

Healthwatch Discharge Report: July and August 2014

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Introduction

The Healthwatch Special Inquiry into hospital discharge took place during July and August 2014. The theme of this work was identified nationally by Healthwatch England, and implemented locally by Healthwatch in Bristol, BANES, South Glos and Somerset.

This document will refer to the four local Healthwatch contracts above as Healthwatchq and to the national organisation as Healthwatch Englandq

This work will be conducted in four phases:

- Phase 1 . evidence gathering and focus groups



- Phase 2 . surveying and analysing themes
- Phase 3 . reporting to local Trusts and making recommendations
- Phase 4 . ongoing monitoring of whether, and if so how effectively, recommendations are implemented at a local level

Engagement

In keeping with our local and equitable approach, Healthwatch provided patient and public groups and individuals with many and varied ways to share their feedback about discharge experiences:

We utilized our *Network of Networks* to appeal for feedback via our volunteer Champions and Representatives.

We contacted partner organisations within the Voluntary and Community Sector (VCS), e.g. Deaf Health Promotion, who referred members to us.

Hospital Trusts and other providers, for example Bristol Community Health, worked with us to signpost patients to have their say.

We continued to ensure that patients were given the opportunity to make confidential freepost submissions to us . for example, via a stand in the Urgent Care Centre at South Bristol Community Hospital. We also reviewed any recent feedback we had already heard, and included this in the report.

We provided an online questionnaire, as well as printed hard-copies of for those who do not or cannot use the internet.

Healthwatch also organised a series of in-depth focus groups with the following groups and communities:

- People who are carers
- People who have had a brain injury
- The Chinese and Vietnamese community
- People who have had a stroke, and/or who are living with the long-term effects of stroke, and their families and carers
- People who have a history of mental ill-health or who are currently living with mental ill-health
- People who have Multiple Sclerosis
- People who are hearing impaired or deaf

A wide range of groups were approached and invited to take part in this work. Groups were approached according to whether they aligned with the Healthwatch priorities as outlined in the workplans. The above groups took the decision to engage with this particular investigation.

Finally, Healthwatch examined existing feedback which discussed discharge, and incorporated this into the report.

Consultation Approach

Healthwatch employed a range of qualitative methodologies using a variety of questioning techniques in order to optimise the accessibility and reach of this enquiry.

Questionnaires

The questionnaires contained a number of structured questions which were used to identify details of the respondents' experience and which allowed us to structure our analysis according to location of discharge and several other factors as dictated by Healthwatch England.

In addition, respondents were given an opportunity to complete an unstructured and free-text section. These statements were analysed qualitatively and informed the findings within this report. Using questionnaires enabled the Special Inquiry to reach a larger cohort than would have been reached using only face to face methods, as a questionnaire approach is less limited by time and resource limitations.

Two hundred and sixty seven people completed a questionnaire.

Focus Group Approach

Focus groups were conducted with a semi-structured approach. Participants were encouraged to lead discussion, and Healthwatch facilitators only prompted when discussions began to lose focus.

Prompts from facilitators involved questions about discharge as recommended by Healthwatch England, including questions about safety of discharge; provision of medication; involvement of carers and family members; and links with primary care and the voluntary and community sector.

This face to face approach enabled the Special Inquiry to explore subjects related to discharge in more detail. This mixed-methods design facilitated the collection of good quality, complementary data from which recommendations have been made. Approximately eighty-eight people took part in a focus group.

Summary of Findings

Although specific groups of patients have differences in their discharge experiences, there are common themes that affect everyone who spoke to us.

The majority of those surveyed (approximately 90%) received little or no Voluntary and Community Sector (VCS) support post-discharge. Many felt that their discharge would have been improved with effective referral into the VCS following treatment within a secondary care setting. This was especially true of those living with long-term conditions, and those discharged following mental health treatment or support.

Many of those surveyed felt that the discharge process should be quicker, and that more effective planning of the various elements involved in their discharge would streamline the process. We spoke to patients who had experienced excellent discharge; however, a more significant proportion shared experiences which included delays of many hours . in some cases an entire day - waiting for medicines to be dispensed or for transport to be arranged.

