospital healthcare and support services that can be delivered in settings such as homes, schools, care homes, and clinics. These services are provided by several different organisations, including the NHS, local authorities, voluntary community social enterprise organisations, and other independent organisations. People of all ages, from birth to the end of life, are supported to remain independent and out of hospital by preventing illness and managing long-term conditions. Community services are usually delivered by a multidisciplinary team. Professionals include community nurses, specialist nurses, advanced practitioners, allied health professionals, consultant doctors and nurses, and unregistered staff.

For adults, services include planned care (*e.g.,* musculoskeletal services, wound care, diabetes, respiratory, community rehab), intermediate care (*e.g.,* post-hospital recovery, in-home assessment), urgent care (*e.g.,* rapid response, virtual wards), end of life care, and support for long-term and neurodevelopmental conditions. For children, services include developmental support (*e.g.,* speech therapy, occupational therapy), specialist health services (*e.g.,* special school nursing, diabetes care, long-term ventilation), and urgent and palliative care.

Community services are an important part of the health system and contribute in important ways to local populations and neighbourhood health; therefore, there is a need to understand how community services are being delivered and what is needed to provide the best quality care.

Nationally, this work is being led by NHS England in collaboration with Integrated Care Boards (ICBs) and will help provide data to understand how care can move from hospital into community settings as part of the NHS' 10 Year Health Plan for England.

Community Services review – South West London

In light of the current plans to accelerate care from the hospital into the community, the ICB in South West London (SWL) commissioned SWL Healthwatch to review the delivery of specific community services in all six boroughs (Croydon, Kingston, Merton, Richmond, Sutton, and Wandsworth).

Services we explored

Croydon: Healthwatch Croydon focused on intermediate services (provided by Croydon Council) and reablement care services (provided by the NHS). Intermediate services support patients at home with daily tasks, and reablement services help patients become independent by providing support and therapy. Both service provisions are assessed after six weeks and may include interventions such as occupational therapy. Healthwatch Croydon engaged the following four service provisions:

- Intermediate Care beds (e.g. Park View – NHS)
- Short-term winter/interim beds (Croydon Council)
- Reablement at home (Croydon Council)
- LIFE at home (NHS)

Kingston: Healthwatch Kingston focused on adding questions to planned/pre-existing community engagement activities with the following target populations:

1) **Early years (children under 5 years)**: Healthwatch Kingston partnered with Kingston Voluntary Action to assess the health and care needs of 0-5 year olds and their families. Engagement questions focused on the consistency of care, care coordination, and personalised care and independence. They spoke to people whose children had accessed a range of community services, including community nursing, paediatric clinics, speech and language therapy, and paediatric medicine, which are typically offered close to home or at the child's school.

2) **Socially isolated, physically Disabled adults**: Healthwatch Kingston worked collaboratively with the Kingston Centre for Independent Living as part of Healthwatch Kingston's planned community engagement for 2024-25. Experiences of physiotherapy, occupational therapy, nursing services, specialist nurses, podiatry, and speech and language therapy were explored as part of a wider consultation in Kingston.

3) **Unpaid carers of people who had received end of life care**: This engagement was conducted as part of a pre-agreed project in partnership with Kingston Voluntary Action to support the SWL Bereavement Services and Support: Gaps Workshops initiative.

Through this engagement, they spoke with people whose loved ones had recently accessed hospice and palliative care community and hospital services.

Merton: Healthwatch Merton focused on community nursing. Community nurses in Merton collaborate with hospitals, GPs, and other health professionals to serve patients who are housebound with physical health needs. Healthwatch Merton collaborated with the community nursing team who are part of Merton Central London Community Healthcare Trust (CLCH).

Richmond: Community services in Richmond are provided by the Kingston and Richmond NHS Foundation Trust (KRFT). Like Healthwatch Merton, Healthwatch Richmond focused on community nursing services, which provide care for housebound patients and patients in care homes with physical needs. Support may involve taking blood samples, administering medications, wound care, and more.

Community nurses in Richmond are divided into three geographically based teams:
- Whitton Corner Health and Social Care Centre (known as Whitton Corner) covers Twickenham and Whitton.
- Centre House covers Sheen, Ham, Richmond, Barnes and Kew.
- Teddington Health and Social Care Centre covers Teddington and Hampton.

Sutton: Healthwatch Sutton focused on the services for people living with frailty. Healthwatch Sutton collaborated with Sutton Health and Care and the SWL ICB to understand the experiences of people living with frailty, to identify good practice and areas of improvement in services for this group, and to understand people's perception of the term "frailty". Residents from the following services were engaged:
- Maximising Independence Service
- St Raphael's Hospice Wellbeing Service
- Urgent Community Response
- St Helier Frailty Hub
- Sutton Virtual Ward

Wandsworth: Healthwatch Wandsworth focused on Proactive Care in the borough which is led by Central London Healthcare (CLCH) Trust. The service is delivered by neighbourhood multidisciplinary teams which includes health and care professionals from different local health services, care and voluntary sector organisations. Proactive care aims to:
- Delay the onset of health deterioration when possible
- Maintain independent living
- Reduce avoidable exacerbation of ill health, thereby reducing unplanned care

Methods

Each of the six local Healthwatch designed engagement methods and asked questions guided by the community service organisation(s) they worked with, and incorporating, where feasible, a core set of questions developed by the SWL ICB. These core questions focused on: the importance of consistent care; coordination across services; the extent to which the service was tailored to patient/unpaid carer needs; and the extent to which the service supported their independence.

We outline the methods used by each local Healthwatch below:

Croydon: Healthwatch Croydon conducted telephone surveys and interviews with four cohorts of patients who use intermediate or reablement services. Patient responses were anonymised for analysis and report publication. Questions were developed to understand patient needs, expectations, and preferences around home-based care or facility-based care. This work was conducted to support ongoing service review and future commissioning by Croydon Council, Croydon Health Services NHS Trust, and the SWL ICB. Participant recruitment was conducted by Croydon Council and the NHS services.

Kingston: Healthwatch Kingston used varying methods to engage patients across different services:

1) **Early years:** Children's community services questions were added to a pre-planned online survey and in-person workshops, to offer an opportunity for people in Kingston to share their experiences of the health and care needs of 0-5 year olds and their families. The responses were analysed to understand important aspects of community care.

2) **Socially isolated and physically Disabled adults:** A series of questions about the health and care needs of physically Disabled adults were added to four workshop surveys. The survey responses were analysed to understand aspects of community care, including the attitude of staff, seeing the same healthcare professionals, quality of care, communication, ease of travel, involvement in care decisions, waiting times, punctuality and service coordination.

3) **End of Life Care:** Questions were added to a pre-existing online bereavement survey to provide further opportunities for people across SWL to share their experiences of services and support for end of life care. The responses were analysed to understand important aspects of hospice and palliative care.

Merton: Healthwatch Merton adapted the survey used in Richmond (described below), which was then administered to participants by the Merton CLCH nursing team. Participants received a paper booklet and were given the option to complete the survey in one of three ways: by filling out the paper copy, scanning a QR code to complete it online, or responding via telephone. The survey had questions focusing on the following areas: staff and quality of care; joined-up care (communication between primary care, community care and secondary care); communication and patient involvement; and experiences of housebound adults and people receiving palliative care.

Richmond: Healthwatch Richmond developed a paper survey that was designed in collaboration with KRFT. The paper survey was distributed by community nurses. Patients had the option to complete the survey and hand it back to nurses, to post it to Healthwatch Richmond in a freepost envelope, or answer the survey over the phone. In addition to the surveys, Healthwatch Richmond conducted "ride-alongs" with community nurses, shadowing them during their rounds to observe how community nurses interacted with patients and families. This provided deeper insight into the challenges of community nursing.

