Croydon residents' experiences of intermediate care and reablement services

June 2025

Table of Contents

Executive Summary

Healthwatch Croydon was commissioned to survey a sample size of 20 patients or carers of patients across four cohorts who recently accessed reablement and intermediate care services in Croydon. Between March and June 2025, 17 individuals ultimately took part. This work supports ongoing service review and future commissioning by Croydon Council, Croydon Health Services NHS Trust, and the South West London Integrated Care Board.

Currently, patients discharged from hospital may be referred to either intermediate care services delivered by the NHS or reablement services, managed by Croydon Council. Intermediate care tends to provide support through direct assistance with daily tasks, either in patients' homes or in designated care facilities. In contrast, reablement focuses on helping individuals regain independence through therapeutic support and practical guidance. Some services, such as occupational therapy, can be accessed under both models.

The primary aim of this research was for Croydon to better understand patient needs and expectations, particularly in relation to the preferred setting of care whether in dedicated facilities or at home. Feedback was gathered through a survey and interviews with patients from four distinct care cohorts. Croydon Council and the NHS services was responsible for identifying and recruiting suitable participants who were currently using the services.

Our findings

- **Vital support from unpaid carers:** Most participants (88%, 15) 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. **See pages 10-13.**

- **Varied involvement in post discharge decision making:** While some participants were very involved (18%, 2) or involved (29%, 5) in decisions about their post-discharge care, others were not that involved (29%; 5) or not all (24%, 4), 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. **See pages 14-17.**

- **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. **See pages 18-23.**

- **Setting goals and meeting them:** Most (65%, 11) were able to set goals and could meet them. However, a third (35%, 6) did not have goals set, **see page 24.** Of the 11 who did have goals set, 7 did meet them. **See pages 25-27**. Nearly two-thirds were involved in goal decisions with most those quite involved (41%, 7) and nearly a quarter (24%; 4) fully involved. However, over a third were not that involved or not at all. **See page 31.**

- **Support needs were varied**: This including support with daily living tasks, physiotherapy and mobility support; home care services and carers; medical monitoring and community healthcare and family involvement and support. Some participants said they had not received much or any support at all. **See pages 28-30.**

- **Service satisfaction:** Over three quarters were satisfied with a majority satisfied (52%: 9) and a nearly a quarter fully satisfied (24%: 4). Some were partially satisfied (18%;3) and 1 (6%) not satisfied at all. **See pages 32-33.**
- **Responsive to culture and background:** Most participants (58%; 10) 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%, 4) 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%; 3) preferred not to comment, suggesting uncertainty or reticence to give a view. **See pages 34-36.**
- **Improvements:** When asked what could be improved, participant 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 met already expectations. **See pages 37-39.**
- **Care home vs care at home:** Most (70%; 12) said services they preferred services at home, while (24%; 4) said 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 always wanted avoidance of unsuitable care settings and faster and more positive recovery. Some however preferred a care home as there was immediate and consistent access to support, and social interaction and confidence in facility services. Some also had previous negative experience being left at home after a fall for some time and therefore prefer care facilities. **See pages 38-42.**

Recommendations

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

- **Recognise and support 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, carers should be provided with appropriate training, information, and access to carer assessments, along with guidance on financial and practical support such as respite services, to help sustain their caregiving role.
- **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.
- **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.

- **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.
- **Consider care homes when no appropriate alternatives are available.** Most want to stay at home but for some 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.

Background

Healthwatch Croydon interviewed 17 participants in the first quarter of 2025 from four cohorts of patients or carers of patients using the reablement services, to understand patients journey and experience and asking what they feel could be improved to the services.

To capture a diverse range of experiences, Healthwatch Croydon interviewed patients currently receiving care across the following distinct cohorts:

- Reablement at Home (5 participants)
- Intermediate Care at Home (5 participants)
- Intermediate Care in a Bed-Based Facility (5 participants)
- Winter Beds (2 participants)

Participants were recruited via the four service team managers, with consent agreed with participants before details shared. On some occasions, permission was given to speak to Healthwatch before consent was givn, but this was completed before the interview began.

The majority of interviews were conducted via telephone. However, a small number were carried out face-to-face during visits to care facilities. All participants were residents of the London Borough of Croydon and had recent experience with the above identified services.

Limitations:

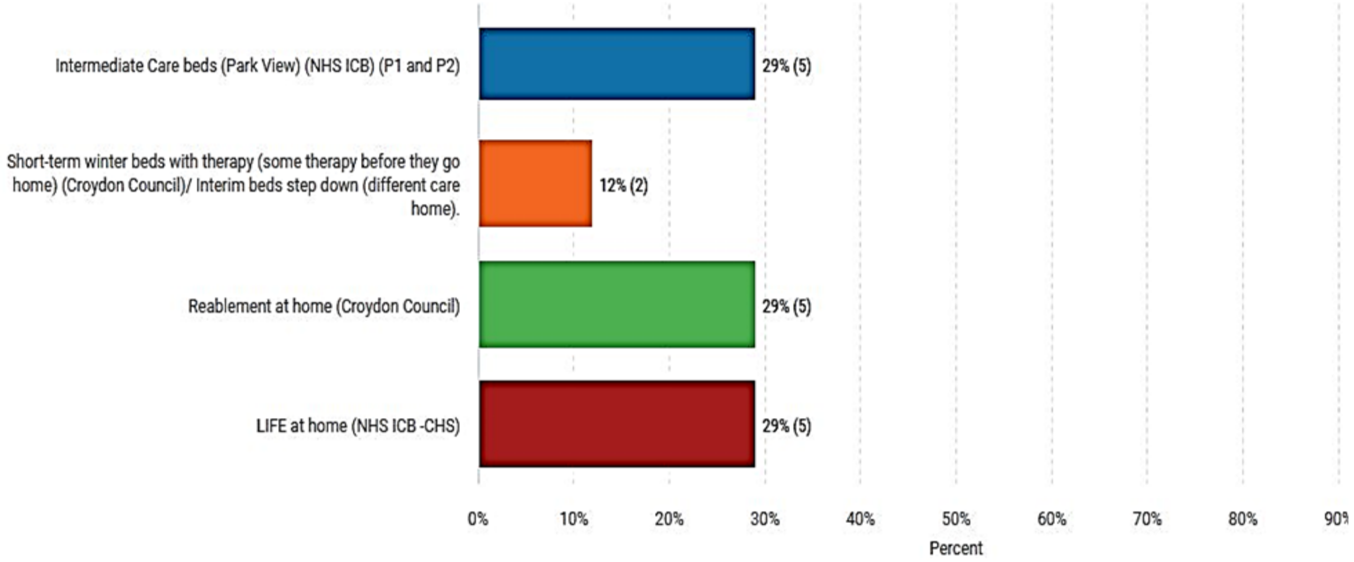
- Recruitment delays
  Despite best efforts, there were delays in accessing patients from the Winter Beds cohort. This was primarily due to the time taken to obtain candidate lists, which impacted the scheduling and completion of interviews within the project timeline. There were many extensions to allow additional time to recruit participants.

- **Participant Availability**
  The health status of some individuals further limited their ability to participate, particularly among those with higher levels of need or recent hospital discharge, reducing the overall response rate.

- **Sample Size**
  A total of 17 participants took part in the survey, slightly below the intended target of 20. While this does not invalidate the findings, the small sample size may limit the generalisability of the results.

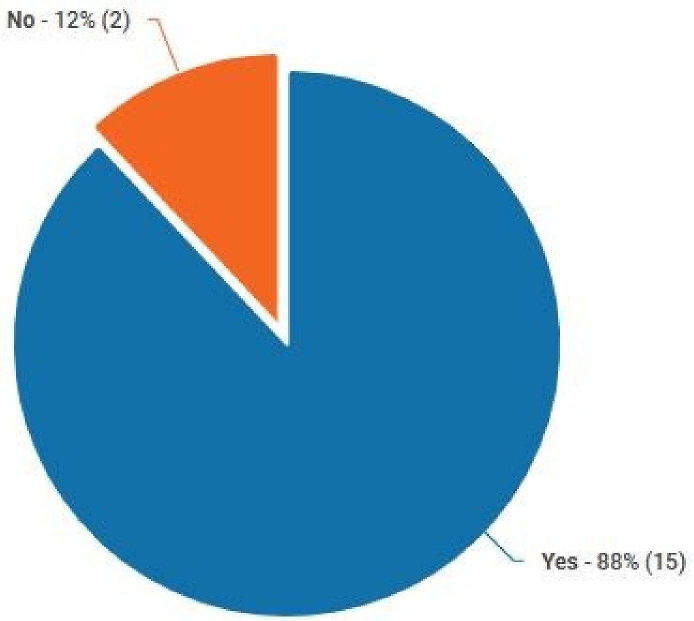
Insights

1. What services have you used after leaving hospital?



A total of 17 participants took part in interviews, distributed across four cohorts. This distribution from the above graph indicates a relatively balanced representation across three of the four cohorts, with short term winter beds having the fewest participants. The consistency in participation among intermediate care beds, reablement at home, and life at home cohorts suggests a steady level of engagement, while the lower number in the short-term winter bed cohort reflect scheduling challenges, availability issues, and other barriers to participation. Overall, the data highlights broad involvement across the groups, providing a diverse range of perspectives for analysis.

2. Do you have support from unpaid carers such as family or friends?



Most participants had received direct support from unpaid carers, including family members or friends. Only a small proportion reported managing independently without this type of informal assistance.

Individual quotes of those who had support from family or friends

"I spent a month in the hospital and have just come out. I am recovering slowly. I have two daughters who have families and children. One of them lives near me and has organized everything for me with Croydon. Although I have two carers coming in twice a day, however my daughter has been a great support."

"Yes, I receive support from my wife and sons. They assist with various household tasks, including cooking, washing clothes, and managing other chores, which greatly eases my daily responsibilities."

"My brother and I both have families and take turns caring for our dad, who lives with us. We have a social care package in place to support him. There was a six-week period when my dad needed additional care. He lives in a bungalow with ramps installed to help him get in and out more easily. We also receive support from the Family and Life team."

"Yes, we have been consistently present alongside other caregivers to support her. Following her stroke, which impaired her speech, our presence has been crucial in facilitating effective communication with the rehabilitation team."

"Yes, my brother, my mum, and I all supported him. With the three of us there, we were able to provide adequate care and take care of the usual household chores. He wouldn't have been able to manage on his own. When my dad came out of hospital, he had very limited mobility, so we arranged for carers to come in to help wash him and assist with getting him back upstairs."

"Yes, I receive support from my wife and family. When my wife is tired or needs a break, we arrange for a carer to help out."

"Yes, I receive support from my family. They've been a great help, offering both emotional and practical assistance throughout my recovery. My family has taken on various tasks, from helping with daily activities like preparing meals and assisting with mobility, to providing the encouragement I need to stay positive. They've really stepped up, especially when I've needed extra support, ensuring that I'm not alone during difficult moments. Their involvement has been invaluable, and I'm deeply grateful for their constant care and dedication."

