[Enter sub-heading]

Carer experience of hospital discharge

healthwatch
Wandsworth

Contents

Summary

[Enter normal text]

Background:

During the pandemic changes were made with the aim of discharging patients at an earlier stage and supporting home-based care arrangements. Carers are often involved in supporting people once they are home, and there was a need to understand how involved carers are in the discharge process and arrangements due to their important role in a patient's recovery. Carers play a key role in helping people get better, they know a lot about the person being cared for and what can help them recover. They see things that staff cannot see and can respond to emergencies to get help quicker. Improvements to involve and support carers should lead to better discharges and save time and resources for all involved. NHS England (NHSE) approached us and other Healthwatch to undertake local research as part of a national study.

What we did:

We interviewed 10 carers between 8th December 2021 and 22nd February 2022. We then reported the findings to local staff across organisations who work on supporting hospital discharges in March 2022. Findings across the Healthwatch were compared to compile a national report on the issues or areas that could improve hospital discharge for carers and patients. Locally we will be following up the findings with organisations operating in Wandsworth.

What we were told and recommendations:

There were carers who had varying experiences, some positive and some identifying issues or room for improvement. We identified themes to focus on to ensure a positive experience for carers and improved hospital discharge processes. These included:

- Identification of carers and their caring role
- Communication and information
- Timing of discharges
- Assessment of carer/caring need post discharge

Read on to hear more about why these topics are important and the impact they have on carers and the patients they support.

Thank you to everyone who shared their experience with us to help us write this report.
Thank you also to all staff and volunteers involved in this research and writing this report.

Introduction

Healthwatch Wandsworth has previously spoken to people in the borough about hospital discharges. During the pandemic changes were made with the aim of discharging patients at an earlier stage and supporting home-based care arrangements.[1] It is generally understood that newly discharged patients are not always able and ready to look after themselves without the support of a carer or family member. What is less understood is whether carers are involved in the discharge process or asked if they are willing and capable of providing carer support. This is an area of concern because patients that have recently been discharged from hospital often require ongoing treatment and assessments, possibly involving specialist equipment and the success of this care plan can rest on the support from a carer.

Healthwatch England and NHSE approached us and seven other Healthwatch to be involved in a national study to understand the experience of carers supporting people who have been discharged since May 2021. It is a priority to understand carer experiences because being a carer is seen as a social determinant of health and helping carers to provide better care and to stay well themselves leads to better outcomes for those needing care and more effective use of health and care service resources.

As part of this study, Healthwatch Wandsworth undertook **10 interviews** with carers between 8th December 2021 and 22nd February 2022. It is important to note that not all carers lived in Wandsworth and neither did all the people cared for. Services in a variety of areas were described.

A **total of 22 people** attended a focus group for staff working on hospital discharge to discuss the findings in March 2022. This included 2 people from Healthwatch Wandsworth (Healthwatch Manager; Research Volunteer) and 3 people from NHS E&I (London Region Carers Lead x1, National team Commitment to Carers programme x2), who were facilitating the workshop. Other attendees included representatives from local councils, NHS services, community groups and charities. Some members of this group met again in May 2022.

Further information about the interviews and focus group can be found in the methodology section below.

Key findings

Despite the broad geographical spread of participants, in the final analysis of the results from interviews and focus group sessions, we identified several common themes important to carers' experience of hospital discharge and post-discharge support.

Identification/recognition of caring role

- Not all carers were identified as such by services and some may not see themselves as carers but a role they have as a relative or friend, with a knock-on effect for communication and knowledge to help support the patient

---

[1] For more information on these new arrangements see Discharge to Assess

- While experienced carers knew how to ask for support and work with care teams, new carers found it more difficult 'to navigate the system' without guidance from a focal point in the hospital

Suggested actions

- Identify a trigger question to help recognise carers
- Ensure identification shared across organisations.
- Use of carer passports
- Consistent emergency planning for patient's admitted who are carers
- A carer liaison officer role in hospitals to provide advice & information to carers and staff has worked elsewhere
- Improve staff awareness around carer issues