Sutton: Healthwatch Sutton conducted semi-structured interviews with people living with frailty about their experiences of health and care services. Interviews lasted between 30 to 90 minutes. When it was conducted in a participant's home, Healthwatch Sutton staff and volunteers conducted the interviews in pairs.

Wandsworth: Healthwatch Wandsworth collaborated with CLCH to develop a telephone survey of patients currently using proactive care services that aimed to identify patient experiences of:

- How well proactive care services communicate both across teams and to patients
- Feeling like they are being listened to and play an active role in their care
- Understanding what proactive care is and how their condition is being managed
- How well proactive care works to avoid unplanned visits to hospital and A&E
- How well proactive care is doing overall and what could be improved

Healthwatch Wandsworth and CLCH have a data sharing agreement which allowed CLCH to share patient responses with Healthwatch Wandsworth for analysis. All patients were given the option to withdraw at any point during the survey and could request for destruction of their data.

Results

In total, we engaged 527 patients and carers.

Borough-specific results

Each local Healthwatch wrote report(s) describing their study cohort(s), results, and recommendations for local community service teams. These reports are summarised in the Annex.

Cross-borough comparisons of the same services

Local Healthwatch generally collected feedback about unique services, with little overlap in the services examined in each borough. Two exceptions are community nursing and end of life care.

Community nursing

Patient and unpaid carers' experiences of community nursing were collected in Merton (n=25) (Annex, pp 31) and Richmond (n=279) (Annex, pp 36), totalling 304 participants. Both services received overwhelmingly positive feedback from service users, with respondents especially applauding the compassionate, high-quality staff.

Patients and unpaid carers in both boroughs pointed to opportunities for improving continuity of care and communication between services. In Merton, there was emphasis on improving the cultural inclusivity of services, and in Richmond, participant feedback more strongly highlighted the need to improve delivery of medications, equipment, and other medical supplies.

End of life care

Seventy responses about end of life care were collected across Kingston (9), Merton (3), Richmond (54), and Sutton (4). In Kingston and Sutton, people shared experiences of using hospice or palliative care services, while in Merton and Richmond, responses about end of life support related to that offered by community nurses.

Across all boroughs, respondents noted that end of life care was an under-discussed topic. Where it was discussed, many participants felt that communication around planning and decision-making could be improved, and not all patients had clarity about what to expect. In Kingston, Merton, and Richmond, patients and unpaid carers highlighted the importance of comfort, symptom management, emotional needs, and selecting the preferred place of death.

Where care was well-coordinated, participants described positive experiences with compassionate staff. In Richmond and Sutton, examples were given of district nurses and hospice staff working together to maintain comfort and dignity. Similarly, Kingston participants valued the South West London Bereavement Service's emotional support.

South West London cross-cutting themes

What's working well across boroughs and services
Patients and unpaid carers overwhelmingly agreed that most staff provide excellent, professional, and compassionate care. While wait times to access services following referral were variable, services were praised as being timely and responsive once they were in care.

What can be improved
We identified eight areas where patients and unpaid carers frequently offered suggestions for improvement, summarised in **Table 1**. Of note, some services had exemplary performance and no recurring suggestions for improvement in certain thematic areas (noted with a check mark), **offering opportunities for sharing best practice.** Some of these themes, and common concerns associated, are also highlighted in the provided **case study.**

Translating feedback into improved services

The suggestions most commonly raised across services and themes in **Table 1** are outlined below. They are ordered according to the number of cohorts that provided pertinent feedback. **We ask the South West London ICB to consider how they can help community services address these concerns and provide oversight to ensure consistent improvement.**

1) **Patients and unpaid carers accessing more than one community service told us that interservice communication and coordination were often inconsistent.** (*based on concerns raised by patients and unpaid carers who have accessed*: Croydon intermediate services, Kingston children under 5 years, Kingston services for socially isolated, Disabled adults, Richmond community nursing service, Sutton services for frail people, Wandsworth proactive care).

2) **Patients and unpaid carers raised concerns about continuity of care, specifically about having to constantly change providers and repeat their needs.** (Croydon intermediate services, Kingston children under 5 years, Kingston services for socially isolated adults with physical disabilities, Merton community nursing service, Sutton services for frail people, Wandsworth proactive care).

3) **Patients and unpaid carers need support (in both digital and non-digital formats) accessing information that can help them navigate health and care pathways, access medication and equipment, and find unpaid carer training, financial guidance, and respite support.** (Kingston services for children under 5 years, Kingston services for socially isolated adults, Merton community nursing service, Sutton services for frail people)

4) **Unpaid carers said that comprehensive end of life planning discussions are not always offered, even where the death of a loved one is anticipated, and would like services to consistently invite such conversations when appropriate.** (Kingston end of life care in hospital and community, Merton community nursing service, Richmond community nursing service)

5) **Concerns were raised that staff were not meeting the communication needs of patients with disabilities, particularly for people who are hard of hearing, making it difficult for them to understand information about their health and care.** (Merton community nursing service, Richmond community nursing service, Wandsworth proactive care)

   The Accessible Information Standard (2025) outlines how commissioners and providers must meet the information and communication needs of patients and carers with disabilities that impact communication.

   Importantly, the June 2025 updates to the Accessible Information Standard increases commissioner responsibilities (see section 'The role of commissioners'). ICBs are themselves subject to the Standard and must ensure that all organisations they commission comply. This includes embedding AIS requirements into procurement processes, service specifications, and provider contracts. According to the update, commissioners should also ensure that each NHS organisation identifies an AIS lead and that board-level accountability for compliance is explicit (see section 'Implementing the standard: an overview').

   The 2025 updates are relevant to service providers. It introduces a sixth step requiring NHS organisations to review patients and carers' communication needs regularly. The updated AIS also states that providers should ensure that records are up to date, appoint a responsible lead for AIS implementation, and utilise the self-assessment framework to monitor compliance. NHS England training modules are provided.

6) **A notable minority said that they did not receive culturally-competent care, suggesting a need for improved staff training in this area.** (Croydon intermediate services, Kingston children under 5 years)

7) **Patients and unpaid carers would like clearer and more specific discharge information, both for themselves and service providers.** (Croydon intermediate services, Merton community nursing service)

8) **Some community nursing patients, particularly those that are housebound, commented that they struggle to receive timely prescriptions and medications.** (Merton community nursing service, Richmond community nursing service)

Limitations

This report provides valuable information about how community services can continue to be improved, especially as services are increasingly moved from hospital to the community during the implementation of the NHS' 10 Year Plan.

However, it does have some limitations. Each local Healthwatch adopted different engagement approaches and questions, and mostly examined different services, limiting the ability to make cross-borough comparisons. The full range of community services offered across South West London were not examined. In addition, though there were some suggestions of mixed cultural competency in the delivery of care, we did not have sufficient data to thoroughly examine whether overall experiences and levels of satisfaction differ by protected characteristics or cultural background. We also did not always have sufficient sample size to meaningfully assess experiences of all the individual services included in this study, which we resolved by aggregating findings among participants with common characteristics (*e.g.,* frail people, children under 5, physically Disabled adults) to explore cross-cutting themes.

The **Annex** describes the limitations of the engagement methods that each local Healthwatch used in more detail.

Summary

Overall, the findings show that South West London community health services offer compassionate, responsive, and highly professional care. At the same time, they point to critical opportunities to improve service coordination, consistency, communication, and to address health inequalities, especially for culturally diverse groups and Disabled people. We have highlighted opportunities for services to learn from each other, as well as specific patient and carer concerns that, if addressed, can help improve services across South West London while addressing between-borough discrepancies.