"Yes, I receive support from a close friend and my sister, who lives quite far away. Even though my sister is miles away, she makes an effort to check in regularly and helps out with coordinating care from a distance. My friend is nearby and provides hands-on support, offering assistance with daily tasks and ensuring I have what I need. Their involvement has been invaluable, and I'm truly grateful for the care and attention they provide, even with the distance between us."

“Just daughter.”

“Yes, I do get support from unpaid carers, including family and friends.”

“Although my son doesn't visit often, I’m fortunate to have a lovely couple who come to see me every day and help in various ways. I also have a few other family members who step in when needed to take care of me and my dog. They live nearby, and we’re very close—they’re like my best friends. It’s really comforting to have family around who I can rely on.”

“In addition, there’s another family who live further away in Southport. Despite the distance, they make the effort to drive down to visit me regularly. When they come, they help with cooking and cleaning, which I really appreciate.”

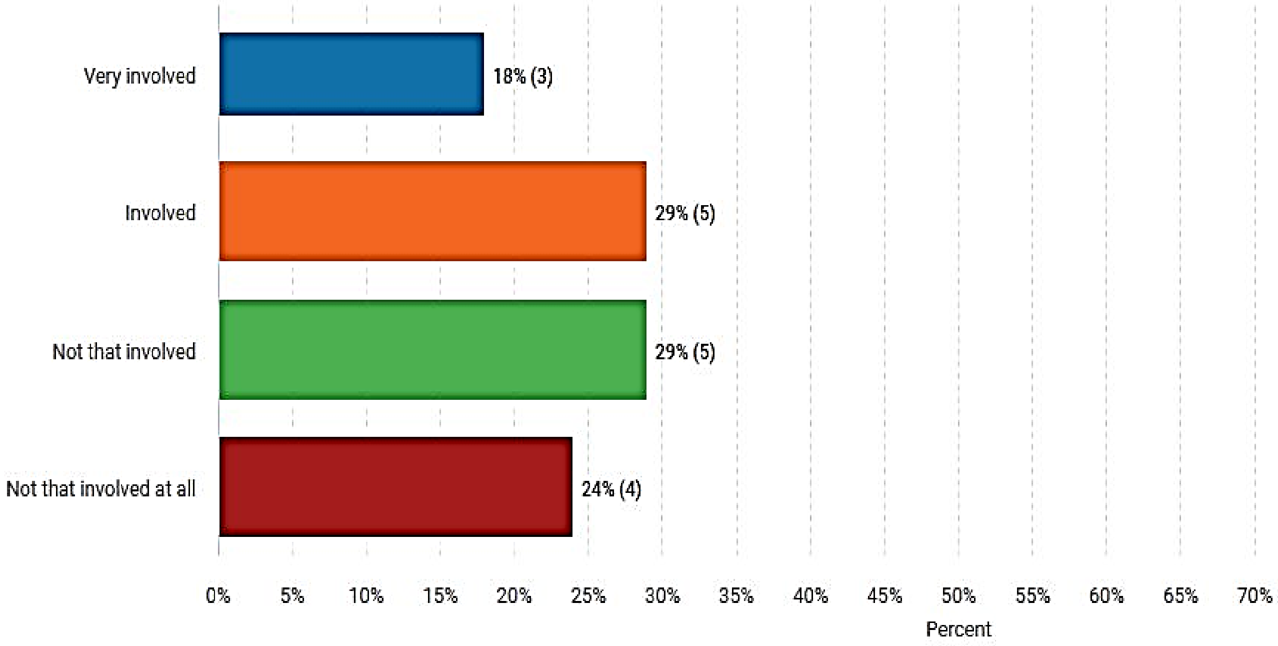
“One of the people who helps me, is especially thoughtful. Every night, she fills my kettle so it’s ready for the morning, turns on my electric blanket to warm up my bed before I go to sleep, and checks that everything is in good order. Her care and attention make a big difference to my comfort and wellbeing.”

“Yes, I receive support from my wife. She helps me with daily tasks that I can’t manage on my own, like dressing and personal care. She’s been a great help, ensuring I’m comfortable and safe, especially after my injury. While my carer assists for a short time each day, my wife steps in to provide the continuous support I need when the carer isn’t around. Her presence is important to me, and I appreciate the care and attention she gives me.”

No direct support

> “I don’t receive direct support from unpaid carers. However, I do get mental support from my sister, who lives in Nottingham. We keep in touch by phone, but she doesn’t provide financial support and isn’t local. I also have a close friend of over 55 years who is my next of kin. We go for lunch every Wednesday.”
>
> “They are not involved in my care.”

3. How involved were you in the decision about your post-discharge care?



Nearly a quarter of participants reported being not involved and a further 29% only partially involved in their post-discharge care planning compared to those who were fully involved 18%, and 29% respectively. This was primarily due to their health conditions at the time of discharge, which limited their ability to participate in decision-making. In such cases, family members or informal carers often made decisions on their behalf. For example, one participant who had experienced a stroke was unable to communicate, resulting in their family taking on the responsibility of coordinating post-discharge care.

Participant quotes from those involved in post discharge decision.

> "Yes, I was involved in the decision about my post-discharge care. I was able to walk upstairs independently, although it was somewhat challenging as decorators were working at the time, with their equipment placed along the corridor."

“Initially, I was in Croydon but was not actively involved in decisions about my post-discharge care. After developing an infection, I was transferred to St George's hospital, where I underwent five operations. As a result, I cannot recall all the decisions made regarding my care. However, I was involved at certain points, particularly concerning my physiotherapy. Despite this, I continue to experience ongoing mobility issues.”

“Although he was unwell, he remained involved and made it clear that he wanted to be at home. There was no way he could have stayed in the hospital on his own. He was there for three weeks, during which we noticed a rapid decline in his health due to mental health challenges.”

“My dad was fully involved in the decisions about his post-discharge care. He was in a good mental state and remained independent, and he was very keen to come home from the hospital. Although we had some reservations about him returning home, we were also concerned about how we would manage his care. He went through a trial period with support in place to assess his needs and ensure the right care was provided.”

“I was involved in the decision about my post-discharge care. While I wasn’t able to make every decision due to my condition, I was actively engaged in discussions about the support I would need once I left the hospital. I worked closely with my family and healthcare providers to ensure that my recovery goals and preferences were considered. This included deciding on the type of care and services required at home, as well as how long the support would last and what specific help I would need. Being involved in these decisions gave me a sense of control over my recovery and ensured my needs were met.”

Participant quotes from those not involved in post discharge decision.

“I have not been involved in the decision-making for my post-discharge care, as my daughter arranged everything and liaised with the care services. She is currently working with social services to secure additional support, known as a domestic package, so I can take short walks. While I can manage most tasks at home on my own, my knee is bad, and I know I need to walk to improve my condition”

“We were not heavily involved in the post-discharge decisions. Despite her stroke affecting her communication, Mum was still capable of making decisions. Carers assist her with bathing, and we encourage her to perform tasks independently to boost her confidence. The carers have been adaptable to her needs”

“I wasn’t heavily involved in the decision-making regarding my post-discharge care, as I wasn’t in the best health at the time. My wife took on the responsibility and made the decisions on my behalf”

“I wasn’t very involved in the decision-making about my post-discharge care, as I was unwell at the time. Due to my condition, I wasn’t in a position to fully participate in the discussions or make decisions about the type of care I would need. My family, particularly my spouse, took on the responsibility of making decisions on my behalf. They worked closely with the healthcare team to ensure that the right support was arranged, as I was not able to contribute as much to those discussions. While I trusted my family to make the best decisions for me, I would have preferred to be more involved, had I been in better health”

"I wasn’t really involved in making decisions about my care after I was discharged from hospital. Before my husband passed away, he had arranged for a trusted family member to look after me, and she has continued to take on that responsibility since then”

“I haven’t been discharged yet, so I’m not in a position to fully answer this question at the moment. However, I am involved in the ongoing discussions about my care, as I’m closely working with my healthcare team to determine the best next steps for my recovery”

4. What information were you given about these services, before your hospital discharge?

Some participants reported receiving clear and supportive information about the services they would receive after discharge. They were informed about the type of help available, the role of carers, and the intended duration of support. See below thematic summary of participants quotes.

Clear and helpful information provided

“Yes, we had a staff visiting and told us what was on offer i.e. speech therapy and physio. We have a big booklet which was fully informative.”

“Before my hospital discharge, I was given clear and helpful information about the services available to support my recovery at home. The staff explained what to expect, who would be involved in my care, and how to contact them if I needed further assistance. This made me feel more confident and prepared for the transition back home.”

“Before I left the hospital, they told me clearly about the help I could get at home. They explained what services would be available, how they would support me, and who to contact if I needed anything.”

"Before I left the hospital, they told me what kind of help I would get at home, like support with daily tasks and getting stronger. They explained that the service would help me get better and more independent. I was told it would last around 4 to 6 weeks, or maybe less, depending on how I improved.”

Physiotherapy-focused information

Some participants specifically highlighted physiotherapy as a well-explained and beneficial part of their post-discharge care.

> “Before my hospital discharge, I was given information about the physiotherapy services I would receive… They also mentioned how long the sessions would last and how often I would need to attend.”
>
> “Before being discharged from St Mary’s, just before Christmas, I was primarily involved in discussions about my physiotherapy… The sessions were highly beneficial.”

Information received through family or previous experience

In a few cases, participants relied on family members or prior experiences with the service to understand what to expect, rather than receiving full information from hospital staff.

> “Yes, I was given information, and my daughter also informed me about the services. I am very impressed by Croydon’s aftercare service.”
>
> “I wasn’t given any information about these services before I left the hospital, but I already knew about them and had used them before.”

Limited or vague Information

Some participants felt that the information provided was vague, basic, or lacking in detail. While some had a general idea of the support available, they felt uncertain about specifics such as duration, the type of care, and how it would help with their recovery.

> “Before my hospital discharge, I was given some basic information about the services provided through the Life at Home NHS program… However, the specifics were a bit unclear, and I wasn’t fully informed about how long the services would last or the exact role of the caregivers.”

“We were given general information on how the service can help patients get better.”

“It was vague.”