Communications and information

- Many carers often felt that they did not know enough about looking after their loved ones, or have enough information on any care programme arranged by the hospital team
- Many suggested that at the time of discharge carers should receive contact numbers or a summary letter about which services have been contacted and who is coming when and why

Suggested actions

- Have earlier conversations with carers, noting that staffing issues can have a significant impact on communication
- Carers would like information about organisations that could help post discharge (including social services or support with day-to-day living, district nurses and carer support) including who is coming why and when
- More information to be added to discharge summaries

Timing of discharges

- Some experienced delays to discharges due to lack of coordination between hospital services, such as delayed medications, unavailability of discharge doctors and delays with preparing the discharge letter
- Some carers reported difficulties organising transport for collection when the day or time of discharge changed, exacerbated by carers not living in London, being at work, or not having their own vehicle

Suggested actions

- Carer feedback suggested consideration of carer transport
- Carer feedback suggested review of hospital pharmacy delays

Assessment of carer/caring needs post-discharge

- Carers did not always feel the home situation was adequately assessed or appreciated -often a patient's needs had increased after the hospital stay
- Not all cares had discussion with staff before discharge
- Example of good practice: physiotherapists received a lot of praise for understanding the broader situation
- Some carers were forced to give up work and lost income
- Most mentioned extreme physical and mental fatigue because of the additional responsibility, mentioning low mood and excessive worrying
- Example of good practice: Some praised Age UK service in getting the home prepared before discharge. Wandsworth Carers centre was mentioned as a brilliant support for the carer by one interviewee. Physiotherapy was important

Suggested actions

- Service staff standard practice should be to check abilities of carers
- Use a sense-check with family/carers, to counteract the tendency to take what patients say about circumstances for granted, involving carers in conversations about what is needed as early as possible
- Provide information about support available for support such as social care via the council or elsewhere

Read on to find out more about carer experiences that highlighted these themes.

Methodology

In collaboration with NHSE and the other Healthwatch we provided comments on the draft survey and interview structure provided by NHSE.

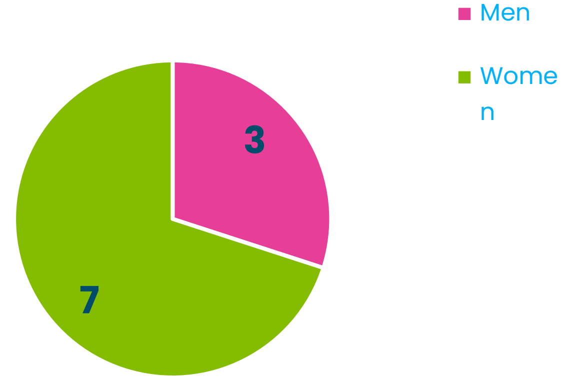
We advertised the opportunity to take part in interviews via social media, our website, our newsletters, and the Wandsworth Carers' Centre bulletin. It was also directly advertised to community groups, including Roehampton Community Shed; WoW Mums Group Meeting; Asian Carers Peer Support Group; Side by Side Wandsworth; NHS Wandsworth Thinking Partners group meeting; Wandsworth Council Co-production and Partnership Group; and Wandsworth Carers' Centre.

People were offered a £40 shopping voucher for taking part in the research. Interviewees were self-selected; a total of 24 individuals expressed an interest in being interviewed, however some did not meet the interview criteria, while others decided to withdraw from the research without providing a reason for doing so.

Healthwatch Wandsworth conducted **10 Zoom interviews** (4 audio only) between the 8th of December 2021 and the 22nd of February 2022. Interviewees said they were unpaid carers for their **mother** (3), **father** (3), **husband** (3), **daughter** (1), **grandfather** (1) and **uncle** (1). Two people said that they were caring for more than one person. Interviewees spent varying times looking after their loved ones: **50+ hrs per week** (3), **20-49 hrs** (3), **1-20hrs** (1), **prefer not to say** (1), **no response** (1).