Table 1. Common thematic areas where patients and unpaid carers shared experiences

☑ = No widespread concerns expressed

Theme	**Croydon** (Intermediate Services)	**Kingston** (services for children <5 years)	**Kingston** (services for socially isolated adults with physical disabilities)	**Kingston** (end of life care in hospital + community)	**Merton** (community nursing service)	**Richmond** (community nursing service)	**Sutton** (services for frail people)	**Wandsworth** (proactive care)
1. Communication & information sharing between service and patients/ unpaid carers	unclear / generic discharge info	☑ vast majority of responses were positive/neutral to survey question 'communication from service was clear/ easy to understand'	service navigation info needs improvement	most patients discussed what was important to them with staff; however, three unpaid carers reported misunderstanding communication that their loved one	77% of respondents felt that communication from the service was timely and clear, but there were some inconsistencies due to inconsistent updates, unclear processes, and practices not being	☑ 93% described communication as timely and clear	service navigation info needs improvement + virtual wards could better communicate with patients about home visits	When asked about communication, patients largely responded in a positive way. However, when asked what could be improved, communication was one of the most prominent themes highlighted.

				was at end of life	able to communicate well with some patients with hearing impairments			
2. Coordination and information sharing between services	coordination needs improvement	mixed reviews of inter-service communication; some families navigating pathways alone	poor communication between services	—	generally reliable communication between district nurses, GPs, and pharmacists; concerns raised about post-hospital discharge and with medication supplies	good coordination between nurses and GPs, paid/unpaid carers, and hospice teams, but frequent GP/hospital referral breakdowns	generally well-coordinated care; some service communication breakdown cited (especially between virtual ward teams and GPs)	60% of patients reported good communication between professionals, especially between GPs and district nurses
3. Involvement of patient and unpaid carers in	mixed involvement in planning, often due to patient ill-health	☑ vast majority felt included in decisions about care	patients and unpaid carers both felt excluded from decision-making	mixed satisfaction with level of involvement with end of life care	☑ vast majority felt included in decisions	☑ vast majority felt included in decisions	barriers to service access, especially GP support, sometimes limited patients’	Not measured

decision-making				planning, where planning occurred			ability to understand what could be done to manage their conditions	
4. Wait times	—	long waits, especially for speech and language therapy, CAMHS, SEND assessment, and autism or ADHD diagnosis	delays in referrals and appointments, especially for physiotherapy and podiatry	—	nurses responsive / usually arrive on-time; reported delays focussed on medication and equipment	nurses responsive / usually arrive on-time; reported delays focussed on medication and equipment	☑ patients appreciated short waiting times between contacting services and accessing care	Not measured
5. Continuity of care	better when care offered at home than in a care home	lack of continuity noted for peds clinics	concerns about continuity of care raised	—	concerns about discharge communication, if lack of nurse continuity impacts tracking patient progress	—	patients expressed concerns; would prefer to see the same provider to not repeat medical history	Continuity of care mentioned as an area for improvement three times across two questions

6. Cultural competency and accessibility	Most (58%) felt service was responsive to culture and background, but 24% reported language barriers, rushed care during religious observances, or unmet expectations around food	Most felt that care was culturally competent, but a notable minority felt cultural needs were overlooked	Disabled people's accessibility needs not consistently met; especially noted difficulty of accessing transport to appointments	—	☑ most felt care was tailored to needs	88% felt service tailored to their needs, though training may be needed to help unpaid carers better support patients with hearing loss	—	67% of patients agreed that their needs were considered. However, accessibility still appeared as a recurring area for improvement, being mentioned 11 times across two questions
7. Support for unpaid carers	unpaid carers need to be better supported; e.g., better included in discharge discussions and provided with	☑ vast majority of parents responded positively/neutrally to questions that asked if the care they received improved knowledge and skills to co-	mixed satisfaction; praise for respite support and home adaptations, but others felt let down by rushed visits and rigid	mixed satisfaction with level of involvement with end of life care planning, where	good support overall; improvements could focus on helping unpaid carers navigate patient / social care pathways and access	☑ vast majority felt supported and informed	unpaid carers expressed the need for a single, central, non-digital source of information to make navigating	Not measured

	training, information, access to care assessments, guidance on financial and practical support (such as respite services)	manage child’s condition + helped them to regain independence	eligibility criteria from social care	planning occurred	to medication + equipment		services easier	
8. End of life care planning	—	—	—	end of life care planning not always done – even where patient did not die suddenly	Only 3 responses; 2 reported having comprehensive conversations about end of life care	some participants said they hadn’t had conversations about end of life and wished that this had been available to them	—	Not measured

Case study

Healthwatch Sutton interviewed a person with frailty who had used the district nursing service. Overall, this participant described their experience as “very good,” noting the kindness of staff, but they also highlighted areas of concern around wait times and continuity of care - themes that arose repeatedly during our engagement with patients and carers across South West London community services.

“District nurses. They come twice a week. Tuesday and Friday, if I'm lucky. I normally know who I'm getting Friday, but I don't always on Tuesday. The district nurses have asked for a GP to come out, and they will fit in with them to let them see what the wounds are like. And they (the doctors) say, well, no, you are under the care of the district nurse.”

“[The] dressing it was too tight on this leg. I rang up Saturday morning. And she (District Nurse) rang up Saturday afternoon. She said, “I'm sorry, I've just got nobody that can come out to you.” She said, “Can you not unravel it yourself?” I said, “Yes but I can't get the compression back up.” But then when they came Tuesday, it was all swollen up. I had to wait till Tuesday because they've got two long-term sick.”

Interviewer: “Did you do anything at that time to try and manage the discomfort?”

“No, I tried to do it, but I knew I had pain. I used to go to the doctors and see a Healthcare Assistant there. They were wonderful. They specialised in legs, but they left.”

Interviewer: “Do you wish the district nursing visit window was more precise?”

“They do their best. A couple of times, yes, they had to postpone it. They did a couple of weeks ago; they couldn't do the Friday, they had to come on Saturday. But when they've got two off long-term sick...And then they get the emergencies as well. Well, as they say to me, you could really do your legs yourself, couldn't you? You know so much, you know what dressings go on and how to do it. But they're all very nice girls.”

Authors

The lead officers of each of the South West London Healthwatch organisations played a consultative role on this project.

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Annex: Borough-specific findings and recommendations

This section provides more details about the research conducted in each borough, including information about the participants engaged, key findings, and recommendations. More detail about these findings have been published by most local Healthwatch in accompanying reports (see Bibliography).

Please note that all questions included in engagement questionnaires and surveys were optional, so the number of responses may not be the same as the number of participants.

Croydon

Services

Healthwatch Croydon focused on intermediate services provided by Croydon Council and NHS reablement care services.

Full report

The published report is available here.

Participants included and use of services

Seventeen participants completed the phone interview survey.

Services	No. of Participants
Reablement at Home	5
Intermediate Care at Home	5
Intermediate Care in a Bed-Based Facility	5
Winter Beds	2

Participant demographics are described below:

Demographics	No. of participants
Gender	• Women: 3 • Men: 14

Age	65-79: 5 80+: 12
Ethnicity	Asian/Asian British – Bangladeshi: 1 Asian/Asian British – Indian: 1 Asian/Asian British – Pakistani: 1 Asian/Asian British – Any other Asian/Asian British background: 1 Black/Black British – Caribbean: 1 White – British/English/Northern Irish/Scottish/Welsh: 11 White- Any other White background: 1

Key findings

The majority of participants were either fully or mostly satisfied with the services received, particularly valuing the positive impact of care on their recovery and ability to manage daily tasks. Those who had satisfactory experiences highlighted supportive staff, effective physiotherapy, and attentiveness to individual needs. However, 18% reported negative experiences, citing areas for improvement such as food quality, communication gaps, staff interaction, and unclear recovery pathways. Other key findings are summarised below:

- Vital support from unpaid carers: Most participants (88%) received vital support from unpaid carers, mainly family and friends. This included help with cooking, laundry, personal care, and in some cases, home adaptations such as ramp installations - all of which played a key role in maintaining their daily independence and wellbeing.