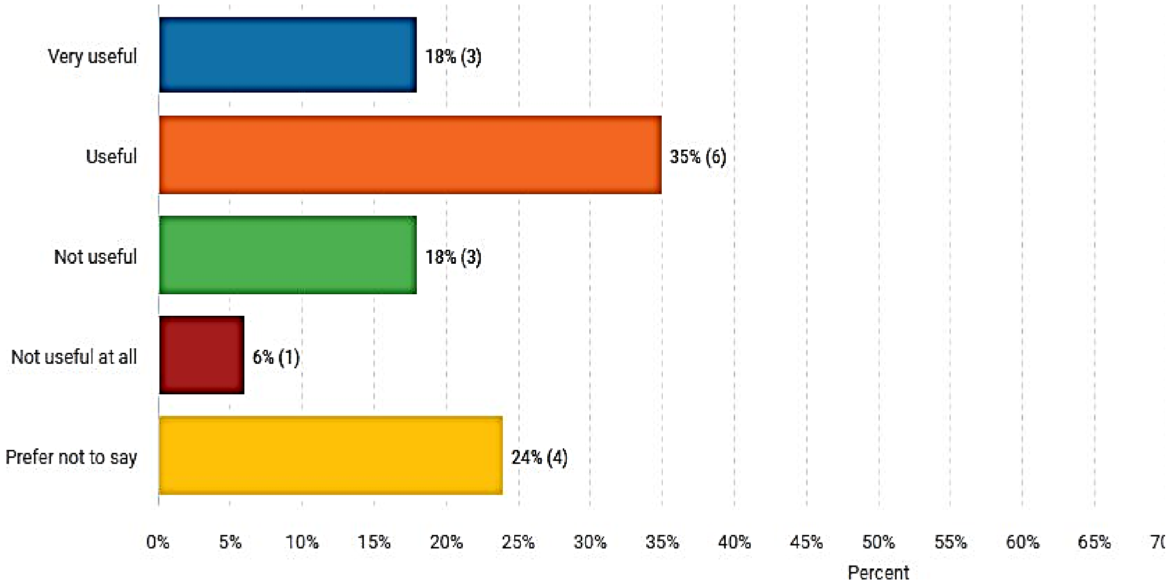
“I was told I would have some support at home, but the specifics on how it would help with my recovery or how long the support would last weren’t clearly explained.”

Discrepancy between promised and delivered support

One participant shared a detailed example where promised support was cut short, which affected their recovery experience.

“We agreed to a 6-week rehabilitation program… but just a few weeks in, we were told the support would end early, after only 3 weeks. My dad was disappointed, as he was starting to regain his confidence and mobility.”

5. Looking back, how useful was the information you were given?



The responses reflect a mixed experience. Over 35% of participants found the information useful, with an additional 18% describing it as very useful in supporting their recovery and providing reassurance. However, 18% did not find the information helpful, citing issues such as lack of clarity, insufficient detail, or poor timing in relation to their individual needs. A further 4% chose not to comment.

Positive experiences from those who found the information useful

Helpful despite challenges

"The information was useful, though I went through a difficult time. My daughter handled most things. I raised a complaint with PALs but haven't heard back."

Essential for recovery

"The information was very useful — I couldn't have done the exercises without the physiotherapists' guidance."

Encouraged questions

“We found the information useful and asked questions when things weren’t clear, like the meaning of 'life team'.”

Clear and reassuring

“The information helped me understand what to expect from recovery and physiotherapy, which made me feel more confident.”

Mixed experiences

Delayed and disjointed information

“We weren’t given information until after discharge, which felt chaotic due to poor communication between hospitals and care services in different boroughs.”

Generally useful, but some gaps

“The information gave me a good overview of services and how they’d help, though a few details could’ve been clearer.”

Participants quote from those who found the information not useful

Generic information, not patient centred

“The information provided was helpful to us but not necessarily to our mum, who had a stroke. If she was alone in the room, the information wouldn't have been useful, as it didn't address her specific situation. It seemed to follow a general framework for post-hospital discharge without considering individual barriers, making it a waste of resources.”

Lack of guidance post discharge

“Looking back, the information I was given was not very useful. I didn’t receive much detail or guidance about what to expect after discharge. There was no clear explanation of the services available to me or how to access the necessary support. As a result, I found myself struggling to navigate the process on my own, which made the recovery period more challenging. Clearer, more comprehensive information would have been incredibly helpful during that time.”

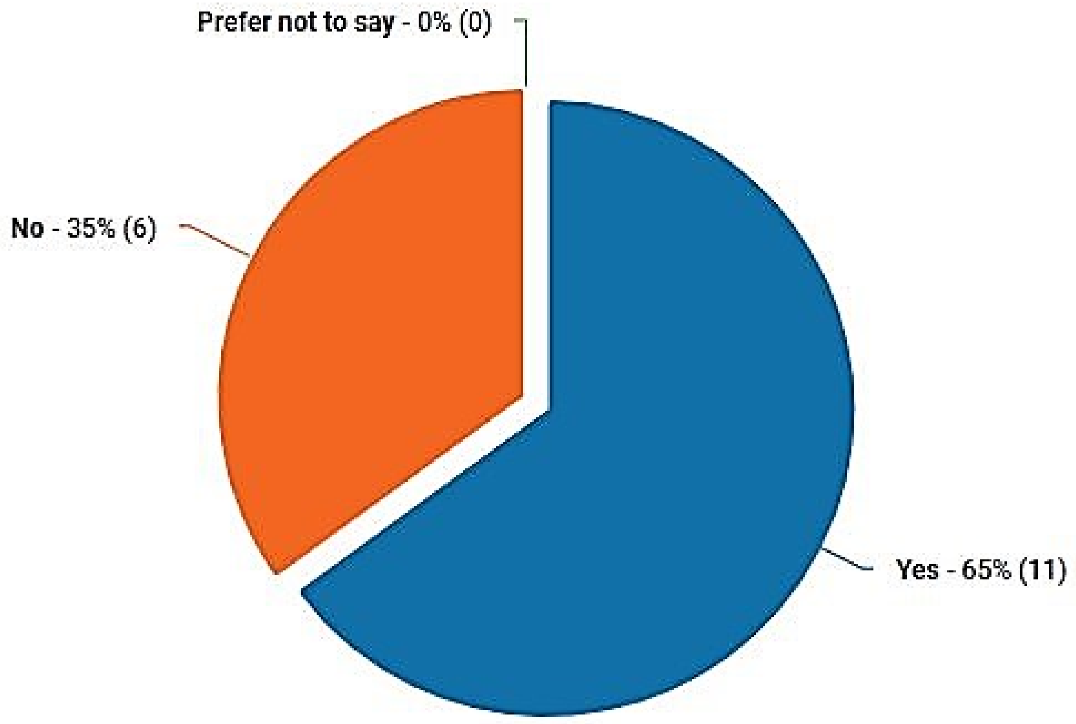
Insufficient clarity and depth

“The information I was given was not very useful. While I received some details about the support available, it lacked clarity and depth. It didn’t fully explain how the services would help with my recovery or give me a clear understanding of what to expect, which made the process a bit more difficult to navigate.”

Minimal communication at discharge

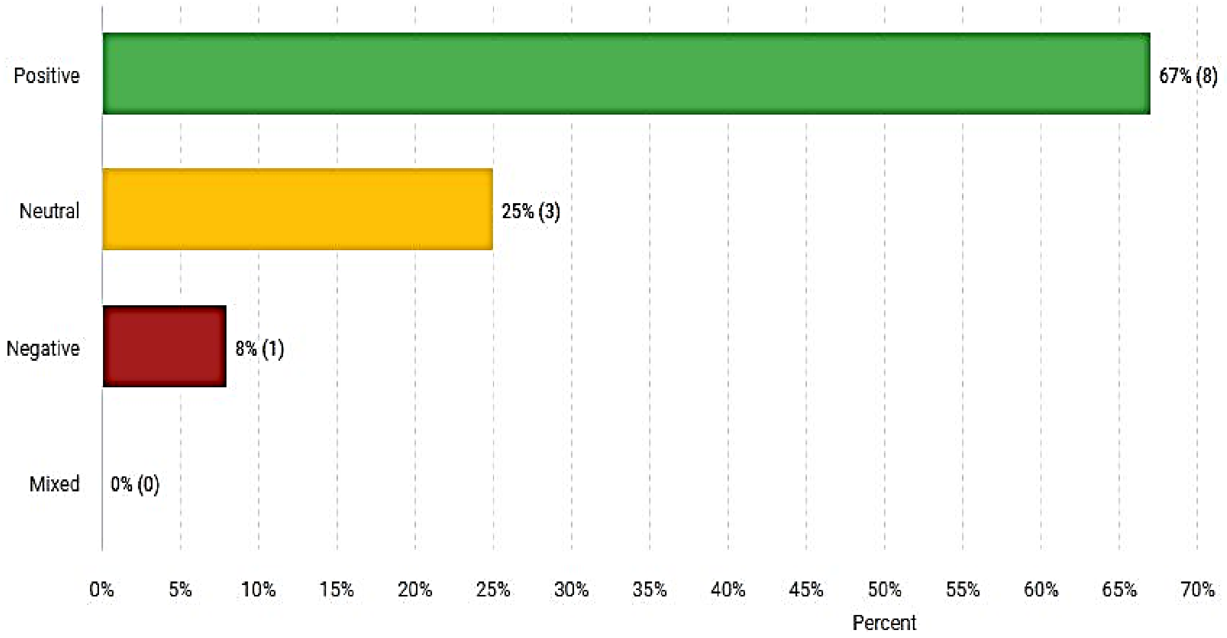
“I wasn't told much when leaving hospital”

6. Did you have clear goals for your recovery set at the beginning?



Most participants reported having clear goals set for their recovery at the outset. These goals helped provide structure, motivation, and a sense of direction during their rehabilitation. However, nearly a third indicated that they did not have clearly defined goals, which in some cases led to confusion or uncertainty about what to expect from the recovery process and what progress would look like. This highlights the importance of setting personalised, well-communicated recovery goals to support patient confidence and engagement.

7. Did you meet these goals?



Among the 12 participants who responded to this question, 67% provided positive feedback, stating they had met their recovery goals. A further 25% expressed a neutral stance, while 8% indicated they did not achieve their goals.

It is important to note that five participants chose to skip this question, which may reflect a lack of clarity around goal setting or recall of their recovery expectations. These findings suggest that, for most respondents, the recovery goals were meaningful and achievable, although there remains room to improve clarity and engagement in the goal-setting process.

Positive experiences of those who met their goals

> “Yes, I had clear recovery goals from the beginning and achieving the goals. One of my main goals was to be able to access the stairs independently so that I wouldn’t need a walking stick. When I first came home, I had a hospital bed downstairs and used a commode, but I aimed to regain enough strength to manage the stairs and sit comfortably in the passenger seat of a car when going out. Following the operation, my leg became an inch shorter than the other, which required me to use two

walking sticks around the house. I also relied on handrails to help with balance and positioning as I worked toward greater mobility."

"There were goals, but we were around her. She obviously wants to do things herself. The goals were useful as we had to put it across to her to encourage."

"Yes, he met the goals. He was to walk outside with his walker and into the garden."

