Enter & View

Queen's Hospital, Romford: In-patient meals

6 October 2016

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
No. 08416383

What is Healthwatch Havering?

Healthwatch Havering is the local consumer champion for both health and social care. Our aim is to give local citizens and communities a stronger voice to influence and challenge how health and social care services are provided for all individuals locally.

We are an independent organisation, established by the Health and Social Care Act 2012, and are able to employ our own staff and involve lay people/volunteers so that we can become the influential and effective voice of the public.

Healthwatch Havering is a Company Limited by Guarantee, managed by three part-time directors, including the Chairman and the Company Secretary, supported by two part-time staff and a number of volunteers, both from professional health and social care backgrounds and people who have an interest in health or social care issues.

Why is this important to you and your family and friends?

Following the public inquiry into the failings at Mid-Staffordshire Hospital, the Francis report reinforced the importance of the voices of patients and their relatives within the health and social care system.

Healthwatch England is the national organisation which enables the collective views of the people who use NHS and social services to influence national policy, advice and guidance.

Healthwatch Havering is your local organisation, enabling you on behalf of yourself, your family and your friends to ensure views and concerns about the local health and social services are understood.

Your contribution is vital in helping to build a picture of where services are doing well and where they need to be improved. This will help and support the Clinical Commissioning Groups and the Local Authority to make sure their services really are designed to meet citizens' needs.

'You make a living by what you get,
but you make a life by what you give.'
Winston Churchill

What is an Enter and View?

Under Section 221 of the Local Government and Public Involvement in Health Act 2007, Healthwatch Havering has statutory powers to carry out Enter and View visits to publicly funded health and social care services in the borough, such as hospitals, GP practices, care homes and dental surgeries, to observe how a service is being run and make any necessary recommendations for improvement.

These visits can be prompted not only by Healthwatch Havering becoming aware of specific issues about the service or after investigation, but also because a service has a good reputation and we would like to know what it is that makes it special.

Enter & View visits are undertaken by representatives of Healthwatch Havering who have been duly authorised by the Board to carry out visits. Prior to authorisation, representatives receive training in Enter and View, Safeguarding Adults, the Mental Capacity Act and Deprivation of Liberties. They also undergo Disclosure Barring Service checks.

Background and purpose of the visit:

Healthwatch Havering (HH) is aiming to visit all health and social care facilities in the borough. This is a way of ensuring that all services delivered are acceptable and the safety of the resident is not compromised in any way.

Introduction

The principal purpose of a hospital is to treat the sick and injured. Most patients are seen and dealt with quickly, and most leave the same day.

Inevitably though, many patients stay as in-patients, some for a considerable period, especially elderly patients who need a support package of care

before they can return home. These patients must, of course, be fed and kept hydrated.

No one expects "hospital food" to match home-cooked food, or indeed that which would be served in a multi-star hotel or restaurant; on the other hand, patients have a right to expect food that is:

- nutritious
- able to meet special dietary requirements (whether of a religious nature such as halal or kosher, of a personal/lifestyle-choice nature such as vegetarian or vegan, or of a medically-necessary or non-allergenic nature such as gluten-free or nut-free)
- provided in a quantity sufficing to satisfy their hunger
- complementary to their clinical needs where necessary and
- served to them in a reasonable manner, with assistance to eat if they need it.

Patients also have a right to be – and remain – hydrated, particularly as hospitals are often dry, warm places where it is possible to become dehydrated quite quickly.

Over the years, there have been many humorous references to inadequacies in the quality and quantity of hospital food – many of the "Carry On" films of the 1950s and 1960s drew much comedic effect out of hospital food, and numerous films and TV programmes since have maintained that caricature.

Against that, clearly it is impossible to satisfy completely the expectations of every patient. What to one person is a perfectly-acceptable meal will be to others either too much or too little: food likes and dislikes are highly personal and no two people will agree on what is their "favourite meal". It is particularly difficult to produce a consistent and acceptable offering when catering for many hundreds of patients for two main mealtimes every day, all with different needs and expectations, not only in quality, quantity and nature of food but in terms of the amount of time and assistance they need to eat it.