- Varied involvement in post-discharge decision making: While some participants said that they were very involved (18%) or involved (29%) in decisions about their post-discharge care, others were not that involved (29%) or not all (24%), often due to poor health at the time. Their condition meant they were unable to fully engage in discussions or provide input, resulting in limited involvement in the planning process.

- Variable and generic discharge information: While some participants provided clear and helpful information, others reported significant gaps in the discharge information provided. While some received basic details, the information was often too generic, lacked clarity, or was not tailored to individual needs - particularly for those with complex conditions like stroke. Several individuals felt unsupported and unprepared for the transition home, highlighting a need for more personalised, comprehensive, and accessible guidance at the point of discharge.

- Setting goals and meeting them: Most (65%) were able to set goals and could meet them. However, a third (35%) did not have goals set. Of the 11 who did have goals set, seven did meet them. Nearly two-thirds were involved in goal decisions with most of those quite involved (41%) and nearly a quarter (24%) fully involved. However, over a third were not that involved or not at all.

- Support needs were varied: This included support with daily living tasks, physiotherapy and mobility support; home care services and unpaid carers; medical monitoring and community healthcare and family involvement and support. Some participants said they had not received much or any support at all.

- Service satisfaction: Over three quarters were satisfied, with a majority satisfied and nearly a quarter fully satisfied (24%). Some were partially satisfied (18%) and one person (6%) reported not being satisfied at all.

- Responsive to culture and background: Most participants (58%) felt the service was responsive to their culture and background. They described it as respectful, inclusive, and considerate care that aligned with their values and preferences. However, some (24%) reported that their cultural needs were not met, often citing issues such as language barriers, rushed care during religious observances, or unmet expectations around food. Meanwhile, some (18%) preferred not to comment.

- Improvements: When asked what could be improved, participants suggested: better communication and coordination; consistency and quality of care; activities and social engagement; reablement and rehabilitation support; facilities and environment; individualised and holistic assessment. Some felt the service already met expectations.

- Care home versus care at home: Most (70%) said they preferred services at home, while 24% preferred care homes. Home was preferred as it was a more familiar and comfortable environment, where patients had a sense of independence and autonomy, and emotional and family support, as well as continuity and personalisation of care. Some, however, preferred a care home as there was immediate and consistent access to support, good social interaction, and they had confidence in facility services. Some also had previous negative experience being left at home after a fall for some time and therefore preferred care facilities.

Limitations

Healthwatch Croydon faced some limitations in its recruitment process. There were delays in accessing patients from the Winter Pressure Beds cohort, primarily due to the time taken to obtain candidate lists and the health status of some individuals, which limited their ability to participate. Additionally, whilst the intended target sample size was 20, a total of 17 participants completed the survey, limiting the generalisability of the results. Despite this, the project successfully gathered a range of perspectives that reflect the lived experiences of individuals receiving rehabilitation and intermediate care in Croydon.

Recommendations

Based on the findings and analysis of this survey, Healthwatch Croydon suggested some recommendations which can help improve the overall patient experience with reablement and intermediate care services:

1) Recognise and support unpaid carers: With over 85% of participants relying on unpaid carers, who are mostly family and friends, these should be formally recognised as part of the care network. They need to be included in discharge and care planning discussions to ensure continuity of support. Additionally, unpaid carers should be provided with appropriate training, information, and access to unpaid carer assessments, along with guidance on financial and practical support such as respite services, to help sustain their caregiving role.

2) Improve patient engagement: Healthcare teams should adopt a more flexible approach to care planning by offering follow-up discussions once patients are better able to participate. When individuals are too unwell to engage at the time of discharge, alternative mechanisms such as involving family members or advocates should be used. Staff should be trained in inclusive communication practices to ensure patients' voices are represented as much as possible, even in challenging circumstances.

3) Provide tailored and accessible discharge information: Discharge communication should be personalised and condition-specific, with clear, jargon-free written materials supported by verbal explanation. For individuals with complex health needs, tailored discharge packs should be developed, including information on medication, recovery timelines, community services, and who to contact for support. Additionally, implementing follow-up calls or visits can help reinforce key messages and ensure understanding after discharge.

4) Improve consistency and clarity in discharge support planning: Ensure all patients and their families receive clear, timely, and comprehensive information about the support available post-discharge. This should include a personalised care plan covering daily

tasks, medical needs, and community services, communicated in a way that accounts for the patient's health, capacity, and cultural context.

5) Consider care homes when no appropriate alternatives are available: Most want to stay at home, but those living at home on their own with little or no support from friends and family might find a care home a better option for recovery as they will be continually supported and not be socially isolated.

Kingston

Overview of work

Healthwatch Kingston explored a wide range of community services: paediatric services (children's community nursing, paediatric clinics, speech and language therapy, and paediatric medicine) offered to people ages 0-5 years; physiotherapy, occupational therapy, nursing services, specialist nursing, podiatry and speech and language therapy offered to socially isolated and physically Disabled adults; and palliative care and hospice services offered at end of life.

Kingston Early Years (ages 0-5 years)

Full report

A report focussed on children under 5 years and their families is available here.

Participants

Survey respondents included those who had used the following services (some of the respondents may have used more than one service):

Service	No. of Participants
Children's community nursing	44
Community paediatric clinics	20
Community speech and language therapy	15
Community paediatric medicine	21

Participant demographics are shown below:

Demographics	No. of participants
Gender	• Women: 47 • Men: 5 • Non-Binary: 1 • Unknown: 1
Age	• 18-24: 1 • 25-49: 49 • 50-64: 3 • Over 65: 1
Ethnicity	• Asian/Asian British - Chinese: 1 • Asian/Asian British – Indian: 1 • Asian/Asian British - Any other background: 1 • Black/Black British – African: 1 • Black/Black British - Any other Black / Black British background: 1 • Mixed/Multiple ethnic groups - Black African and White: 2 • Mixed/Multiple ethnic groups - Asian and White: 1 • Mixed/Multiple ethnic groups - Any other Mixed / Multiple ethnic background: 1 • White - British/English/Welsh/Scottish/Northern Irish: 32 • White – Irish: 2 • White - Any other White background: 4 • Eastern European: 2 • Any other ethnic group: 2

	● Prefer not to say: 2 ● Other (please specify): 1

Key Findings

Across all services, respondents cited waiting times and communication breakdowns as consistent issues. Coordination between services was often poor, leaving parents to manage multiple complex pathways themselves. While cultural competency was often strong, some families felt their values and beliefs were overlooked or misunderstood. Families strongly valued being listened to, participating in shared decision-making, and continuity of care.

Children's community nursing

Families generally rated this service positively, with most describing their experience as "good" or "very good." Parents and unpaid carers praised the dedication and caring nature of staff, and over 60% felt the service was culturally responsive. However, a notable minority felt cultural sensitivity could be improved.

Community Paediatric Clinics

Experiences were mixed. While two-thirds rated the service positively, a quarter rated it as "bad." Families appreciated the support received during the diagnostic process, especially for autism spectrum disorder. However, concerns were raised about long waiting times and inconsistent follow-up. Cultural awareness was seen as fairly good (70%), though gaps in continuity and communication between services were noted.

Community Speech and Language Therapy

This service received some of the most critical feedback. Ratings ranged widely, with more than a quarter describing the service as "very bad." The most common concerns were long waits (sometimes exceeding a year), administrative errors, and lack of communication. Around two-thirds felt their cultural needs were acknowledged, but nearly 10% felt they weren't at all.

Community Paediatric Medicine

Experiences with paediatric medicine were also varied. While nearly half rated it positively, about a third had negative experiences. Key issues included limited access, poor communication, and challenges in coordinating care across services. Around 63% felt the service was culturally responsive, but 13% felt their background wasn't considered.