"Yes, I did have clear goals for my recovery from the beginning and met them. After my stroke, one of my primary goals was to regain the ability to walk with the help of my walker. I also aimed to be able to move around the house more freely, including getting into the garden and going outside. These goals gave me something to focus on and helped guide my progress, as I was determined to regain my independence and improve my mobility."

"Yes, am still on my recovery journey and I had clear goals for my recovery from the start. My main goal was to regain my mobility as quickly as possible and to work towards becoming more independent in my daily activities."

"Not all of the goals have been met yet, as I am still on my recovery journey. While progress has been made, there's still work to do before I reach all my recovery goals."

"I am still on my journey; however, being alive gives me hope to work towards achieving my goals."

"Yes, clear goals for my recovery were set at the beginning. The healthcare team explained what I needed to work on and what to expect, which helped me stay focused and motivated during my recovery."

Neutral experiences

"Yes, he wanted to be walking independently. That was what he told the nurses at the very beginning."

"Yes, I did. My goal was to stay alive and not give up."

"Not really" She did at the beginning and was initially provided with a mobility frame upon discharge, but since then, her condition has worsened."

8. Please say what was discussed to support you.

Themes included support with daily living tasks; physiotherapy and mobility support; home care services and carers; medical monitoring and community healthcare; family Involvement and support. Some had limited or no discussion of support.

Support with daily living tasks

“We talked about the help I would get at home, like someone helping me with daily tasks and looking after me.”

“Yes, support was discussed, including arranging for assistance with daily tasks and mobility. My family and a carer helped ensure I had the necessary support at home.”

“From the Life at Home NHS perspective, it was discussed that I would receive support with daily tasks, mobility assistance, and help with any medical needs at home.”

“Before I was discharged, we discussed the type of support I would need at home, including help with daily tasks, wound care, and follow-up appointments.”

Physiotherapy and mobility support

“The support discussed was around physiotherapy.”

“What was discussed to support me was physiotherapy. They explained that the physiotherapist would work with me to help improve my movement and strength after my injury.”

"We have arranged for him to get a physio to assist him build his strength."

Home care services and carers

"We were told about having two carers coming in 4 times a day... The physio team and rapid team also check blood pressure."

"An agency arranged for a carer to support me after I came out of hospital. A lady used to take me out for walks."

"She now receives four carer visits per day, with double-handed care."

"Additionally, we arranged and paid for a carer who would come in the mornings and evenings to assist with daily tasks."

Medical monitoring and community healthcare

"The care home has provided me with everything I need... They conduct regular blood tests and check-ups to monitor my health.

" The physio team and rapid team also check blood pressure... The district nurse came to dress him."

"She currently has a sore on her back... being treated regularly by district nurses."

Family involvement and support

"My younger daughter recently took me to the supermarket for a short walk."

“My family was there to help as much as they could.”

“I help him use the walker when going upstairs and downstairs, and I always walk behind him for extra support.”

Limited or no discussion of support

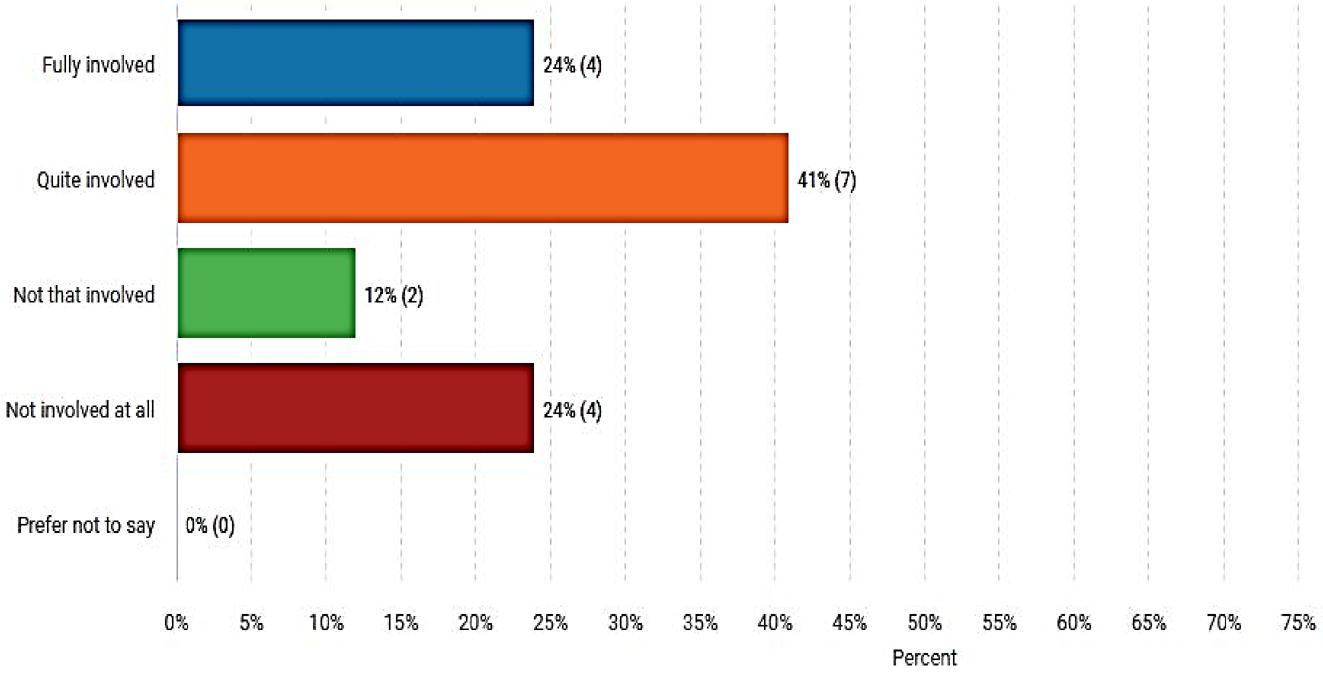
“No discussion about support.”

“There wasn’t much support discussed or offered.”

“They didn't mention it.”

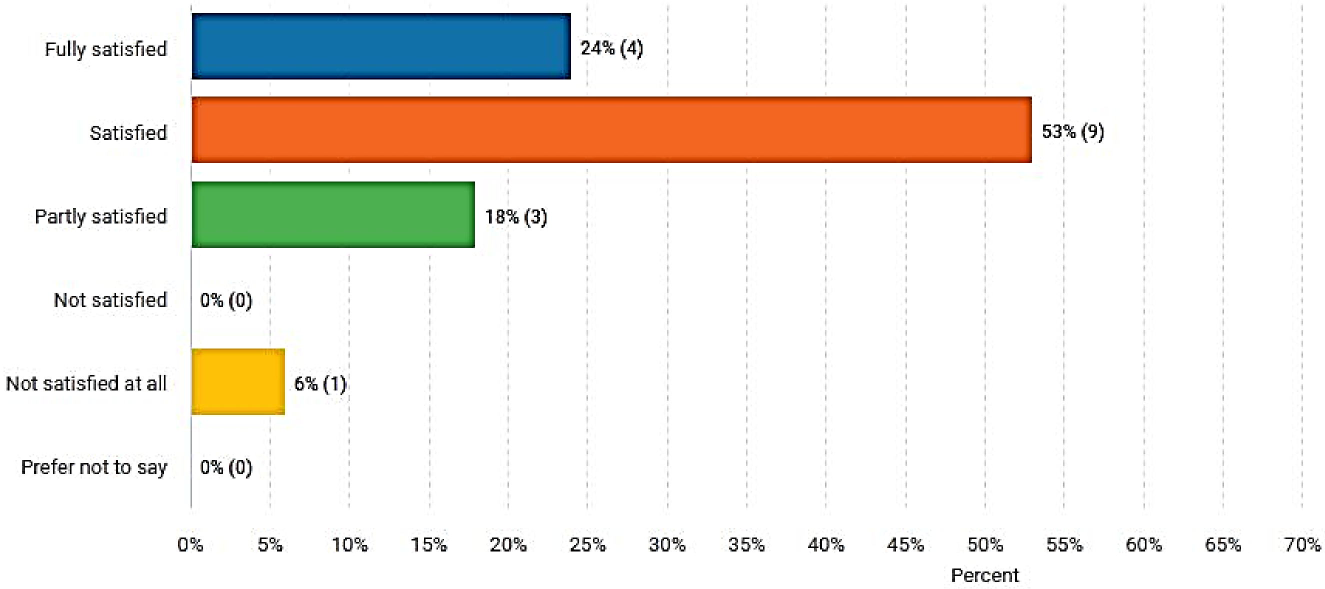
“No not very good mentally, as had a stroke. Not clear in brain.”

9. How involved were you in decisions over these goals?



Most participants (65%) reported being involved in decisions over their goals. However, a significant portion (24%) said they were not involved at all, with a small number indicating only limited involvement. This suggests variability in how well individuals are engaged in goal setting during their care.

10. Were you satisfied with the service you received?



While the majority (77%) expressed satisfaction (either fully or mostly), a notable minority (18%) had partial or negative experiences. This highlights that although the service performs well overall, there are areas that require improvement to ensure more consistently high-quality care and satisfaction.

Mostly positive satisfactory experiences

These participants expressed overall satisfaction with the care and support received, highlighting good staff attitudes, helpful services, and feeling well looked after.

"Yes, I was satisfied with the service I received. The support provided was helpful, and the care I received made a positive difference in my recovery."

"Yes, I was satisfied with the service I received through the Life at Home NHS program. The support provided helped with my daily tasks and recovery, and the carers were helpful and attentive to my needs."

"Yes, I was fully satisfied with the service I received. The staff here are really kind and caring… I feel safe and well looked after in this nursing home."

"Yes, I was satisfied with the service I received. The support was helpful, and the physiotherapy sessions would play a key role in my recovery."

"Yes, I was satisfied with the service I received. The reablement service was good, and the staff were friendly and supportive throughout. They made me feel comfortable and well cared for."

"The service and staff attitude were great. I felt supported."

"Yes, I was satisfied with the service I received. The staff were supportive, informative, and made sure I was comfortable with the care plan before leaving the hospital."

Mixed satisfaction

These participants were somewhat satisfied but raised concerns about specific aspects, such as food quality, care coordination, or needing to rely on family support.

"Yes, I was satisfied with the overall care I received… However, I was not satisfied with the food. It was consistently cold."