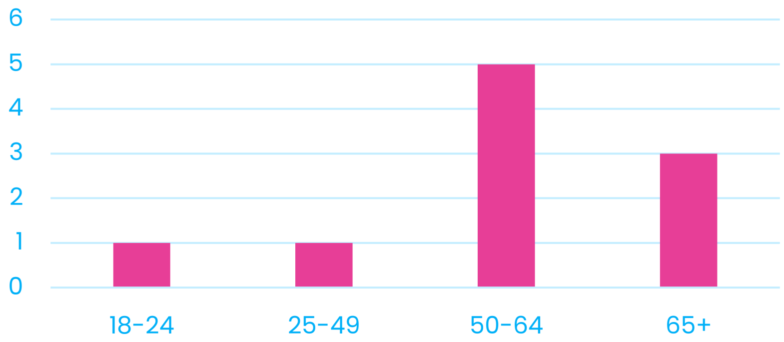
Demographics of participants

Gender



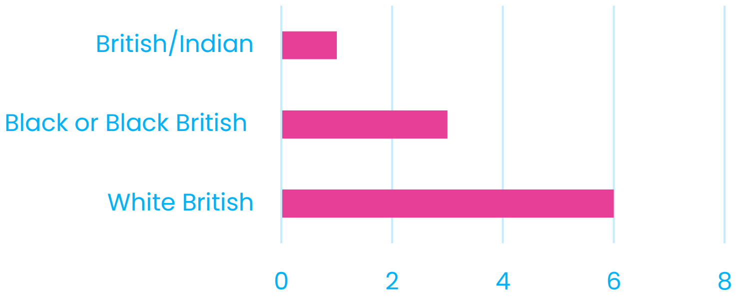
For comparison: 48% of Wandsworth are male

Age



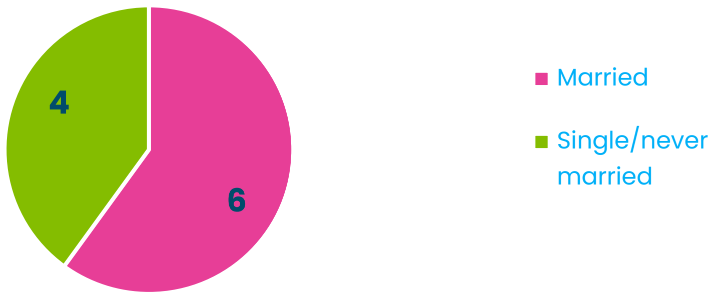
For comparison: 72.6% of Wandsworth are aged 16-65

Ethnicity



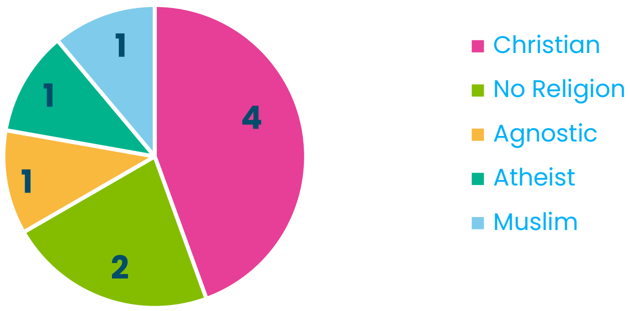
For comparison, in Wandsworth: 48% White British, 13% Black ethnicity, 13% Asian ethnicity

Marital status



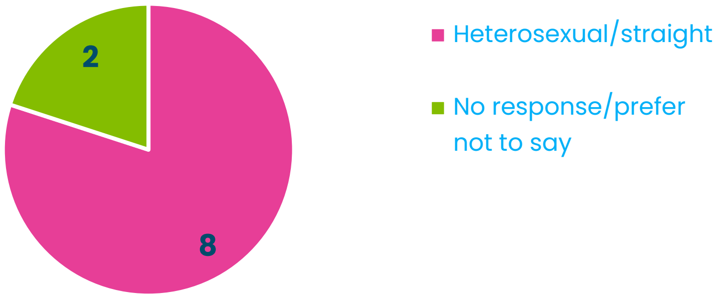
For comparison: 33% of Wandsworth are Married