Limitations

Healthwatch Kingston added in questions to pre-planned/existing community engagement, which increased time to complete surveys and potentially increased participant 'burnout'. This may have inadvertently limited participant engagement.

Recommendations

Healthwatch Kingston presented the following list of recommendations to improve the experiences of children and families accessing services in the borough. Importantly, while the scope of the report extended beyond evaluating community services, the recommendations are relevant to the continued improvement of these services:

1) Improve integrated care coordination for families managing multiple health and care pathways.
2) Prioritise early years family mental health – perinatal, postnatal, and childhood trauma support (such as ensure trauma-informed care for birth and postnatal health – listen to mothers).
3) Improve wait times for speech and language therapy, CAMHS, SEND assessment, and autism or ADHD diagnosis.
4) Ensure inclusive, culturally sensitive services, especially around dietary, faith, and parenting norms.
5) Expand accessible children's centre provision, especially in 'deprived areas' (such as Norbiton, Chessington and Hook and Tolworth).
6) Ensure continuity of care where possible to ease emotional burden on families.
7) Invest in staff training about neurodiversity, disabilities, and long-term conditions.
8) Include parents in decisions about the care of their child to ensure they don't feel dismissed.
9) Strengthen communication systems between services (such as, one point of contact per family).

Kingston Services for Socially Isolated, Physically Disabled Adults

Full report

A report focused on the health and care needs of socially isolated, physically disabled adults is available here.

Participants

Thirty-nine people participated in the workshop, with 27 people completing the health and care needs survey administered during this workshop. Some attendees were paid or unpaid carers supporting the people they care for to participate. Participant service use is shown below; not all participants accessed community services (and some of the participants may have accessed more than one service).

Service	No. of participants
Community physiotherapy	11
Community occupational therapy	11
Community and District Nursing Service	11
Specialist nurses (e.g. diabetes, heart failure, continence, respiratory)	10
Community podiatry	9
Community speech and language therapy	7
Falls and bone health	5
Enhanced Care in care homes	4
Community palliative care	4
Intermediate Care: rehabilitation, reablement and recovery	4
Proactive anticipatory care	3
2-hour Urgent Community care	3
Virtual Wards	2

Participant demographics are described below:

Demographics	No. of participants
Gender	Women: 9 Men: 6
Age	25-49: 9 50-64: 1 Over 65: 8
Ethnicity	Asian/Asian British - Any other background: 1 White - British/English/Welsh/Scottish/Northern Irish: 6 Other (Please specify: included 'Mixed', 'Afghans', Iraqi and' white Caucasian.): 4

Key findings

Participants identified the aspects of services most important to them as: continuity of care, timely access to service and appointments (physiotherapy and podiatry particularly suffered in this area), disability-friendly infrastructure and transportation, compassionate staff, and active participation in their care.

Limitations

Healthwatch Kingston added in survey and workshop questions to pre-planned/existing community engagement, which increased time to complete surveys and potentially led to reduced completion rates.

Recommendations

Healthwatch Kingston's report captures the experiences of socially isolated, physically Disabled people and extends beyond their use of community services. The full list of recommendations that they provide in this report is recorded below for continuity. These recommendations are grouped into: service delivery and coordination, accessibility and infrastructure, information and communication, and inclusion and representation.

Service delivery and coordination

1) Develop integrated care coordination across health and social care for Disabled adults.
2) Improve continuity of care and communication between NHS services and other providers.
3) Ensure transport options are not a barrier to attending appointments.
4) Ensure consistent respite and longer visit times for unpaid carers, especially those supporting individuals with complex needs.

Accessibility and infrastructure

1) Increase investment in accessible infrastructure including public toilets, crossings, 'Changing Places' facilities, and step-free access.
2) Provide more physically accessible and affordable venues for activities, particularly for adults 25–65.
3) Reinstate and strengthen disability awareness training for transport staff and the public.

Information and communication

1) Improve the usability and accessibility of Connected Kingston and other local information platforms.
2) Offer printed, phone-based, and in-person information channels to reach digitally excluded residents.
3) Promote a centralised, regularly updated "what's on" guide, including details about accessibility, inclusion, and representation.

Inclusion and representation

1) Ensure Disabled people are involved in all stages of service design, especially in major public planning.

2) Embed cultural competence and anti-discrimination training in all frontline services.
3) Recognise the impact of social isolation on mental health and invest in community-led befriending, peer support, and inclusive events.

Kingston End of Life Services

Full report

A report focussed on bereavement and end of life services is available here.

Participants

Nine unpaid carers who had experience with hospice or palliative care services for their loved ones were included.

Demographics of unpaid carers:

Demographic	No. of participants
Gender	• Women: 8 • Unreported: 1
Age	• Under 18: 1 • 18-24: 3 • 50-64: 2 • 65-79: 2 • Unreported: 1
Ethnicity	• Asian/Asian British – Indian: 1 • White - British: 4 • White - Irish: 1 • White- Any other White background: 2 • Unreported: 1

Key findings

Due to the structure of the survey and the data collection process, it was not possible to isolate specific responses about palliative care provided by community services from the nine participants who answered questions related to end of life care (responses include those who received both community and hospital care). However, valuable insights were still gathered. Participants shared what mattered most during this time, including:

- What could be offered to keep them, or the person they cared for, comfortable
- Managing any symptoms (*e.g.,* pain, anxiety, breathlessness, confusion, *etc.*)

- Emotional/psychological needs
- Where they/the person they cared for would prefer to die (*e.g.,* at home, in a care home, hospice, hospital, *etc.*)

When it came to decision making, 44% of participants felt they were involved in decision making as much as they wanted to be, while 33% reported that they would have liked to be more involved.

Forty-four percent of participants felt that the patient's final days were well planned, whereas 33% felt that their final days were not well planned. Relatedly, 22% of participants said the patient had an advanced care plan in place, 33% reported that the patient did not, and 44% did not know whether one was in place. Sometimes this was due to a patient dying suddenly, but this was not always the case.

Limitations

Healthwatch Kingston added in survey and workshop questions to pre-planned/existing community engagement, which increased time to complete surveys and potentially led to reduced completion rates. The survey also did not contain a 'filter' question to isolate responses from those who had used community (versus hospital) hospice or palliative care services.

Recommendations

Healthwatch Kingston did not publish any recommendations specific to palliative care or hospice in their accompanying report, which focussed mainly on people's experiences of bereavement support. The key findings described above demonstrate, however, that there is room to improve this service through enhanced inclusion of patients and unpaid carers in decision-making and improved advanced care planning.

Merton

Service

Healthwatch Merton focused on the community nursing service at the Central London Community Healthcare NHS Trust.

Full report

The accompanying report is currently not available for publication.