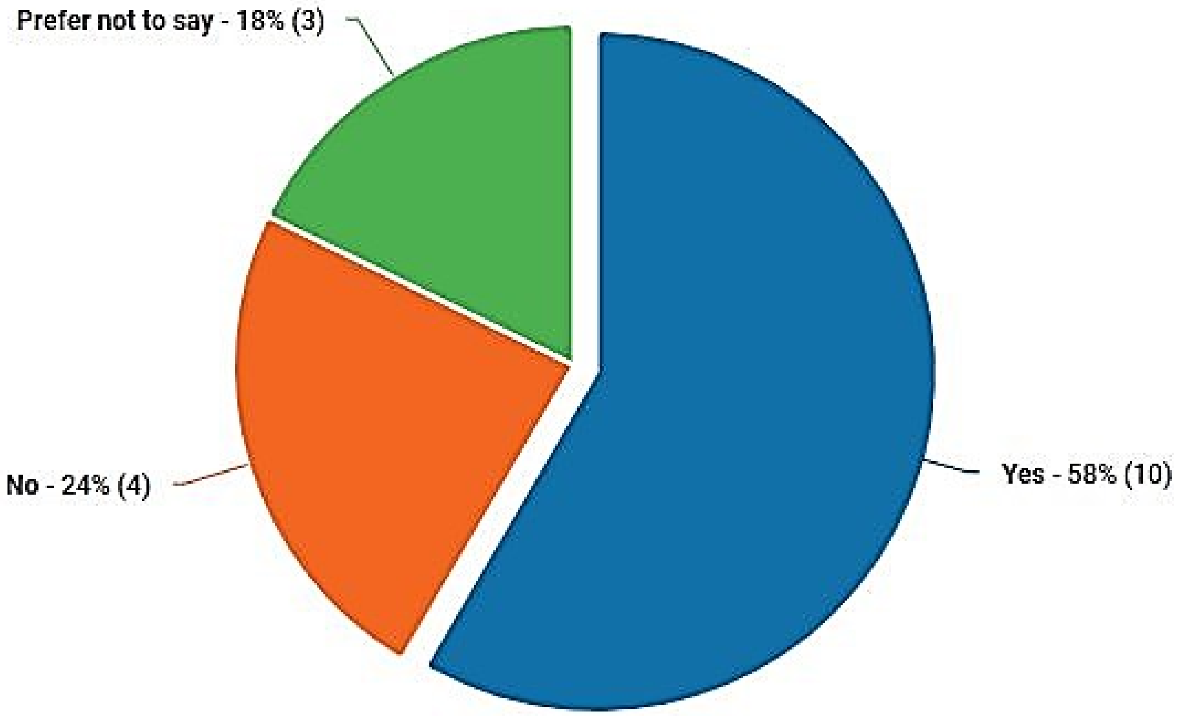
"Yes, in a way, I was satisfied with the service I received… I felt there were gaps in the communication and coordination of care… aspects that could have been improved."

"Yes, I was satisfied with the care I received at the Nursing home… However, I was very disappointed with the way I witnessed some nurses treating patients at CUH."

"He was satisfied. We had huge reservations about carers… communication… quality of care… language was an issue."

"Although the existing care package is generous… it does not appear to be structured in a way that enables any real progress."

11. Do you feel the service was responsive to your culture and background?



59% of participants felt the service was responsive to their culture and background, citing respectful and inclusive care. However, 24% said their needs were not met due to issues like language barriers, rushed care during religious periods, or food expectations. Meanwhile, 18% preferred not to comment, highlighting both positive experiences and gaps in cultural responsiveness.

Positive cultural responsiveness

- Many respondents felt respected and understood, with staff showing consideration for cultural needs and personal values.
- Respondents highlighted staff asking appropriate questions, creating a supportive and inclusive environment, and making genuine efforts to accommodate cultural preferences.

> “I felt that the service was responsive to my culture and background. The staff demonstrated a clear understanding of my needs and were respectful of my cultural preferences. They provided care in a considerate and inclusive manner, which made me feel valued and well-supported.”

"The service was responsive to my dad's culture and background. He was asked appropriate questions, and he was able to express himself clearly. We felt that he was respected and understood throughout the process."

"I feel the service was responsive to my culture and background. The staff were respectful and considerate of my needs, taking the time to understand my preferences and ensure I felt comfortable. They asked the right questions to accommodate any specific cultural aspects, and there was a genuine effort to make sure the care provided aligned with my values and expectations. Overall, I felt that my cultural background was taken into account, which made the service more personal and respectful."

"I feel the service was responsive to my culture and background. They were respectful and considerate of my needs, ensuring that my preferences were taken into account during my care."

"I feel the service was responsive to my culture and background. The staff were respectful and took the time to understand my needs, ensuring that my preferences and values were considered in the care I received. They were attentive and made an effort to create a comfortable and supportive environment that aligned with my cultural background."

"They understand and respect my culture and background. I feel comfortable and happy with the way they treat me."

"We feel the service was responsive to her cultural and background."

"I felt the service was responsive to my culture and background. Staff treated me with respect, communicated clearly, and made an effort to understand my personal preferences and values. This made the experience more comfortable and inclusive for me."

"The service respected my culture and background. The staff were understanding and patient with me."

“The service was respectful of my culture and background. I felt understood and treated with care.”

Mixed or limited cultural responsiveness

- Some participants mentioned language barriers, especially in sensitive contexts like after a stroke or during Ramadan, where rushed or ineffective communication affected care quality.
- A few respondents acknowledged that mainstream services struggle to effectively tailor support for diverse cultural needs, despite otherwise neutral or acceptable service.

Negative or absent cultural responsiveness

- At least one respondent felt clearly let down, particularly noting that expectations around hot food weren’t met, reflecting a lack of cultural understanding.
- Some provided neutral or unclear responses such as "No comment", "Not applicable", or "Not sure", suggesting uncertainty or disengagement around the question.

“No, I didn’t feel the service was responsive to my culture and background. For example, I am accustomed to meals being served piping hot, which reflects my cultural expectations around food preparation and service.”

“The language was an issue and people from classic care had to rush his care and come in and out because it was Ramadan period “

“The culture itself is fine, however assessing the service's responsiveness to our cultural background is challenging within mainstream settings.” After her stroke, my mother's speech was impaired, rendering phone interpreters ineffective. However, having an interpreter physically present might have made a difference.”

12. What improvements would you suggest?

When asked what could be improved, participant 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 met already expectations.

Communication & Coordination:

Many participants highlighted the need for better communication between families, hospitals, and care providers, especially around discharge planning and post-care arrangements.

“Improve communication between hospital, family, and care services.”

“Ensure discharge plans are clearly communicated.”

“Provide contact numbers for missed appointments.”

“Earlier and clearer discussion about care package continuation or pauses.”

“Coordination lacking between services (e.g., GP, district nurses).”

“Poor discharge planning without involving families.”

Consistency and quality of care

Participants requested more consistency in the quality of care and attitudes of staff across wards and agencies.

“Some wards had excellent care; others lacked compassion.”

“Mixed experience with carers from certain agencies.”

“Suggest training staff in communication and compassion.”

“Assign a dedicated primary nurse for continuity.”

Activities and social engagement

Several respondents expressed a desire for more structured activities to reduce isolation and improve mental well-being.

> “Better promotion of available activities like cookery classes”.
>
> “More social engagement opportunities within care facilities.”
>
> “Reduce feelings of loneliness through group and individual hobbies.”

Reablement and rehabilitation support:

Gaps were identified in access to physiotherapists and the effectiveness of reablement services.

> “Include trained physiotherapists in rehab teams.”
>
> “Increase efforts to support recovery and movement.”
>
> “Care package timings do not allow for meaningful rehabilitation”.

Facilities and environment:

Small environmental adjustments could make a significant difference in patient comfort.

> “Improve room layout and table sizes for accessibility.”
>
> “Address excessive TV noise in communal areas.”
>
> “Consider larger rooms for manoeuvrability.”

Individualised and holistic assessment:

Standardised approaches were seen as inadequate; participants wanted more person-centred care.

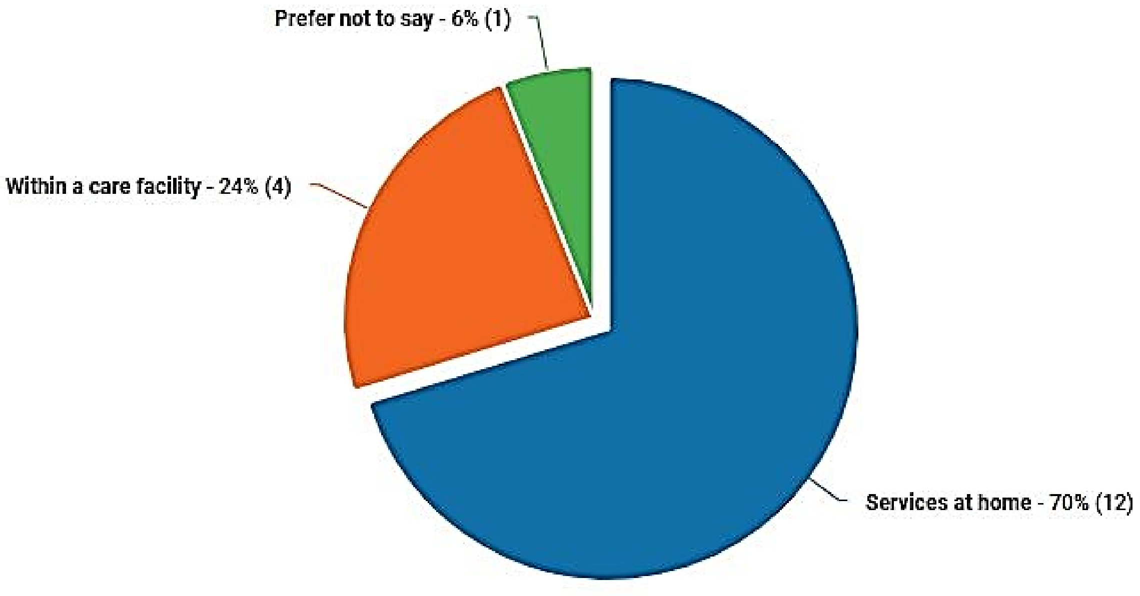
> “Avoid a one-size-fits-all model in assessments.”
>
> “Tailor care to specific patient needs and contexts.”

No suggestions / satisfied

A few respondents reported complete satisfaction and had no suggestions for improvement.

> “Felt the service met expectations.”
>
> “Did not see any area requiring improvement.”

13. Would you prefer to receive these services at home or in a care facility?



Preference at home and key reasons:

Familiar and comfortable environment

“More relaxed and supported in my recovery."

“Helps me feel comfortable and independent.”

“I love the comfort of my home and space.”

Sense of independence and autonomy

“Allows me to maintain some independence and stick to my routine.”

“He is quite intellectual and professional... has more autonomy at home.”

Emotional and family support

“Home care also allows me to be surrounded by my family.”

“Support from family around him.”

Continuity and personalisation of care

“Same carer comes in regularly.”

“Care is more personalised and better tailored to needs.”

Avoidance of unsuitable care settings

“Would have disagreed if told to go to a care home like Parkview.”

Faster and more positive recovery

“Environment feels less institutional and more personal.”

Preference In a care facility and key reasons:

Immediate and consistent access to support

“In care home, I receive consistent care and comfort.”

“Always someone available to help – feel safer.”