Religion



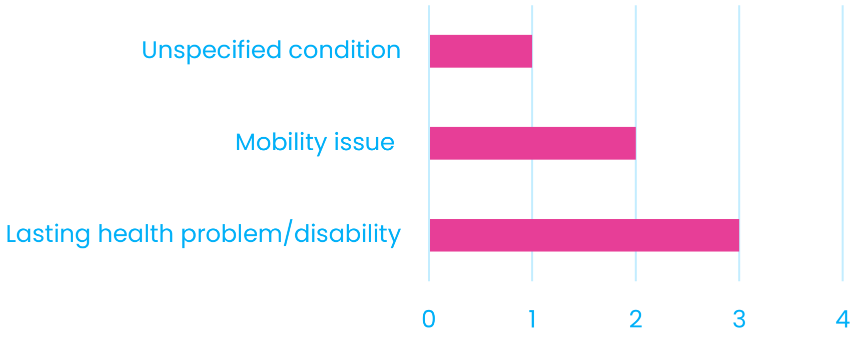
For comparison, in Wandsworth: 27% No Religion, 53% Christian, 8.1% Muslim

Sexual orientation



For comparison, in Wandsworth: 2.6% of population identified as LGBTQ+ in 2013-5

Health/disability



For comparison, in Wandsworth: 6% disability that limits mobility

In the interviews, there was a slight underrepresentation of men and younger age groups (most participants were over 50). There was a slight overrepresentation of individuals identifying as White British (10% more) and Black (20% more) and married people (100% more). We had a higher representation of people living with disability and/or mobility issues than the Wandsworth population. Due to the sensitive nature of the topic and non-disclosure, it is difficult to tell how representative the current sample was of the Wandsworth population with regards to sexual orientation.

Focus Group with local staff

A **total of 22 people** attended a Focus Group to discuss the findings of our survey and agree a series of steps that could be taken in response to the issues raised by carers. Attendees included 2 people from Healthwatch Wandsworth; 3 people from NHS E&I (London Region Carers Lead x1, National team Commitment to Carers programme x2), who were facilitating the workshop; as well as representatives from local councils, NHS services (including our local acute hospital and community services), community groups and charities who support patients and carers during and after discharge from hospital. We were not able to identify a GP to attend, but on reflection we think a representative of GPs would have been useful. We divided in to two groups to hold the discussion and there was a good level of contribution from the attendees.

Our findings

Identification/recognition of caring role

Interview findings

All carers we interviewed considered themselves to be the main carer of the person they looked after. All of them felt that as family members, it was their duty to care for their loved ones. Most of our carers have been looking after their loved ones for years to some extent (some were full time carers while others helped with errands and hospital appointments) before their recent hospital admissions. While two interviewees reported being identified as main carers straight away in A&E, this was not the case for everyone, with a knock-on effect for communication and knowledge to help the patient (see below).

For many the health of the person they cared for had been declining over a few years and often they had complex health issues and a series of hospital admissions. In these cases some carers had experience with caring for someone and had certain strategies and support systems put in place already. This included respite; paid carers; carers arranged by social services; shared care with other family members. Some interviewees also mentioned that they had learned ‘how to navigate the health and social care system’ throughout the years of caring for their loved ones, although this was not everyone’s experience, and some carers found this navigation difficult without guidance from a focal point in the hospital. Experiences appeared more positive for those who were able to work with care teams and when they were more used to the system, compared to those who were new carers or where their loved one had been previously more independent. For example, they said they knew how to 'tick the boxes' for discharge.