Healthwatch Havering set this report in hand because of reports from patients and others alleging inadequate dietary arrangements [1] (not necessarily at Queen's Hospital).

As an initial step, several wards in Queen's Hospital were visited on 6 October 2016 at lunchtime to enable Healthwatch members to observe the delivery and presentation of the midday meal, the help available to those patients who needed assistance with feeding and how patients with varying needs coped with their meals. The team comprised of seven Healthwatch members, who visited individual wards in pairs or threes.

Following that visit, members of Healthwatch Havering met senior staff from the hospital and its catering contractor to discuss various issues, emerging from both the Enter & View visit and earlier patient reports.

Nutritional standards

NHS England (NHSE) has identified 10 key characteristics of good nutrition and hydration care [2]. These are:

1. Screen all patients and service-users to identify malnourishment or risk of malnourishment and ensure actions are progressed and monitored.
2. Together with each patient or service user, create a personal care/support plan enabling them to have choice and control over their own nutritional care and fluid needs.
3. Care providers should include specific guidance on food and beverage services and other nutritional & hydration care in their service delivery and accountability arrangements.
4. People using care services are involved in the planning and monitoring arrangements for food service and drinks provision.
5. Food and drinks should be provided alone or with assistance in an environment conducive to patients being able to consume their food (Protected Mealtimes).
6. All health care professionals and volunteers receive regular raining to ensure they have the skills, qualifications and competencies needed to meet the nutritional and fluid requirements of people using their services.

[1] See for example "Fix Dementia Care: Hospitals" – The Alzheimer's Society 2016
[2] NHS England (NHSE) website: https://www.england.nhs.uk/commissioning/nut-hyd/10-key-characteristics

7. Facilities and services providing nutrition and hydration are designed to be flexible and centred on the needs of the people using them, 24 hours a day, every day.
8. All care providers to have a nutrition and hydration policy centred on the needs of users, and is performance-managed in line with local governance, national standards and regulatory frameworks.
9. Food, drinks and other nutritional care are delivered safely.
10. Care providers should take a multi-disciplinary approach to nutrition and hydrational care, valuing the contribution of all staff, people using the service, carers and volunteers working in partnership.

The catering service at Queen's Hospital must be judged against those criteria. In addition, sources of advice and guidance on nutritional standards and guidance used by the hospital include the British Dietetic Association [3], BAPEN (a charitable organisation that seeks to advance the nutritional care of patients as well as the wider community, which has produced a Malnutrition Universal Self-Screening Tool [MUST]) [4] (see later in the report), Public Health England (Healthier and More Sustainable Catering: Nutrition principles) [5] and Government Buying Standards for Food and Catering Services from the Department of the Environment, Food and Rural Affairs (DEFRA) [6].

Catering arrangements

Catering services at Queen's Hospital (and at its sister hospital, King George in Goodmayes) are provided by Sodexo Limited under contract to the Barking, Havering and Redbridge University Hospitals Trust (BHRUT). Sodexo provides a range of non-clinical services at the two hospitals, including canteen/restaurant facilities for staff and public (such as a Costa Coffee outlet). Different arrangements for catering apply at King George Hospital, so the observations in this report are not necessarily relevant to the in-

[3] BDA website: https://www.bda.uk.com/publications/professional/NutritionHydrationDigest.pdf
[4] BAPEN website: http://www.bapen.org.uk/
[5] PHE website: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/347883/Nutrition_principles.pdf
[6] DEFRA website: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/347883/Nutrition_principles.pdf

patient service at that hospital (which was, in any event, not included in the study now reported on). Catering is part of a Total Facilities Management contract following a competitive tendering exercise for which the evaluation criteria valued quality 60% and cost 40%. The food is sourced from a major hospital catering supplier, Tillery Foods, based in South Wales [7] but which has a London depot in Croydon.