The majority of those who spoke to us praised the quality of care they received and the attitude of staff. However, this feedback was often qualified with unhappiness over rushed conversations with medical staff and a general perception of a lack of patient and family involvement in decision-making. This trend was especially true among patients for whom English is a second language and was a concern that was often shared by carers and those for whom they are caring.

Less-common but more serious concerns were raised regarding potential gaps in discharge and medication provision in some instances. This was true in cases involving a patient moving into a care home or being discharged back to an area in which they did not previously live, for example. Healthwatch will work with local Trusts and stakeholders to identify whether any such gaps exist and if so how to close them.

1. Survey Feedback

The findings of the questionnaire into discharge have been listed below.

The findings below were prompted by the following question:

What do you think could be improved for people when being discharged from a hospital, health unit or care home?

Efficiency of Discharge and Planning for Post-Discharge Care (110 Comments)

The procedural element of discharge needs to improve and discharge needs to happen faster.

Discharge should be planned more carefully, and earlier in the care pathway, to ensure that when necessary the patient can be discharged with relatively little delay.

Procedural accuracy for complex discharge (weekend or holiday discharge, discharge into a care home, discharge to another part of the country or discharge for those with continuing complex needs) should improve, including a proper and robust system to ensure the safe provision of notes to the patient and to their GP.

The following elements of discharge need to be planned out and organized ahead of time to expedite the process:

1. Transport, where needed should be booked in advance and ready at the point of discharge
2. Medication should be ready upon discharge. No patient should be waiting several hours for pharmacy services in order to be discharged
3. Staff should provide a thorough and honest assessment of the ongoing needs of the patient post-discharge, which should include input from carers and family members where appropriate
4. Discharge must include provision of information on how to access support post-discharge, including charitable or voluntary sector support
5. The links between secondary care, and primary and social care need to be examined to ensure smooth transition post-discharge.

Communication and Discussion (45 Comments)

A significant proportion of patients feel that clinical staff do not listen meaningfully to their views, and that decisions are sometimes rushed in order to move them out of hospital and back into the community.

Patients want to feel that families and carers are being consulted and kept informed.

Where a patient does not fully understand something, they want to be given time, space and support to understand it better.

Patients who have specific requirements or needs want compassionate and sensible recognition of their needs (this includes people with sensory impairments, older people, people with learning difficulties and others). If a translator is required, then the Trust should identify this quickly and act to provide translation services, with the consent of the patient.

Some patients would like to be helped to understand what happens next after they are discharged, via verbal discussion rather than written materials.

Recommendations

1. Hospital Trusts to examine how the speed of discharge can be improved. This should take the form of a survey or questionnaire provided to patients so that discharge can be planned in advance, preferably as early as practically possible. Transport, destination of discharge and post-discharge support should all be included in this planning.

Many respondents to the Healthwatch Special Inquiry felt that timely planning in advance of discharge would have helped to improve their experience of the process:

“Involve me and my Carer from the beginning. If discharged after procedures done by a consultant who is not in the hospital then for there to be a forward plan discussed with me and my carer so that the junior doctor who discharges me knows what the consultant wanted to happen next”.

2. Hospital Trusts to outline how they ensure safe discharge when discharge is complex. Several reports were heard by Healthwatch about patients being discharged and discharge notes not getting to their GP. This is often the case in instances where patients are discharged into care homes in other local authority

areas or in instances in which staff do not appear to have followed the correct procedure for processing and forwarding discharge notes.

“Discharge into a care home means that sometimes notes about medicines cannot go to a local GP or pharmacist as patient has moved to another location... on each hospital discharge, (carer) has had to chase round the pharmacist to ensure each new medication package is... delivered”.

3. Patients and carers should be helped to be aware of what constitutes good quality and safe discharge to encourage them to feel more in control of the process:

“Give patients a written tick list of all the processes/gateways that have to be completed to reach discharge. Make sure that all staff needed to carry out the processes are available at the right time...”