Past negative experience at home

"Fell and remained on floor for three days before discovery."

"Carer only there for 30 minutes—left alone afterwards."

Social interaction

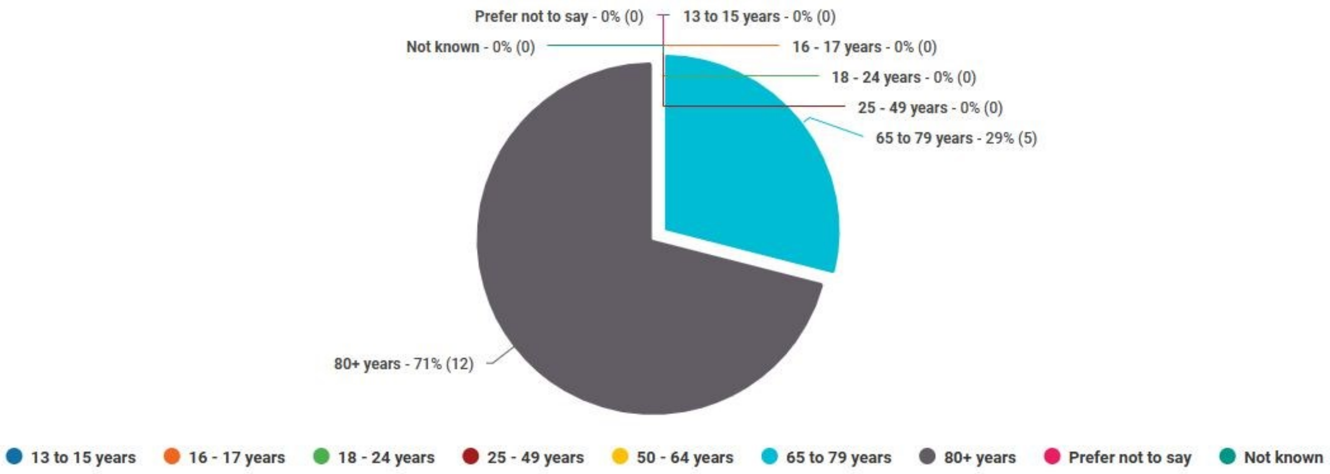
"Chance to be around other people helps reduce loneliness."

Confidence in facility services

"Support for things like showering daily that I can't manage alone."

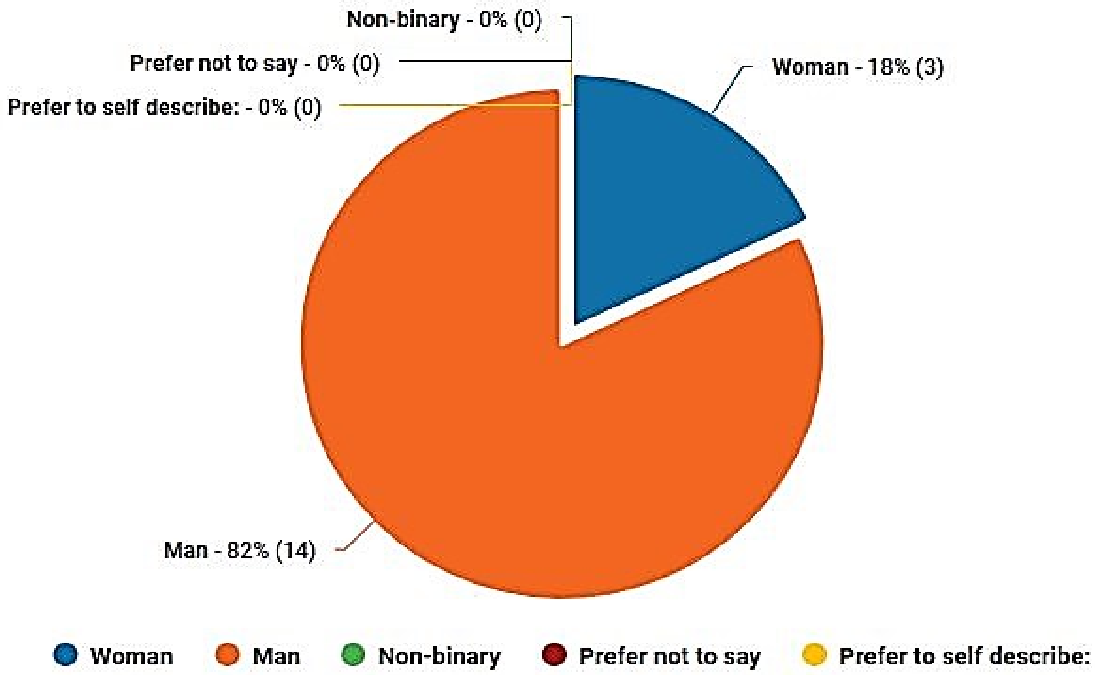
Demographics

14. Please tell us your age



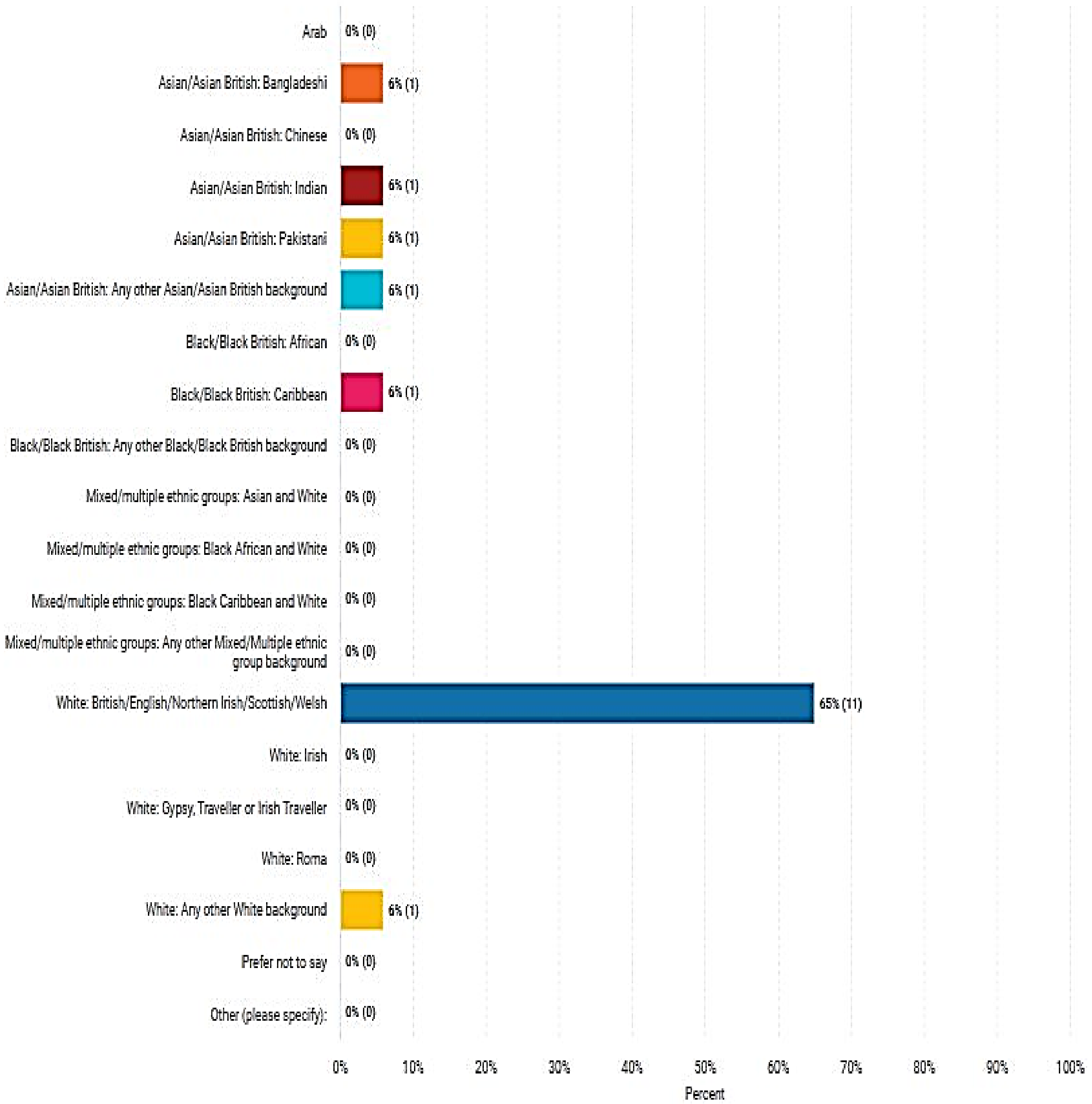
A substantial 71% of participants were aged 80 and above, indicating that the feedback largely reflects the experiences and needs of the very elderly population. The remaining 29% were aged between 65–79.

15. Please tell us your gender



A significant 82% of interview participants were men, indicating a strong male majority in the respondent group. Only 18% were women, highlighting a gender imbalance in participation.

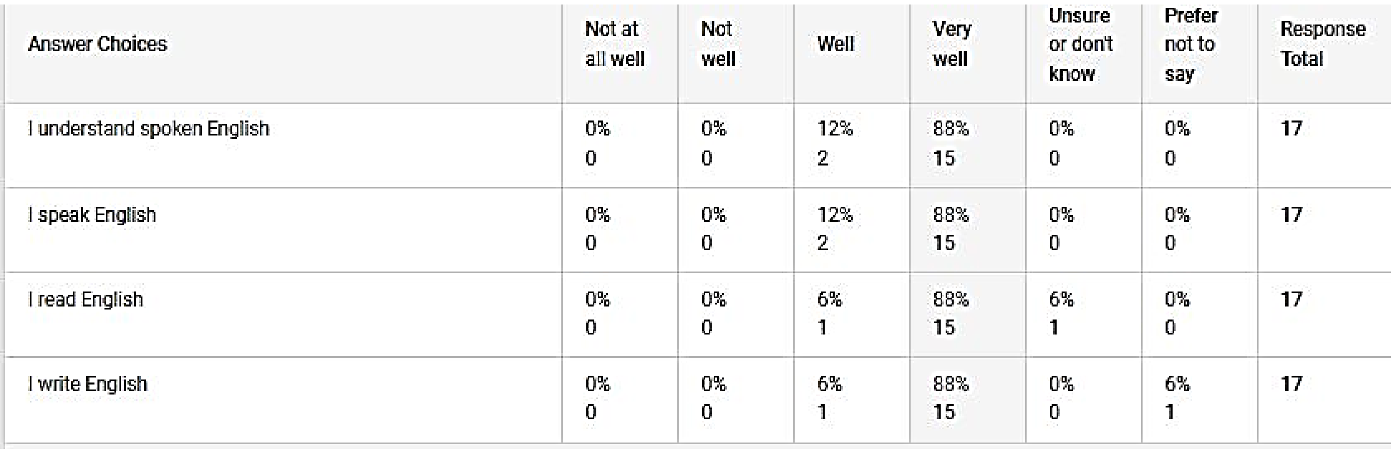
16. Please select your ethnicity



Most participants were 65% White British, meaning the findings are largely shaped by the experiences and cultural expectations of this ethnic group.