Furthermore, the recent hospital admissions almost always meant added pressure on the carers as the level of care for their loved ones often increased tremendously immediately after discharge (e.g., most people required full-time care after their admissions; follow-up appointments, alterations of living space) and required carers to familiarise themselves with new procedures (e.g., new medications, changing a catheter, managing a stoma bag, caring for a new-born baby, helping a loved one move around the house).

Two people admitted to hospital were both carers themselves and interviewees expressed concern that hospital staff had failed to properly account for the impact of their admission on the family members they cared for. One carer we interviewed felt that despite their emphasising that they were caring for two people, these circumstances weren't considered in aftercare and recovery plans. Another interviewee talked about when their relative was admitted to hospital who was a carer themselves. The relative did not discuss their caring role with the staff and so no one was aware of the potential consequences. The interviewee felt that more could be done to find out about the patient's circumstances.

Other issues discussed by interviewees under this theme include:

- Many were made to feel that only the patient's situation was relevant, and that little consideration was given to the carer's situation, e.g. not living locally, work commitments
- Many people felt that there was a presumption that the carer would 'get on with it'.
- Some explained that it was tiring to be the sole visitor and would have appreciated support from another family member. An example of good practice: one carer was pleased that exceptions were made for multiple visitors which helped patient 'delusions' relating to advanced Parkinson's Disease
- One carer described how the hospital stay had allowed them to 'relax a bit' because there are other people to monitor the situation.
- One carer was not recognised by staff on multiple visits they made on the same day and felt under scrutiny when being questioned about their visit.

Personal story:

> No one in the hospital asked interviewee if she was father's main carer, but hospital has her contact details as next of kin. Said that she had to ring up the different wards to 'track father down', and during this process it was checked if she was next of kin, but not actually asked if she was his main carer.

Next steps

Focus group suggested actions

Action A: Consistent emergency planning for carers and use of Urgent Care Plans.

Action B: *Identified as quick win*: Identify a trigger question to help recognise carers.
Think about their attitudes to caring more, due to the impact of culture and view of caring role.
Recognising carers when the cared for arrives in hospital and use right language to trigger response.

Suggested question to ask possible carers to better identify carers discussed:

"Do you provide help (unpaid) to a friend or family member who, because of illness, frailty, disability, a mental health problem or an addition and cannot cope without your help."

(based on national definition – but replaced the word care with help)

Suggested question to ask before discharge (hospital teams)/after discharge (social care and community teams):

"Is there someone you do or might be able to get help from with day to day living such as help to get about (e.g. getting dressed or washing) and help with getting meals."

Action C: *Identified as quick win*: Use of carer passports and identification on hospital management systems (such as admittance forms). The GP care record could also be a mechanism to highlight if there is a carer involved. Identification should be shared between organisations.

Action D: Review support for people who have dementia or delirium in hospital because there is often a significant change in the person who is discharged. Commission more support for delirium at home and redesign the service so there is more short-term support

Action E: *Identified as quick win* A carer liaison officer role in hospitals to provide advice & information to carers and staff has worked elsewhere. This could be a base for the carers' centre in hospital to give advice and information and to advocate help people navigate.
Carers suggested they would like a 'check in' to see how they are doing and to check they have the carer support at the right level. They would like a 'Carer Champion' to advocate support.

Action F: *Identified as quick win*: Improve internal communications and staff training to increase confidence and awareness around carer issues.

Communications and information

Interview findings

This theme covers carers' communications with the hospital about the condition and location of the patient; details of the practical arrangements for discharging the patient; and information on the post-discharge care, namely the care plan. There were some positive experiences of communicating with the NHS and other organisations. Although many interviewees highlighted that they were the initiators of communication.

When communicating with hospital staff, as many as half of the carers interviewed thought information on the condition of the patient was ambiguous. In more than one case the carer was not actually informed which ward the patient had been taken to after A&E. Here it is important to refer back to the first theme, and the importance of identifying the patient's carer at an early stage. On a more positive note, it would appear that for patients with long-term and/or complex needs, hospitals tend to involve and communicate with carers.