4. Patients have reported that they want to be provided with options for post-discharge support. Healthwatch can provide a free and comprehensive support service via the WellAware database. WellAware leaflets can and should be provided to patients upon discharge. Hospital staff should be trained in what the database does and how to proactively refer into it:

“It would have been nice to be offered support or charities I could contact. But I'm young and savvy so I suppose it wouldn't occur to them...”

5. Where possible and applicable, more time should be taken to make patients and carers feel involved in the discharge process. A discharge liaison employee or similar, or even a trained volunteer in some circumstances, could provide this kind of communication and support.

“I was under the impression I would be in for the weekend from the nurses, but consultant was very keen to discharge me and made me feel pressured and difficult when I was anxious about it...”

Positive Statements / Complements

Positive statements received from the public about their discharge generally corroborate the recommendations taken from the negative or mixed feedback, as above.

For example, we received some feedback about how pleased patients were with family and carer involvement in their discharge, and about how valuable it was to be given some information on post-discharge support. Many people fed back to us about the good quality of care they received from hard-working nurses, doctors and other staff.

Respondents valued being treated compassionately and being made to feel cared-for.

- %Staff explored my social and family set-up before discharge+
- %was given excellent information on how to get post-discharge clinical support+
- %was ordered a taxi to get home+
- %received compassionate and effective care+
- %was generally happy with the service+
- %The care on the ward was excellent+
- %The (hospital) staff were excellent+
- %The care agency and nurses made my experience a good one+

2. Complaints Advocacy Feedback

Part of the Healthwatch contract involves supporting patients to make an NHS complaint.

We have not deliberately sought to include information from ongoing complaints in this report, but have provided a summary of the themes taken from ongoing complaints below:

There is a common theme of premature/inappropriate discharge from all acute services, often with very serious outcomes including emergency readmission and in some cases the death of the patient. This theme is particularly prevalent in the elderly population.

Advocacy services are supporting cases in relation to premature discharge of Mental Health service users to primary care. The Independent Mental Health Advocates (IMHA) service has observed that patients under section of the Mental Health Act can sometimes be discharged too early for appropriate arrangements to have been made, such as accommodation or a comprehensive support package.

3. Focus Group Feedback

Carers Support Centre

Summary

Commentators felt that more care should be taken to involve carers and patients during the discharge process and that discharge should be planned more effectively.

Pre-discharge Communication

More or improved communication between hospital staff/community services staff and patients, carers, neighbours of the patients who can support them.

“Ask the patient/carer, ‘is there someone we can notify that you’re coming home?’”

Carers would like to be better served by a dedicated staff member in the hospital who can liaise between staff and the patient/ their carers.

Post-discharge Support

Participants would like post-discharge support to be well-connected and more thorough. There were concerns raised about arrangements around medication post-discharge, as well as a sense that once someone has been discharged, support tails off too quickly.

“Hospital to provide appropriate amounts of equipment and medication for the patient on discharge”.

“Hospital should telephone the patient at a pre-determined time one week after their discharge and check that the support in the community that was arranged in the discharge plan is actually being provided. They should ask: How are you? Is the support we included in your discharge plan working? Do you need any signposting to support services..?”

In addition, what could be termed ‘customer service’ could be better thought-through across sectors.

“Send the prescriptions straight from hospital to GP so patient doesn’t have to book an appointment with their GP after discharge”.

And;

“Give the patient a number for the ward that they can use if there are any issues after they’re discharged”.

Finally, participants wanted a single point of access into the Voluntary and Community Sector (VCS), which fitted with an overall desire for services to treat the whole person rather than the specific condition that led to hospitalisation.

“Have one contact number the patient/ carer can contact to find out up to date support available from community and voluntary based services”.

And;

“Look at the whole person, not just the specific illness/ injury they’ve been admitted to hospital for or are receiving treatment in the community for”.

Recommendations

Better and timelier planning for what happens when a patient is discharged.

This should include provision of a single point of entry into the VCS for support, better arrangements around medication and the provision of a friendly check-up for patients who hospital staff decide would most benefit from this service. This phone call check-up could potentially be provided by a trained volunteer.