On average, some 2,200 meals are prepared and served each day, and the average cost of feeding a patient is about £10.50 per day.

Hospital management told Healthwatch that:

> The Trust has monthly patient dining meetings with Dietitians, Speech and Language Therapists, Sodexo Catering Manager and the Trust's soft Facilities Manager Contract Manager, to keep up to date with any new catering developments and ensure food quality and nutritional standards are continued to be met.
>
> Dietitians are involved in meal taste tests which are held on the wards, and the Nutrition and Dietetic Department undertake 'Nutrition - how are we doing' audits to monitor patients' experience of the food and mealtimes. The results of the audits are reported to the Trust's Nutritional Advisory Group for review.

In addition:

> Meal taste tests are carried out monthly by the Trust Facilities Team, Dieticians, Catalyst Quality and Performance Manager Sodexo Management team, Tillery Valley food supplier, Senior Sisters/Charge Nurses, nurses and Healthcare Assistants.

Food is delivered from Tillery Foods frozen and ready to be reheated. It is stored in the hospital's food storage area until required, when it is taken by trolley (called a "food cassette") from the food storage area in the hospital to appropriate ward. On arrival at the ward, the trolley is connected to the electricity supply and the food is prepared for serving hot.

A range of foods is available through a variety of menus. Food for patients who do not have special dietary requirements is varied by rotation of menus over a two-week period; food for patients who have special dietary

[7] Tillery Valley Foods website: http://www.tilleryvalley.com/home.html

requirements is also available – should a patient require a specialised menu not generally catered for, a diet chef is available to discuss their specific needs with that patient.

There is inevitably wastage of food. In 2015/16, 176 tonnes of food waste were recorded, approximately 6% of the total waste tonnage at Queen's Hospital [8]. Food waste is collected separately and recycled.

Serving arrangements

In common with many hospitals, food orders used to be based on choices made by patients the previous day. This inevitably meant that many patients were served food not of their choice but that of the patient who had previously occupied the bed.

To overcome that, and to ensure compliance with a recommendation following the PLACE inspection that food be ordered within five hours of the time it is due to be served, the hospital is introducing the use of Saffron, an electronic, tablet-PC based, ordering system (similar in concept and operation to the ordering system used in an increasing number of restaurants). A "host" (an employee of Sodexo) takes the patient's order which is sent electronically to the food store so that meals can be prepared.

Once the food has arrived at the ward for final preparation and is ready to be served, ward staff report to the ward kitchen area and take the food to the patient.

Mealtimes are "protected", which means that all routine and non-urgent medical and nursing tasks are suspended and all available staff are used to take meals to patients. Where a patient is unable to feed themselves, assistance should be available either from staff or from volunteers to ensure that they are fed. Staff receive regular training in nutrition and food preparation and handling.

[8] Source: Barking, Havering & Redbridge University Hospitals Trust, in response to enquiry from Healthwatch, October 2016

The visit

The visit on 6 October involved three teams of Healthwatch members. As different teams were involved, the following accounts of their observations accordingly reflect their different experiences: two teams had a generally good impression of the arrangements they observed but the third found the experience disappointing.

Bluebell Wards A and B – specialities: medical and respiratory

There are six bays, each with four beds, in each ward (together with four barrier rooms, which the team did not enter), which have mainly elderly people as patients. There are four Consultants responsible for these wards, and nursing staff including a Matron and a Senior Sister.

The team was met by the Duty Manager, who escorted them around, introducing staff whenever possible.

The team visited Bluebell B ward first, where there were three duty stations, all staffed. In addition to the wards (48 beds plus 4 barrier beds), a Friday day clinic is held each week for day patients. The team was told that visiting is from 10.30am to 7.30pm daily.