Participants

There were 25 completed responses to the survey. Participant demographics are shown below:

Demographics	No. of participants
Age	• 18-24: 0 • 25-49: 0 • 50-64: 4 • 65-79: 9 • 80+: 10 • Prefer not to say: 2
Gender	• Woman: 13 • Man: 9 • Non-binary: 0 • Prefer not to say: 3
Sexuality	• Asexual: 0 • Bisexual: 0 • Gay man: 0 • Gay woman/lesbian: 0 • Heterosexual/straight: 22 • Pansexual: 0 • Prefer not to say: 2 • Not known: 1
Ethnicity	• White - English, Welsh, Scottish, Irish or British: 17 • Other white: 0 • Asian or Asian British - Indian, Pakistani, Bangladeshi, Sri-Lankan, Chinese or other Asian background: 1 • Black or Black British - Caribbean, African or any other black background: 2 • Mixed Ethnicity: 1 • I do not wish to disclose my ethnic origin: 2 • Any other ethnic group: 2
English speaking ability	• Main language is English: 21 • Main language is not English but can speak it well: 3 • Speaks little to no English: 0

Financial position	• Very comfortable: 2 • Quite comfortable: 14 • Just getting by: 5 • Really struggling: 1
Accessibility needs	• Visual impairment: 2 • Physical impairment: 15 • Deaf or hard of hearing : 4 • Sensory impairment: 1 • Cognitive impairment: 1

Key findings

The report shows strong overall satisfaction with community nursing services in Merton, especially in relation to staff demeanour, care quality, and communication. Where concerns arose, they were often related to service consistency, coordination between multiple providers, and the need for clearer communication around logistics or planning, particularly in more complex or sensitive areas of care. More detailed findings are summarised below:

- Staff attitude and care quality: All respondents agreed (40%) or strongly agreed (60%) that staff providing care had a positive and caring attitude. Comments highlighted professionalism, kindness, and reassurance from nurses. All 26 respondents also felt that the care they received was of high quality. While the majority praised the skill and compassion of staff, a few noted variability in care quality, particularly when care was delivered by multiple nurses, leading to inconsistencies in technique, sensitivity, or hygiene during treatment.

- Timeliness of visits: 65% of respondents said nurses usually arrive within the expected two-hour window. Other participants noted that while most users experience punctual care, there are occasional issues with delays, cancellations, or lack of clarity around visit times.

- Communication: 77% of respondents felt that communication from the service was timely and clear. Many appreciated clear, prompt updates, especially when visits needed to be rescheduled. However, some preferred more proactive contact and expressed difficulty due to hearing impairments, lack of consistent updates, or unclear processes during staffing shortages.

- Patient involvement in care decisions: 85% felt involved in decisions about their care. Only one respondent strongly disagreed, and the remaining respondents said the question did not apply to them. Positive comments reflected a sense of shared decision-making and family involvement. Some respondents, however, deferred decisions to staff out of trust, while others reported a lack of consultation or contradictions between nursing staff and doctors, reducing clarity and trust.

- Tailored care to accessibility and cultural needs: Most respondents felt care was tailored to their needs. Comments reflected satisfaction with professional staff and family involvement in reviews. However, a few raised concerns about unmet practical needs (*e.g.,* not being able to shower due to leg wounds) or lack of continuity when different nurses attended, making it hard to track progress.

- Joined-up care between services: Feedback on coordination across services was mixed. While several participants praised reliable communication between district nurses, GPs, and pharmacists, others described confusion, particularly about post-hospital discharge or with medication supplies. Some respondents had to navigate multiple services themselves or through family members, highlighting fragmentation and a need for clearer cross-service pathways.

- Timely delivery of equipment, medication, dressings, and continence products: Most patients reported timely and reliable access to essential supplies. Positive feedback was received regarding pharmacies, occupational therapy services, and dressing delivery. However, delays were reported, especially for medication and equipment post-discharge. Some noted confusion about responsibilities, particularly between healthcare teams and social services, for items like continence products.

- End of life care: Only three respondents answered questions on end of life care. Of these, two reported having discussed aspects such as symptom management, family involvement, and comfort measures. Not everyone recalled discussing cultural or spiritual needs.

Limitations

While Healthwatch Merton's research reflects valuable and authentic experiences from people receiving community nursing support in the borough, the relatively small number of responses limits how representative the findings can be across the wider population. The data also relied on self-reporting, which may be influenced by memory, personal interpretation, or emotional context. Nonetheless, the insights gathered highlight important trends that can help shape future engagement and service improvement.

Recommendations

The feedback gathered through this project highlights both the strengths of community nursing in Merton and areas where patients and carers would welcome further improvements. Based on these findings we have identified key recommendations to support more consistent, patient centred and reliable care.

1) Strengthen Communication and Information Sharing

   Ensure that the community nursing teams continue to prioritise proactive communication, making use of phone calls, texts, or alternative formats especially for people with visible and hidden disabilities.

2) Improve Joined-Up Care Between Services

   Some respondents highlighted difficulties in coordination between GPs, pharmacists, hospitals, and community nurses. Clearer roles, responsibilities, and smoother referral pathways would help reduce confusion and delays. There is a need to increase or continue regular multi-disciplinary meetings as well as develop better information-sharing protocols.

3) Support Tailored and Individualised Care

   While most respondents felt that their care was adapted to their needs, there were notable concerns around continuity (e.g., seeing different nurses each visit) and specific needs like wound care or accessibility. Ensuring that care is consistently person-centred, with attention to cultural, physical, and family circumstances, is key.

4) Address Practical Issues Around Supplies and Deliveries

   Feedback suggested delays and confusion in accessing dressings, equipment, continence products, and medication. Reliable supply chains are fundamental to quality care. Community teams could work with pharmacies and suppliers to streamline ordering and delivery systems as well as help in communicating this process to their patients and carers which can help remove stress for them.

5) Strengthen End-of-Life Care Discussions

   Although only a few people responded to the end-of-life section, it revealed the importance of sensitive, early, and thorough discussions around preferences, comfort, and family involvement. NICE (2019) guidance on end-of-life care highlights the need for proactive communication and planning, ensuring patients and families feel supported at this critical stage. If not happening already, community nursing teams must consider embedding these discussions more routinely, even when patients do not raise them directly.

Richmond

Service

Healthwatch Richmond focused on the community nursing service provided by the Kingston and Richmond NHS Foundation Trust.

Full report

The full report is available here.

Participants

279 patients and unpaid carers completed Healthwatch Richmond's survey and provided sufficient information for the surveys to be analysed.

Service	No. of participants
Whitton Corner Health and Social Care Centre (known as Whitton Corner) covers Twickenham and Whitton	188
Centre House covers Sheen, Ham, Richmond, Barnes and Kew	60
Teddington Health and Social Care Centre covers Teddington and Hampton	26
I don't know	5

Participant demographics are summarised below:

Demographic	No. of participants
Gender	Women: 117 Men: 81 Prefer not to say: 3
Age	25-49: 9 50-64: 19 65-79: 58 80+: 168 Prefer not to say: 4

Ethnicity	● White - English, Welsh, Scottish, Northern Irish, British: 212 ● Any other White Background: 16 ● Asian or Asian British: 9 ● Black or Black British: 5 ● Mixed ethnicity: 6 ● Any other ethnic group: 0 ● Prefer not to say: 6

Key findings

The findings from 279 patient and unpaid carer participants demonstrate high satisfaction with community nursing services, especially regarding staff professionalism, care quality, and personal rapport. While challenges exist - primarily around inter-service coordination, medication delivery systems, and consistency of end of life planning discussions – participant feedback offers strong evidence of compassionate, responsive care. Furthermore, Kingston and Richmond Foundation Trust's responses to recommended improvements shows a commitment to future service enhancements.

More detailed findings are provided below:

- Staff attitude: Respondents consistently praised community nurses for their professionalism, kindness, and compassion. Patients expressed strong trust in both the individuals and the service overall.

- Timing of visits: The majority of respondents were highly satisfied with the timing, flexibility, and punctuality of nurse visits.

- Care Quality: 99% of respondents feel that they receive high quality care, once again citing the nurses' kindness and professionalism. Patients also highlighted cleanliness, hygiene, and respect for their home environment.

- Communication: 93% described communication as timely and clear. While the comments cite occasions where communication lapsed, there is no indication of a pattern of communication breakdown.

- Patient involvement: 88% of respondents felt involved in decisions about their care. Patients described being listened to, consulted, and offered choices about treatments (*e.g.,* injection sites, dressing preferences), and unpaid carers also felt included and informed. Nurses were seen to respect patient autonomy, even in cases of disagreement or non-compliance with medical advice.