Headway (Somerset)

Participants had been discharged from a variety of sites, as follows:
Musgrove Park Hospital, Yeovil District Hospital, Bristol Heart Institute, Frenchay, Yeatman Hospital Sherborne, Williton.

Summary

Participants felt that the overall quality of care that they received in hospital was good. However, serious concerns were raised about post-discharge support and planning, and about the sometimes chaotic nature of the discharge process.

“None of the respondents felt well enough and ready to leave hospital when they were discharged. Most individuals... felt disorientated, especially those with brain injuries”.

Post-discharge Planning

Perhaps of greatest concern were reports of a lack of clear instructions around medication.

‘...gave me a bag with tablet in but no instructions’.

All participants stated that they had not received a treatment or care plan upon discharge, and that no ongoing rehabilitation or therapy services were arranged for them. Those questioned felt that they had no input into the discharge process, and that it was something done to them, rather than with them.

“A score of 1/10 was given when asked if they felt involved in the decision-making process to leave the hospital”.

Some participants felt that their discharges had been delayed as they expressed that the nurses were overworked and did not have time. There was no memory of any offer to arrange transport.

When asked if family or community support were asked about on discharge, the universal response was an emphatic **no**.

Voluntary and Community Sector Support

When the respondents were asked if they had been told about WellAware, or any charities or community groups that could support them after discharge, the collective response was **no** with the exception of some who had family members who had been put in contact with Headway by the Neurology team at Yeovil District Hospital.

Recommendations

Hospital Trusts to examine whether they are offering appropriate discharge support to patients with a brain injury and their families or carers. This should include referring into the VCS in all instances.

Chinese and Vietnamese Community

Summary

The majority of feedback at this focus group was regarding Bristol hospital services. Many themes that came out of this focus group fit with the general themes that

arose from the questionnaire results - for example, a lack of referral to the VCS after discharge and concerns about a lack of involvement in the discharge process.

However, some culturally-specific findings were also uncovered which underpin much of what was discussed, and which are detailed below.

Language Barriers

People from the Chinese and Vietnamese community are not sufficiently supported to understand what is happening during care, discharge from care and post-discharge. Translation services need to be more widely available, including for those who are conversant in basic English, but who struggle with medicalised English. Services should not assume that a person who can hold a basic conversation will understand pharmaceutical or medical terminology.

“When she asked for interpretation the respondent was told that her English ‘is fine’”.

And;

“At first she asked for an interpreter but was told that this service was not provided, there was no budget and she would have to pay. They did eventually get an interpreter but they spoke Mandarin not Cantonese. They had to communicate by writing things down...”

Patient Involvement and Staff Attitude

Feedback regarding the attitude of staff was very mixed. Many participants went to great lengths to praise the quality of some of the staff that had helped them. However, many participants felt that language barriers resulted in more cursory consultation and less involvement in decision-making. Some also felt that they were discharged earlier than was appropriate, without really understanding the process.

Post-discharge Support

Participants felt that it would be good to have a source of culturally-appropriate support after being discharged, that they could access themselves.

“There is only one Chinese link worker for the whole of Bristol and she only works 2 days per week. This makes it difficult for Chinese speaking people to access support after discharge”.

Recommendations

Interpretation services should be planned before discharge, and then made available during the process. Staff should take the time to decide with a patient whether they are able to understand more complex English, including medical and pharmaceutical terminology.

A method of providing culturally-appropriate support following discharge should be made available to Chinese and Vietnamese patients. The WellAware database includes a translation feature which would fulfill this need.

MS Therapy Centre

Summary

Generally, feedback about staff attitudes towards participants was positive, and standards of care were felt to be good. However, participants did feel that consultants were often brusque and did not give them enough time to discuss their health during consultations.

Post-discharge Support

All participants were grateful for continuing support received following discharge, but the provision of and quality of support varied hugely from person to person.

All participants felt that more VCS referral information should have been provided upon discharge to empower them to find out about things like home adaptation services, the MS therapy centre and other services.

Feedback about physiotherapy services was generally poor. Access to the service was said to be difficult, and the waiting list was observed as being too long.