Communications around discharge arrangements were identified as problematic by many interviewees. Some reported difficulties organising transport for collection when the day or time of discharge changed, exacerbated by carers not living in London, being at work, or not having their own vehicle. In one case the hospital arranged for the patient being discharged to be taken home by ambulance without informing the carer in advance. Fortunately, they happened to be working from home at the time.

Beyond practical arrangements at the time of discharge, some interviewees said they were concerned that they did not know enough about looking after their loved ones or have enough information on any care programme arranged for the patient. The level of care needed to support the patient often had changed or increased compared to before the hospital stay so there was a sense that there was a great need for information. Not everyone's experience was the same, however, as some carers told us they did receive explanations of medication and aftercare. In any case, many suggested that at the time of discharge carers should receive contact numbers or a summary letter about which services have been contacted and who is coming and when and why. It appeared that some carers felt that if they had had more information and were involved more in conversations before discharge there could have been better preparation for a return home and other support put in place if needed.

Next steps

Focus group suggested actions

Action G: Have earlier conversations with carers, noting that staffing issues can have a significant impact on communication.

Carers suggested that regular updates from the hospital, for example, once per day would help avoid continuous phone calls from carers and be less time-consuming for hospital staff.

Consider conversations with carer as a 'handover'.

See Department of Health training for staff about compassionate conversations

Action H: Avoiding 'false starts' for discharge, including those sent to the discharge lounge too early in the day

Action I: *Identified as quick win* Providing general information and support for carers for pathways 1-3 (where there are sensitives for people who have capacity and do not want information sharing with others).
Leaflets can be stocked and given out in the Transfer of Care area.
A letter or leaflet about what people are going home with could be used, similar to that used in 'Neuro'.

Carers would like information about organisations that could help post discharge (including social services or support with day-to-day living, district nurses and carer support) including who is coming why and when. Those not entitled to social care would benefit from information about organisations and things that could support them, including voluntary sector services and this should be done early on, e.g., one person said Wandsworth Carers Centre helpfully signposted to Age UK to get the home prepared.

Action J: More information to be added to discharge summaries

Action K: Support for hospital staff with communicating with families and managing expectations, including training for transfer of care hubs.

Action L: Conversations about plans also need to include conversations about finances and potential means testing.

Action M: Patient portal may hold information that would be useful but this has only just launched so unsure about whether discharge summaries will be on there:
https://www.stgeorges.nhs.uk/patients-and-visitors/mycare-st-georges-patient-portal/

Personal story:

One interviewee rang 3-4 times a day to see what was going on, got different information every time, e.g., being discharged but then wasn't, being moved to a different ward, different information on where father was and what was happening and what was not.

No one was talking to them about discharge, even though it happened 6 hours earlier than was supposed to – everyone just assumed that interviewee would be about and nobody asked her.

Another interviewee said that communication was initiated by the hospital, the GP and interviewee. They received updates on grandfather's condition, the GP was feeding back to hospital and vice versa; the interviewee was also able to ask questions which would then get answered and described the communication as 'two-way traffic.

Note this interviewee stated they were identified as a carer early in the process.

Timing of discharges

Interview findings

- Some experienced delays to discharges due to lack of coordination between hospital services, such as delayed medications, unavailability of discharge doctors and delays with preparing the discharge letter
- Carers at times had to make multiple trips to and from the hospital due to delays in discharge
- Some reported being kept waiting for collection or transport for a long time
- Some carers said that people were discharged sooner than the carers thought they should be because they were still unwell or limited in their movement

Next steps

Focus group suggested actions

Action Q: Carer feedback suggested consideration of carer transport

Action R: Carer feedback suggested review of hospital pharmacy delays

Assessment of carer/caring needs post-discharge

Interview findings

Caring for somebody can be a full-time job and it is important carers feel prepared and supported when taking on such a large responsibility. The intensity of support a cared for person needed often increased after they were discharged. There were some positive experiences but not for everyone. The importance of information, communication and involving carers was clear when some were left feeling as though their home situation hadn't been adequately assessed or appreciated and when support staff visited the home they did not always communicate with the carer. A few carers had had a discussion with staff prior to discharge about arrangements at home. It appeared that most felt it was most useful to have contact with organisations that could help prepare for discharge as early as possible, for example one mentioned how Age UK had helped prepare the home for discharge.