There is a significantly low representation of minoritised ethnic groups i.e. participants from Asian Indian, Pakistani, and Caribbean backgrounds each made up only 6% of the total, indicating limited insight into the experiences of diverse communities.

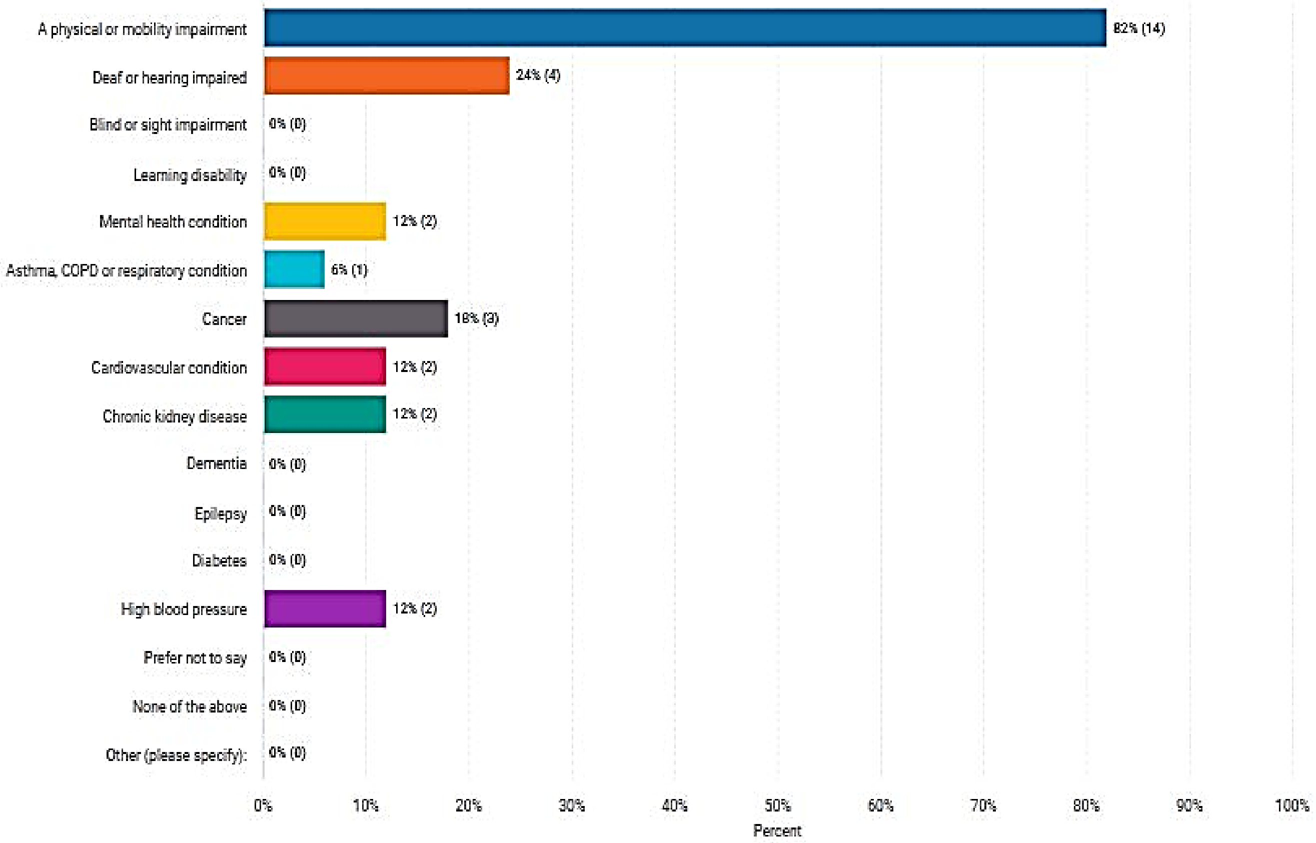
17.How well can you understand, speak, read and write English?



Answer Choices	Not at all well	Not well	Well	Very well	Unsure or don't know	Prefer not to say	Response Total
I understand spoken English	0% 0	0% 0	12% 2	88% 15	0% 0	0% 0	17
I speak English	0% 0	0% 0	12% 2	88% 15	0% 0	0% 0	17
I read English	0% 0	0% 0	6% 1	88% 15	6% 1	0% 0	17
I write English	0% 0	0% 0	6% 1	88% 15	0% 0	6% 1	17

A significant 88% of participants reported strong proficiency in English, stating they could speak, understand, read, and write it very well. An additional 12% indicated they could speak English well, the high level of English proficiency among participants suggests that language was likely not a major barrier for most in understanding or accessing services.

18. Which of the following disabilities or long-term diseases do you have?



Most participants (82%) had a mobility or physical impairment, highlighting a significant need for accessible environments and tailored support for individuals with reduced mobility. Additionally, 24% were deaf or had hearing impairments, emphasizing the importance of effective communication methods, such as hearing support services or visual aids.

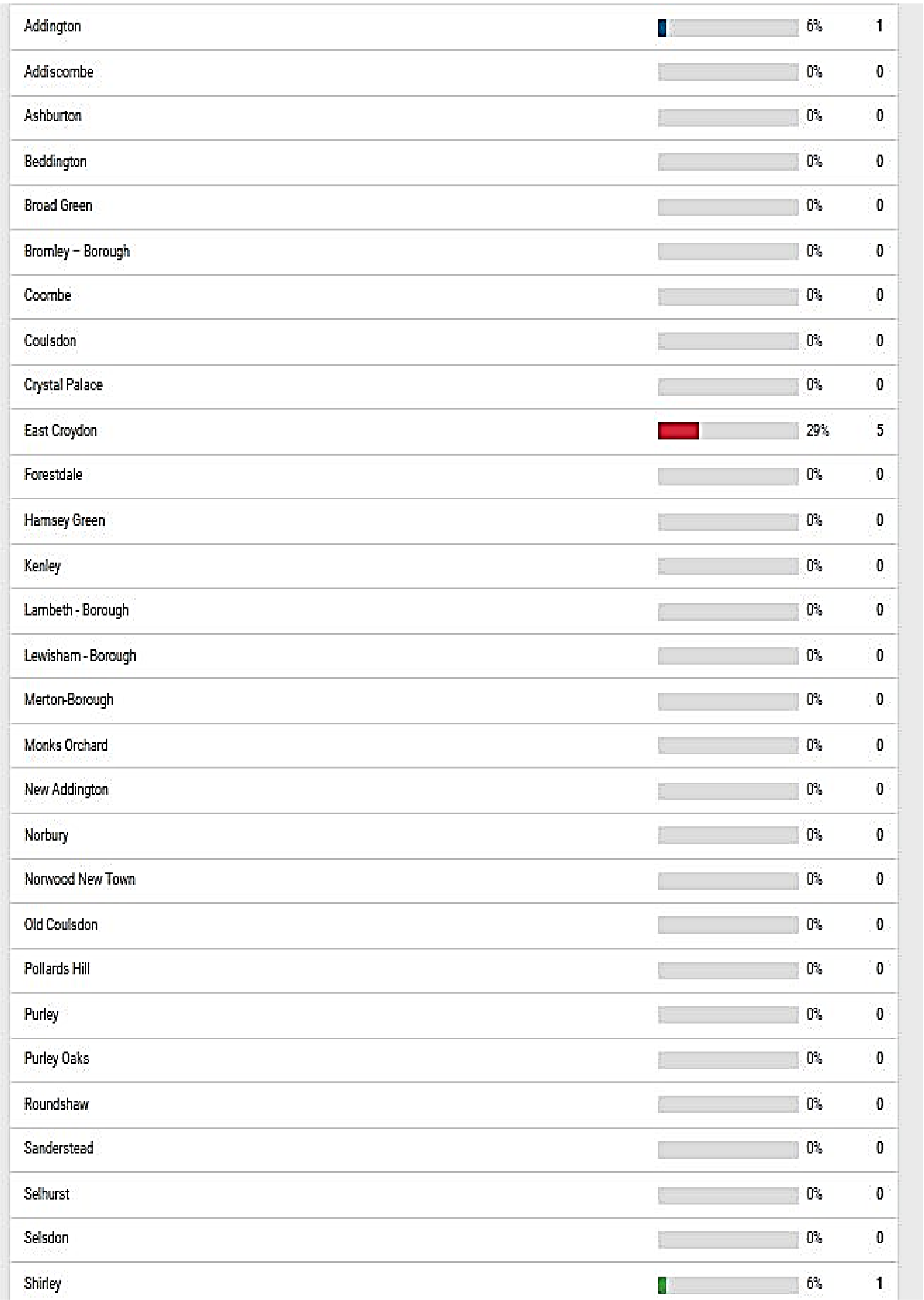
While only 12% reported other health conditions like mental health issues, cardiovascular disease, high blood pressure, or chronic kidney disease, these still represent important aspects of holistic care needs. Notably, 18% had cancer and 6% had respiratory conditions such as COPD or asthma.

19. Have you been diagnosed with any of the following?

Autism or ASD		0%	0
Dyspraxia		0%	0
Dyscalculia		0%	0
Dyslexia		0%	0
ADHD/ADD (attention deficit hyperactivity disorder, attention deficit disorder)		0%	0
Tourette's		0%	0
Prefer not to say		0%	0
None		94%	15
Other (please specify): Hide		6%	1

A significant majority (94%) of participants reported not having been diagnosed with any neurodevelopmental conditions such as autism, ADHD, dyslexia, dyspraxia, or dyscalculia. One individual identified having a hernia, which was recorded under the “other specific conditions” category.