“Another member said they had to break a bone before they could access physio”.

Communication

The group discussed specialists and consultants and agreed that these professionals only gave each person 10 minutes of their time. Participants were concerned that a lack of support was contributing to readmission in some instances.

“One person felt ‘fobbed off’ and was told to direct any questions to the MS Nurse”.

One participant thought it was bad that his specialists had not informed him of the diet people with MS should follow. The participant had to research this on their own. He was worried that the time spent not following dietary advice had resulted in poorer health and potential readmission into hospital for MS-related problems.

The Discharge Process / Dignity

One participant had an experience of discharge being delayed for eight hours because of the wait to see the pharmacist. They had been moved out of the hospital bed, and so had to wait in the family room instead.

Another participant said they were discharged only one day after their stoma operation. They said that they were not ok to leave to the Stoma Care Nurses at the BRI and had to learn how to change their stoma on their own.

Recommendations

Better post-discharge VCS support should be provided to patients with MS, and could reasonably be expected to address other issues raised during this focus group - such as a perceived lack of time to discuss health matters and access to physiotherapy.

Stroke Support Group

Summary

The discussions at this focus group were regarding local Bristol hospitals.

Participants shared experiences of discharge which corroborate much of the questionnaire feedback detailed above, such as a desire for better communication from medical staff, and for the discharge process to be streamlined. However, several issues emerged that were of importance to this group, as detailed below:

Medication and Safe Discharge

Three specific concerns were raised around safety of discharge and safe provision of medication.

“Medication was ordered by hospital, GP contacted commentator to tell her it was ready to collect, but... it’s the wrong medication. Lots of changes to medication in

hospital and after discharge is confusing. Commentator worried she might have started taking wrong medication and been ill”.

And;

“Commentator’s father was given a double dose of medication on discharge. He was not told it was a double dose. Home care agency were confused by the dosage and had to double check with the hospital”.

And;

“Commentator had a stroke in June 2014. He was discharged and went home on the bus. Hospital staff did not check he got home safely even though he travelled home alone”.

Post-discharge Care and VCS Referral

Participant feedback about support provided following discharge was mixed. Several felt that they were not sufficiently supported, whereas another participant had an excellent experience of discharge.

“Commentator found it difficult to get through to (hospital) staff on the phone after their discharge from the hospital. They were not given a contact name and this made it hard to speak to someone who could help”.

And;

“Commentator had a wonderful discharge experience. First 4 weeks after discharge someone visited her at home every day to help and signpost her to services that could support her. On the day she arrived home, workmen came and made alterations to home. She thinks all this was organised by the hospital following treatment for her stroke. They also referred her for physiotherapy. ‘I am so grateful for the care’”.

The group was unanimous that there should be a more regular and organised system for referring to the VCS, as any referral that was made appeared to be the result of individual good practice rather than robust systems.

“The HITU receptionist recommended (commentator) went to Headway. Commentator has been volunteering at Headway and has found the volunteer work

very beneficial to their recovery. Commentator does, however, worry that if it hadn't been for the receptionist, they would not have got support from Headway. Referral to Headway should be in an official discharge pathway"

And;

"Group felt information about support services (e.g. Voluntary sector services) should be given out on discharge. At the moment group members felt they only found out about support services through word of mouth not from professionals".

Recommendations

All staff involved in discharge should ensure that stroke patients are properly assessed and supported during discharge. Where possible, a check-up phone call or service should be offered to ensure that the patient has been discharged safely.

Referral to VCS support services should be offered to patients who have had a stroke as part of every discharge process. Information could be given to patients and their families or carers about the Well Aware health and wellbeing database which has up to date information and contact details for VCS support services.

Deaf Health Promotion: people with a hearing impairment, or who are deaf

Summary

We received feedback regarding discharge services from a cohort of people who are deaf and/or have a hearing impairment. This cohort were generally happy with the quality of care received and responses about staff attitudes and clinical quality were similar to responses received from respondents who are not deaf or hearing impaired.