Some also reported that no consideration had been given to their own health issues, whether they could manage all the duties required of them in addition to their own commitments, or their physical/mental capacity to accommodate the needs of the person they were caring for. For example, it had not been considered whether there were stairs if a person had limited mobility and if carers could support lifting and carrying. Physiotherapy was identified as particularly important, as carers struggled to support people with limited mobility. For some there was a delay in physiotherapy support.

After a period of providing care, most interviewees reported extreme physical and mental fatigue because of the additional responsibility, as well as low mood and excessive worrying.

In terms of support, some reported receiving no information about carer/social care support, indicating a booklet detailing what needs to be arranged and who to contact would be useful. Community/district nurses were mentioned as being unavailable by some, and one interviewee reported being disappointed that district nurses didn't visit after the hospital indicated they would and they told us there were often delays or staff would not turn up . Social care support and assessments were praised where they happened, but some felt it was needed if they didn't have it.

Some of the feedback was more positive, with physiotherapists receiving a lot of praise for understanding the broader situation. Some said Age UK had helped prepare the home before discharge and Wandsworth Carers centre was mentioned as an important source of support by one carer. Video appointments and virtual access to support were described as helpful in the right circumstances.

The responsibility of caring meant some individuals made the decision to give up work and lose income. Over the course of the interviews we also learnt that care packages and programmes were often paid for by the unpaid carers and/or their families, representing another financial consequence of caring role.

Finally, there were also a few stories that indicated that the attitude of the person being cared for towards accepting support impacted on support that was arranged and how much information and support the carer had. More than one person highlighted that their relative had lived relatively independently before they were admitted to hospital and minimised the support that they said was needed in discussions with staff about arrangements.

Next steps

Focus group suggested actions

Action N: Service staff standard practice should be to check abilities of carers

Action O: Use a sense-check with family/carers, to counteract the tendency to take what patients say about circumstances for granted.

Personal story:

One interviewee told us that Wandsworth had good system, efficient: full package of care was provided for the first two weeks, because their husband was so weak and dependent. They told the interviewee what was going on and explained to her what and how to do.

The council thought that interviewee was at the edge of being able to cope and helped set the family up with services in the community like extra respite care so the interviewee could go out once a week for 2 hours.

Another interviewee said their relative 'doesn't want outside help'. That makes things more difficult and things have to get to crisis point. The interviewee was not involved in decisions being made, mother made own decisions and family not asked if they would care for her and never saw anything written down.

Support from own GP or patient's GP

- Most of the carer's GPs did not check in with carers about how they were doing; only one carer's GP touches base with her regularly and receives annual check-ups as a carer. Some carers did not see a point in notifying their GP of the situation.
- Carers valued interactions with the GP of the person they cared for. Examples of good practice included:
    - Often cited as source for support, advice, medication information, check-ups and monitoring
    - Some acted as a link between hospital and cared for/carer
    - Involved in multiple aspects of care, including underlying/longer term-conditions

Conclusion

Our work focused on carers' experience of hospital discharge arrangements and support with home-based care since the beginning of the COVID-19 pandemic when measures were taken to try to alleviate some of the pressure on hospital services by discharging patients earlier. Through our interviews and focus groups we have looked in detail at carers' experiences; those experiences include communicating with hospital staff following admission, care plans to guide the care of patients post-discharge, practical aspects of discharge, and support for home-based care.

We found numerous examples of good practice by hospital staff from admission through to discharge. We found that some interviewees were identified as main carers straight away by A&E and this seemed to have a positive impact on communication more generally, with carers being given regular updates on the patient's condition while in hospital. For people with long-term complex needs, we were told that hospitals tended to involve carers at an early stage, helping them to understand the treatment and ultimately the care plan. Others were pleased with the allowances hospitals made when it came to visiting arrangements and telecommunication with patients. Ambulance staff also came in for praise for reassuring and comforting carers during admission, and helping patients settle back into their homes following discharge.