- Tailored care: 88% agreed that the nursing service was tailored to meet the unpaid carer or patient's needs, including cultural needs. However, the Healthwatch Richmond team observed an instance where a hard of hearing patient struggled with communication with the nurse, suggesting a potential training need around the Accessible Information Standard.

- Care coordination: 77% of respondents felt that the different services that support them communicate well with each other, though qualitative feedback provided a more mixed response. Coordination was generally praised between nurses and GPs, paid carers, and hospice teams. However, feedback regarding hospitals and GP referrals was more critical, citing poor information sharing, incomplete referrals, and fragmented systems. Respondents reported having to repeat information or chase updates themselves. The report suggests the lack of interoperability between hospital and community IT systems exacerbates these issues.

- Deliveries of equipment, medications, and supplies: Responses indicated mixed satisfaction. While some received same-day delivery of equipment, others experienced delays and unresponsive suppliers. For medications, some praised the shift to home delivery, but delays in prescription deliveries led in one known case to hospital admission. Some patients also noted challenges with orders for creams, continence products, and dressings, products that are all supplied and delivered by different providers.

- End of Life Care: Only 54 respondents (19% of the total sample) answered multiple choice questions about end of life care, with just 10 leaving usable comments. Positive responses highlighted sensitive, respectful care aligned with patient wishes; however, some participants said they hadn't had conversations about end of life and wished that this had been available to them.

Limitations

Healthwatch Richmond reported that methodological limitations potentially impacted responses. Nurses handed out surveys to participants, which could have introduced bias towards inviting participation from patients and unpaid carers known to be more likely to share positive feedback. Responses were also not anonymous to the nursing staff (indeed, on some occasions nurses supported participants in completing the survey), which again could skew responses positively.

Recommendations

Healthwatch Richmond's report sets out the recommendations below to the Kingston and Richmond Foundation Trust (who have already responded as shown) and to the South West London ICB (which are also set out in the recommendations in the body of the current document).

Recommendations to the Kingston and Richmond Foundation Trust and their response:

1) Share positive feedback contained within this report with staff.
   "An email will be sent sharing the report with all our community nursing staff."

2) Ensure clear communication to patients regarding timing of visits.
   "It was good to see that the majority of our patients were clear on our visits. We will review our current communication we give to patients to reinforce the notification of our visits, any communication of any changes, and we will also look to how to ask questions and what to do in an emergency situation."

3) Ensure clear communication from staff to patients regarding what to do in an emergency or if a patient has questions. "See above."

4) Ensure staff understand and implement the NHS Accessible Information Standard, with particular relevance for hearing impairments.
   "AIS and reasonable adjustments have been rolled out in our community services. This is included in our Electronic Patient Record System and staff have received training. We also have a wealth of resources on our intranet for staff."

5) Ensure that Kingston Hospital staff know what information is needed when making referrals to the community nursing team.
   "There is a current work stream looking at the referral form the hospital fill-in to support discharge to community teams. This is an on-going piece of work as part of Kingston and Richmond ED and flow workstream."

6) Create links with the Richmond GP alliance to improve communication and referrals from GP practices.
   "We are currently in discussion with GP partners to agree what areas of work will be the initial priority projects."

7) Review systems in place to ensure end of life patients get the care and support they need.
   "As part of the work we are doing in the urgent and emergency care delivery board work there is discussion about approach to end of life care. The team have training from Princess Alice Hospice and are planning some training with the Kingston and Richmond Pastoral care team to support with having difficult conversations."

8) Review systems around prescriptions and medications for housebound patients, particularly relating to expediting prescriptions.
   "We will complete an audit reviewing the prescription process and average length of time for patients to get their prescription."

Recommendations to South West London ICB

1) Review systems in place to enable joined up working between primary, secondary, and community services.

2) Review systems around prescriptions and medications for housebound patients, particularly relating to expediting prescriptions.

Sutton

Services

Healthwatch Sutton conducted semi-structured interviews with frail people who accessed a range of services, including Maximising Independence Service, hospice, urgent community response, a frailty hub, and virtual wards.

Full report

The report is available here.

Participants

Twelve participants were interviewed:

Service	No. of participants
Maximising Independence Service	4
St Raphael's Hospice Wellbeing Service	4
Urgent Community Response	2
St Helier Frailty Hub	1
Sutton Virtual Ward	1

Participant demographics are described below:

Demographics	No. of participants
Gender	Women: 5 Men: 7
Age	50-64: 1 65-79: 2 80+: 7 Prefer not to say: 2

Ethnicity	White - British/ English: 9 Black - Caribbean: 1 Sri Lankan: 1 White - European: 1

Key findings

People with frailty in Sutton generally had positive experiences with local community services, particularly valuing the kindness, professionalism, and responsiveness of staff. However, navigating services could be challenging and respondents called for a single, accessible point of contact that wasn't solely digital. While the quality of care was praised, some noted issues with continuity, communication between services, and difficulties maintaining exercise routines without group support. More detailed findings are presented below:

- Staff Manner and approach: Staff were widely praised for being friendly, respectful, and treating patients as equals, with a relaxed, personable manner that made participants feel comfortable and humanised. Many noted how addressing patients by their first names and maintaining an informal but professional tone fostered trust. However, concerns were raised about cultural understanding, with one participant reporting a miscommunication about her husband's ethnic background. Others acknowledged the strain on NHS staff but continued to express admiration for their dedication under pressure.

- Access to information: Participants generally found out about health services through healthcare professionals such as GPs, district nurses, and physiotherapists, as well as community organisations like Age UK Sutton and Sutton Council. While family members and online searches also helped, some participants (particularly unpaid carers) expressed the need for a single, central, non-digital source of information to make navigating services easier for those less comfortable with technology. Although platforms like the Sutton Information Hub exist, there was uncertainty about whether a health-specific directory is available. Particular concerns were raised about uncertainty of how to access services like hydrotherapy and community transport.

- Joined-up care: Participants also appreciated responsive and well-coordinated care, citing rapid visits from district nurses and timely access to medication and assessments as examples of services working efficiently. However, there were some cases of communication breakdowns between services, such as between virtual ward teams and GPs.

- Seeking help: Some participants felt resigned to chronic conditions like arthritis and back pain, believing that little more could be done, which discouraged further help-seeking, especially when GP access was difficult.

- Social approaches to care: Programmes like Maximising Independence were seen as motivating due to their group format, accessible pace, and supportive environment, with participants finding it easier to stay engaged when exercising alongside others. Conversely, many struggled to maintain routines at home and requested more tailored, simpler follow-up support. Some also noted a loss of NHS-run day centres, which had once provided both social and physical support.

- Continuity of care: Participants expressed concerns about continuity of care and wanted to see the same staff consistently to avoid repeatedly explaining their medical history.

Limitations

Due to the nature of services explored, there was a limited sample size, so findings may not reflect the average experiences of people living with frailty in Sutton, or the full range of services they may use.

Recommendations

Healthwatch Sutton posed a series of questions for consideration for the local community services commissioner, Sutton Health and Care, to guide improvement of their services:

Accessing services

- Is there a single point of information for finding out about services for frailty in Sutton?
- How many of the services for frailty can people access through self-referral?
- How accessible are services for frailty? Is there parking available and does this include Blue Badge spaces? Is transport also available?
- People’s support networks play a significant role in taking them to healthcare appointments and collecting their medication. Is there any work in Sutton to identify those with frailty who are isolated, don’t have a support network and therefore may not be accessing services?

Communication from services

- Should services for frailty explain to users what frailty is and what level of frailty they have? This could address people’s assumptions about frailty, such as that it only applies to end of life. Services could also clarify the difference between ‘frailty’ and other terms such as ‘disability’.
- Do services for frailty play a role in communicating key information to users, such as how to apply for a Blue Badge, how to access Dial-a-Ride, how to contact Occupational Therapy?