Several common themes emerged from this feedback which align with the general trends seen throughout the data, such as delays in the discharge process relating to pharmaceutical provision and transport.

However, several cohort-specific issues were also identified, as below.

Information Provision

People who are deaf or who have a hearing impairment reported experiencing particularly poor provision of information throughout their care pathway, and also post-discharge.

“Staff had no idea how to communicate with me”.

And;

“It would be more helpful if the consultant and nurse could inform me of the next stage rather than just move me into a position they want me to be in”.

In addition, some respondents were concerned about a lack of information sharing between agencies and sectors involved in their care.

“Better information sharing. I was told by the optician that I had a low risk of glaucoma, but the hospital didn’t tell me this”

This group reported that they were sometimes unsure about medication, and unsure of what to do in an emergency or where to go to get further information and support.

“I should have been informed of post-discharge support”

Reasonable Adjustments

This group also reported significant frustration over the lack of reasonable adjustments made by hospital services to cater for their requirements.

“The hospital was unable to send texts to arrange for transport home, this is a problem for deaf families”.

And;

“It would be helpful if there was an electronic display... as I have to constantly watch out for my name each time the nurse calls out”.

And;

“Equipment in the hospital was inaccessible e.g. no subtitles on the TV”.

Provision of Interpretation

Several respondents reported that they had not been offered interpretation- in some cases even after specifying that they needed it. It was clear from those who had received this support that it was highly valued.

“Interpreters must be provided for deaf patients”.

And;

“I was fortunate that I had a sign language interpreter with me during discharge – this helped. I was able to access information and ask questions”.

Recommendations

Trusts should sign up to the Deaf Health Charter which has been locally commissioned by Bristol CCG (Clinical Commissioning Group). Recommendations within the charter should be implemented to ensure that the needs of deaf people are met.

Gender

Summary

A proportion of respondents were happy to specify their gender, and as a result it is possible to examine gender-specific themes that emerged from the feedback.

VCS and Other Post-Discharge Support

Men were only half as likely as women to be offered a referral into the VCS during discharge (5% of men stated that they had been offered this service, compared to 10% of women).

Follow-up contact from primary or secondary care was very similar regardless of gender, with one third of men and women stating that they had received contact.

Discharge Process . Delays

Men were less likely to experience delay during discharge than women (36% of men reported no delay compared to 27% of women).

4. Healthwatch . Continued Monitoring

Healthwatch will continue to monitor the issues raised within this piece of work as part of our ongoing role as patient and public champion.

We will continue to invite patients and the public to feed back to us their experiences of discharge, and will monitor and publicise improvements that arise from this report.

5. Conclusions and Implementation

Healthwatch is happy to recommend the following to all hospital trusts. We will work with trusts and trust patient experience groups to monitor whether these recommendations are implemented and whether they are having the desired effect.

This report and recommendations will also be publically available and disseminated widely throughout the region.

1. The discharge process for many patients needs to be planned and implemented more efficiently. Where possible, planning should begin early in the patient pathway, and should include and incorporate all elements of safe discharge to avoid any delays. Where the exact date of discharge is uncertain, as much planning as possible should be completed in advance of discharge.

2. Discharge processes must include a thorough and effective process for ensuring that patients can access voluntary and community sector (VCS) support within their community. Patients should be empowered to maintain and improve their wellbeing post-discharge to avoid the potential for distressing and unnecessary readmissions. Healthwatch can provide a VCS signposting function for local Trusts as part of our commissioned service.

3. Where possible, and especially in circumstances that involve vulnerable and/or older people, the hospital should examine whether they could provide a check-up service to patients after discharge. It is clear that many patients will not require this service, so the discharge process should include an assessment as to whether the patient would benefit from a check up in order to avoid using resources unnecessarily.

4. Hospitals should consider whether they are doing enough to listen to the views of patients, families and carers during the discharge process. Views should be

meaningfully incorporated into decision-making in order to empower patients to feel in control of their care.

This report was produced by Healthwatch Bristol, B&NES, South Gloucestershire and Somerset. For copies in another format, or to find out more, please contact us using the details below.



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