20. What area do you live in?

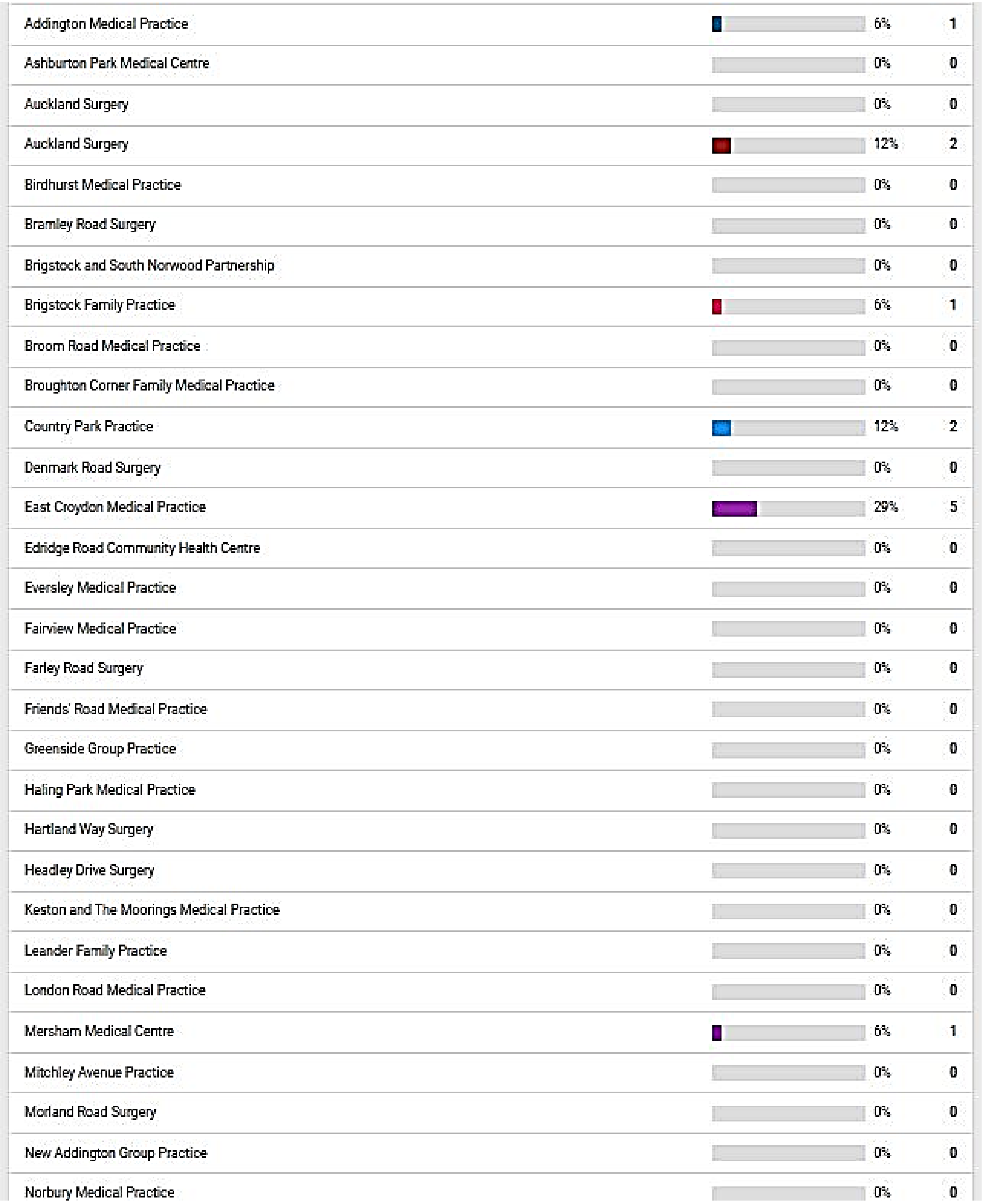


Addington	6%	1
Addiscombe	0%	0
Ashburton	0%	0
Beddington	0%	0
Broad Green	0%	0
Bromley – Borough	0%	0
Coombe	0%	0
Coulsdon	0%	0
Crystal Palace	0%	0
East Croydon	29%	5
Forestdale	0%	0
Hamsey Green	0%	0
Kenley	0%	0
Lambeth - Borough	0%	0
Lewisham - Borough	0%	0
Merton-Borough	0%	0
Monks Orchard	0%	0
New Addington	0%	0
Norbury	0%	0
Norwood New Town	0%	0
Old Coulsdon	0%	0
Pollards Hill	0%	0
Purley	0%	0
Purley Oaks	0%	0
Roundshaw	0%	0
Sanderstead	0%	0
Selhurst	0%	0
Selsdon	0%	0
Shirley	6%	1

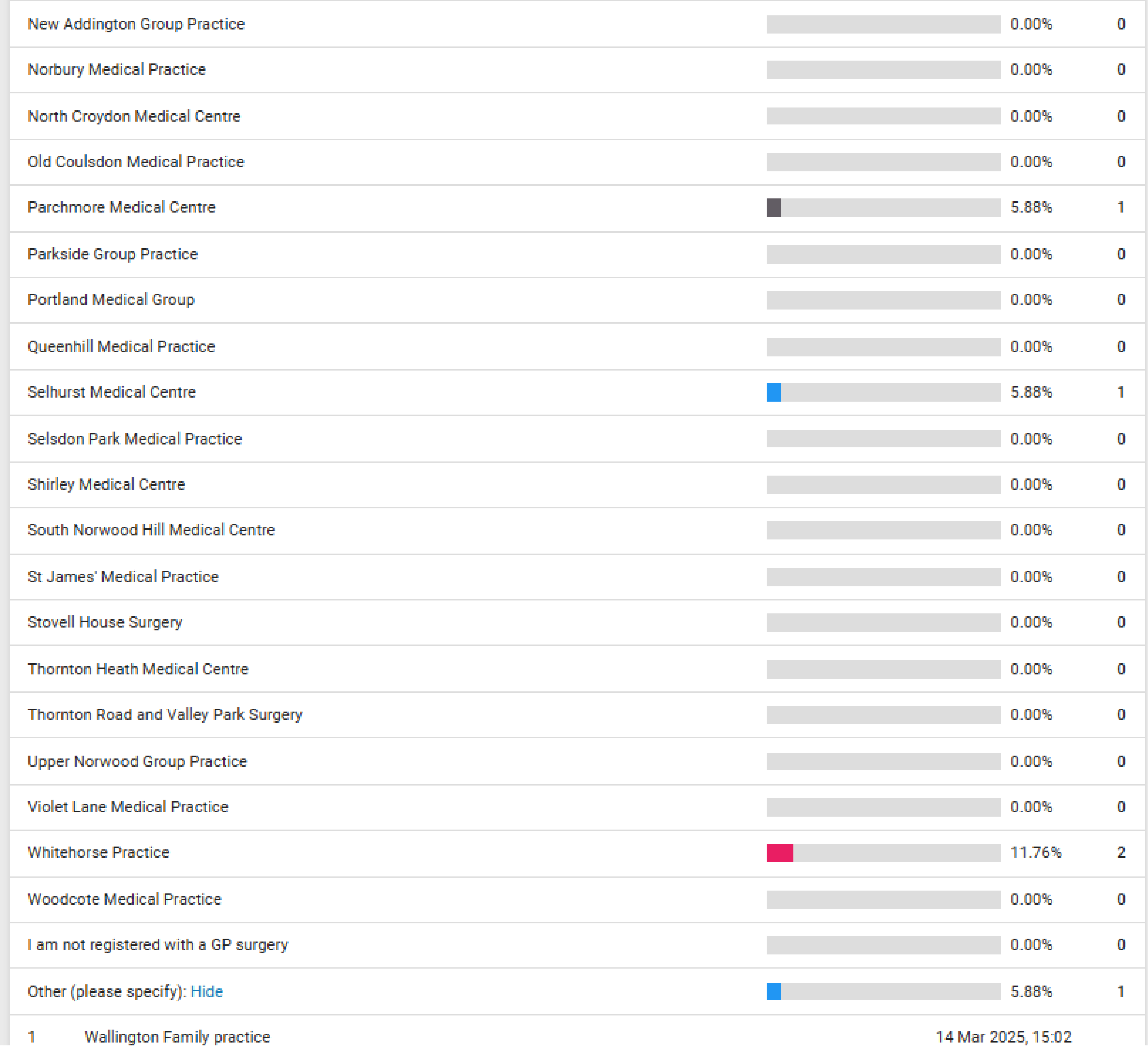
South Croydon	0%	0
South Norwood	12%	2
Southwark – Borough	0%	0
Surrey – County	0%	0
Sutton-Borough	6%	1
Thornton Heath	6%	1
Upper Norwood	12%	2
Upper Shirley	0%	0
Waddon	6%	1
Wandsworth – Borough	0%	0
West Croydon	18%	3
Whyteleafe	0%	0
Woodcote	0%	0
Woodside	0%	0

Many of the respondents lived centrally in East Croydon and West Croydon, with some in South Norwood, Upper Norwood. One respondent came from Thornton Heath, Addington and Shirley. The south of the borough was not represented in the sample

21. Which of the following GP practices are you currently registered with?



Addington Medical Practice	6%	1
Ashburton Park Medical Centre	0%	0
Auckland Surgery	0%	0
Auckland Surgery	12%	2
Birdhurst Medical Practice	0%	0
Bramley Road Surgery	0%	0
Brigstock and South Norwood Partnership	0%	0
Brigstock Family Practice	6%	1
Broom Road Medical Practice	0%	0
Broughton Corner Family Medical Practice	0%	0
Country Park Practice	12%	2
Denmark Road Surgery	0%	0
East Croydon Medical Practice	29%	5
Edridge Road Community Health Centre	0%	0
Eversley Medical Practice	0%	0
Fairview Medical Practice	0%	0
Farley Road Surgery	0%	0
Friends' Road Medical Practice	0%	0
Greenside Group Practice	0%	0
Haling Park Medical Practice	0%	0
Hartland Way Surgery	0%	0
Headley Drive Surgery	0%	0
Keston and The Moorings Medical Practice	0%	0
Leander Family Practice	0%	0
London Road Medical Practice	0%	0
Mersham Medical Centre	6%	1
Mitchley Avenue Practice	0%	0
Morland Road Surgery	0%	0
New Addington Group Practice	0%	0
Norbury Medical Practice	0%	0



New Addington Group Practice	0.00%	0
Norbury Medical Practice	0.00%	0
North Croydon Medical Centre	0.00%	0
Old Coulsdon Medical Practice	0.00%	0
Parchmore Medical Centre	5.88%	1
Parkside Group Practice	0.00%	0
Portland Medical Group	0.00%	0
Queenhill Medical Practice	0.00%	0
Selhurst Medical Centre	5.88%	1
Selsdon Park Medical Practice	0.00%	0
Shirley Medical Centre	0.00%	0
South Norwood Hill Medical Centre	0.00%	0
St James' Medical Practice	0.00%	0
Stovell House Surgery	0.00%	0
Thornton Heath Medical Centre	0.00%	0
Thornton Road and Valley Park Surgery	0.00%	0
Upper Norwood Group Practice	0.00%	0
Violet Lane Medical Practice	0.00%	0
Whitehorse Practice	11.76%	2
Woodcote Medical Practice	0.00%	0
I am not registered with a GP surgery	0.00%	0
Other (please specify): Hide	5.88%	1

1 Wallington Family practice 14 Mar 2025, 15:02

Loca GP surgeries were used by patients and carers.

Appendix

You can view a preview version of the survey at: -

https://www.smartsurvey.co.uk/s/preview/JAWXLN/A593BB861C7D71A6185536E133B515

Committed to quality

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