- Do services for frailty, such as the virtual ward, tell users about each home visit from a health care provider in advance?

Medequip

- Is there an issue with Medequip watches and Parkinson's? Does the watch fail to send alerts when people with Parkinson's fall and shake on the ground?
- How long do Medequip watch wearers wait for someone to come and help them up when they fall? Is there data available on this for Sutton residents?

Wider support

- Participants wanted to remain as independent as possible. Should they be encouraged to accept more support, particularly at home?
- Services for frailty are likely to have contact with unpaid carers. Do they play a role in identifying them and signposting them to relevant support?
- How can services for frailty be culturally competent and recognise the role that faith plays for some in coping with their health?

Wandsworth

Service

Healthwatch Wandsworth focused on proactive care services provided by Central London Healthcare NHS Trust.

Full report

The report will be published online when complete:
https://www.healthwatchwandsworth.co.uk/news-and-reports

Participants

There were 46 completed responses to the survey. Participant demographics are shown below:

Demographics	No. of participants
Age	• 45-54: 4 • 55-64: 4 • 65-74: 11 • 75+: 27
Gender	• Woman: 25 • Man: 21 • Non-binary: 0 • Prefer not to say: 0

Sexuality	- Heterosexual/straight: 43 - Prefer not to say: 3
Ethnicity	- White - English, Welsh, Scottish, Irish or British: 31 - Other white: 0 - Asian or Asian British - Indian, Pakistani, Bangladeshi, Sri-Lankan, Chinese or other Asian background: 5 - Black or Black British - Caribbean, African or any other black background: 9 - Mixed Ethnicity: 0 - I do not wish to disclose my ethnic origin: 0 - Any other ethnic group: 1

Key findings

Patient knowledge of proactive care and their condition: Overall, most people reported not understanding what proactive care services were (70%) and only 9 people (20%) answered that they at least had some understanding of them. Alongside this, we found that most people did not receive an opt-in letter (which normally includes a description of the service), with 91% of people responding that they did not receive this. It is likely that not receiving or remembering receiving this letter is a factor in the general lack of knowledge of proactive care services.

Although most people did not report having a good understanding of proactive care services, most people (72%) suggested that they have better knowledge of their condition because of the support received by proactive care services.

Communication amongst professionals: We asked patients if they believe that there is enough communication amongst the healthcare professionals in their multidisciplinary team. However, it is worth noting that there seemed to be some confusion around what this question was asking with some responding regarding the level of communication between themselves and professionals, e.g., some reporting not being able to book a GP appointment. Responses such as this have been removed.

Of the remaining 43 responses we found that most people responded positively believing that there was good communication between professionals (60%). Good communication between GPs and district nurses was specifically mentioned by two people, ‘communication between GPs and DN is good…’.

Although responses were majority positive there was still some negativity with 9 people (21%) responding that they do not feel that there is enough communication. Some commented on professionals not being up to date and the lack of continuity of care as a result, ‘professionals very disconnected’, ‘no one knows what’s going on’.

Overall, there seems to be good sentiment around communication between the multidisciplinary teams of the proactive care services, however, there is still room for improvement as it is not consistent.

Inclusion in care: Most people (81%) reported that they did feel like they had an active role in their care. There was some dissatisfaction with 13% of people noting that they did not feel involved in their care, with some citing specific incidents where their needs were not taken into consideration: ‘the DN didn’t want to visit due to him having a dog, DN proposed to him since he’s capable to walk the dog, he’s also capable to attend the clinic for wound care. Based on this, DN stopped visiting’. This suggests that people mostly feel involved in their care and that their needs are being considered, however, this is still not the case for over 10% of patients.

Information, advice and guidance: 89% of patients were confident that they would know who to call if they had any questions about their care. 50% of patients reported that they would contact the GP and of the two patients that stated they did not know who to call they both guessed they would call the GP. This suggests that people largely know where to receive support, and this is normally the GP, including for those who are unsure.

Additionally, when asked if they did need further information, advice or guidance to support their health, 61% of people reported that they did not need anything further. This suggests that most people were generally satisfied with the level of information they had.

Independence and A&E visits: 41% of people agreed that proactive care services have helped them to regain or maintain independence. 20% of people disagreed, suggesting that there is still room for improvement with proactive care’s ability to help people remain independent. It should, however, be noted that 71% of people agreed that proactive care services helped them to avoid unplanned visits to A&E. This suggests that although there is mild agreement with proactive care’s ability to maintain independence, most patients have successfully been able to avoid unplanned visits to hospital or A&E.

It would be interesting to understand if patient independence is somehow related to decreased A&E visits, e.g., do proactive care services provide care where patients do not feel independent, however because of this level of support provided, do patients have less opportunities for accidents that result in A&E admissions.

Suggestions for improvement: When asked how could proactive care services be improved further, 46 people responded, however one response was not clear enough for inclusion. Of the remaining 45, 41% stated that they had no concerns and did not believe that the services needed improvement. 56% of people made suggestions for improvement with accessibility being the most common suggestion (17%). Here people mentioned difficulty making appointments due to physical difficulties, 'as a housebound you [have] great difficulty filling up forms.'; and issues with using technology, 'e-consult not suitable for everyone, specifically if no have a smart phone. In my case, I have to wait 3 days for the GP to call back.'. Accessibility was also mentioned by 9% of people when asked on which areas they would like further information, advice and guidance.

In addition to accessibility, communication was the second most reported area that needed improvement with 11% of people stating there is a need for better communication both between professionals and professionals to patients. Other areas for improvement include:

- Suitable appointment times – (n=3, 7%)
- Standardised and more consistent care – (n=2, 4%)
- Better staff training – (n=2, 4%)
- Continuity of care (seeing the same professionals) – (n=1, 2%)
- More consideration of patient needs and concerns – (n=1, 2%)
- More holistically responsive care e.g., housing concerns – (n=1, 2%)
- Better follow up after discharge – (n=1, 2%)

Recommendations

Overall, proactive care services see positive patient experiences with many people being satisfied with the care received. However, things are not perfect and there is still some patient dissatisfaction around key elements of the service. We have made the following recommendations for improvement below:

Communication:

- Improve communication from the service to patients from day one. Many patients do not recall receiving an opt in letter and do not have a good understanding of exactly what proactive care is.
    - We recommend ensuring that letters are sent and that patients are also asked about this at the first point of contact with professionals to ensure that understanding is established.

- Although there was good reporting on level of communication between professionals, especially between GPs and district nurses, there were still reports of a lack of information sharing between teams.

    - We recommend further understanding on where the gaps in communication lie and how we can improve them. This may also be improved by boosting continuity of care, where patients are seen by the same professionals, lowering the need for resharing of information.

Accessibility:

- Accessibility was noted as one of the main areas for improvement by respondents, which included comments on both the accessibility of online services such as e-consult for older patients and general accessibility for those with physical disabilities such as vision impairment/blindness.
    - We recommend ensuring that the Accessible Information Standard is being properly adhered to so that patients are offered multiple different ways in which they can book and attend appointments, fill in forms, and have their accessibility needs met.

Patient independence:

- The least amount of patient satisfaction reported was around patient experiences of regaining or maintaining independence whilst under proactive care services. We saw that most patients either did not have an opinion on this (responding ‘neutral’) or disagreed that their independence was being maintained or reestablished.
    - We recommend further understanding on this and identifying factors such as whether this is related to patients not feeling like the services are accessible enough and which increases their reliance on others to navigate their healthcare.

A&E visits:

- Patients reported proactive care services supporting them in avoiding unplanned A&E visits.
    - We recommend further understanding on the factors that are allowing up to 71% of patients to avoid hospital and A&E for further learning on how to boost these numbers, as nearly 30% of patients do not agree that proactive care services have helped them to avoid hospital and A&E.

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