These positive experiences may serve as a useful reference point when it comes to discussing some of the challenges carers reported experiencing, particularly for those who do not identify as a carer or have not done so until recently. While some interviewees were identified as main carers straight away, others were not, and this had a knock-on effect for carers in terms of communicating with hospital staff, accessing information, and understanding what kind of support was available. We have seen how some carers were left feeling unprepared at the time of discharge, unfamiliar with the care plan, and unsure who to contact for support after the patient returned home. Our focus group was tasked with identifying practicable solutions to the key issues and came up with a series of actions that any hospital could implement. The failure to identify carers at an early stage could be addressed by standardising a trigger question or instituting the use of carer passports. A carer liaison officer would help with both the timely identification of carers—getting them involved at an early stage—and the provision of advice and information to carers and health professionals throughout the process. In handing over caring responsibilities at the end of the hospital stay, more information about support services and care plans could be added to discharge summaries, which carers could then consult if in need of additional support.

Carers also reported good practice among staff involved in discharge and support for home-based care. Some said they knew in advance when the patient would be discharged and this allowed them to make arrangements for collection, where appropriate, as well as prepare the home ready for the patient's return. Some medical staff reportedly helped make patient's home suitable for rehabilitation and care and ensured appropriate care arrangements were in place before approving their discharge. Carers expressed appreciation when discharge doctors and nurses explained new medications and/or aftercare to them, as this gave them a sense of being more prepared. And once the patient had returned home, carers were grateful for support they received from health and social care staff.

Once again, we can use these examples as evidence of good practice that happens under the right conditions. However, we also need to flag instances where carers felt unsupported, uninformed, and underprepared. Whereas some carers were given forewarning of when the patient was to be discharged, others experienced delays due to a lack of coordination between hospital services, such as unavailable medications, unavailable discharge doctors, and delays preparing the discharge letter. Changes to the day or time of discharge complicated transport arrangements for carers, especially those not living in London, maintaining work commitments, or not having their own vehicle. The apparent breakdown of communication was not restricted to the day of discharge in the experience of some of our interviewees, some of whom reported not feeling as though the home situation had been adequately assessed or appreciated. Still others highlighted a lack of information about carer/social care support and the failure of community/district nurses to visit the patient at home.

Remedial actions, suggested by our focus group participants, to avert carers experiencing extreme mental and physical fatigue because of their responsibilities included introducing a standard practice whereby service staff check abilities of carers, using a sense-check with family/carers to avoid taking what patients say about their circumstances for granted, and distributing information on support for carers in the Transfer of Care area.

This report contains findings that can be used by individuals and teams to improve the experience of caring and associated health outcomes, for both the carer and the cared-for. Measures to reduce the time people spend in hospital and to encourage home-based care where clinically safe to do so are already being taken. By understanding how these changes may be impacting patients and carers, health providers are better placed to determine best practices under the new Discharge to Assess arrangements. As all organisation involved in providing health and care continue to have increasing pressures and demands, it will be a challenge to focus on all of the actions, however, we hope that as some of the actions identified were described by staff as 'quick wins' that this report will be helpful to those looking to further develop hospital discharge support. Improvements to involve and support carers should lead to better discharges and save time and resources for all involved. Carers play a key role in helping people get better, they know a lot about the person being cared for and what can help them recover. They see things that staff cannot see and can respond to emergencies to get help quicker.

healthwatch

Healthwatch Wandsworth
3rd Floor Tooting Works,
89 Bickersteth Road,
Tooting,
SW17 9SH
www.healthwatchwandsworth.co.uk
t: 020 8516 7767
e: information@healthwatchwandsworth.co.uk
@HWWands
Facebook.com/hwwands
healthwatchw