The team arrived at midday and the heated food trolley arrived on the ward at 12.10pm. Meal times are "protected", which means that no routine work or doctors' rounds take place during them, to ensure both that staff are available to concentrate on feeding and that patients are not avoidably disturbed from their meals; lunch time is noon to 1pm. Coffee or tea is offered at about 2pm hours

The team observed that patients' hands were cleaned with wet wipes prior to their eating. A "red tray" and "red jug" system was in operation (to indicate to staff those patients who needed help with eating and drinking) and all patients had access to plenty of drinks, including water. The team noticed one jug that was nearly empty; it was quickly filled when staff were made aware. Tables

were well positioned.

The food arrived hot, had an acceptable appearance and a pleasant odour. It was vegetarian goulash, beef stew and dumplings with mashed or sautéed potatoes and macedoine of vegetables (obviously from a freezer). Plates were served with covers that were removed at the bedside. The menus had been ordered earlier that morning which the staff told the team was better, with patients usually getting food of their choice, rather than the choice of the patient who had previously occupied the bed. One man was eating tuna salad and one lady had chosen ham sandwiches which had been unwrapped for her.

The team noted, however that, despite the pre-ordering system, the last patients to be served (usually those in the bays) sometimes were given what was left, rather than what they had ordered. For example, one patient told the team that she had been served quiche for both lunch and dinner the day before the visit, which was corroborated by a visitor. Condiments and serviettes were available and help was being given to those who needed it by staff (nurses and health care assistants (HCAs)), and visitors were also helping. Most meals were being eaten and the patients whom the team spoke to were mostly quite happy with their meal. The team noted a lack of fresh vegetables, that hot desserts were served at the same time as the main course, and had thus cooled by the time they came to be eaten, rather than being served separately. They also considered that better quality fruit juice could be offered.

The team was told that dietary requirements were assessed on admission and that notes about such requirements were displayed above the beds; and that requirements seemed to be adhered to. Patients were weighed and the dietitian was involved in that. Some patients were having puréed food, and one liquidised. The patient in question told the team that he did not like having liquidised food as it did not taste nice from a plastic feeder.

Although the staff seemed hard pressed all the time they were very

cheerful and treated their patients kindly and with respect. Almost all patients to whom the team spoke were full of praise for the staff, as were their visitors.

One of the younger patients to whom the team spoke, however, happened to be a dietician by profession and she described the food as "appalling, with little nutritional value at all". She was very critical of the lack of fresh vegetables and fruit.

Dessert on the day of the visit was rice pudding or yoghurt. The whole meal is presented to the patient at the same time so a hot dessert soon gets cold before being eaten. The dietician patient was also very critical of the cartons of fruit juice, which she said had no flavour and was just coloured sugar water. She was, however, the only person to voice criticism. Having professional background knowledge of dietary matters, her comments are noteworthy but it is equally notable that she was the sole critical voice.

Portions were not large but appeared adequate. The team was told that patients could ask for more food and that snacks were available (however, when the team enquired later whether food was available on the wards, they were told there was none). The plates were cleared after a reasonable time and the waste was disposed of in a black plastic sack.

The team noted one elderly lady, bedbound, in Bluebell A who had, unnoticed, fallen asleep with her lunch on her lap, which had gone cold. The team drew her to the attention of a nurse, who woke her up, removed the cold lunch and then helped her eat some cold rice pudding.

No leaflets or information appeared to be available for patients, visitors or staff about time procedures on the wards and no-one appeared to use the anti-bacterial hand wash, despite there being four barrier rooms.

The staff told the team that they were happy with the meal

service. They spoke freely and were generous with their time despite being very busy; they seemed to be a good team working flat out, which the team found impressive.

HCAs and Nurses complete the fluid charts and the nurses monitor them. Comfort rounds are made about every two hours, consisting mainly of toilet needs and drinks. A Sister said she thought it was necessary to have several menus to accommodate the diverse dietary needs and ethnicities on the wards. Patients had a variety of illnesses, although those with respiratory problems were the majority on these wards. All patients are assessed using the Malnutrition Universal Screening Tool (MUST), which takes place on admission.

The team noticed that one bed that was very low, with a mattress on the floor next to the bed. Staff explained that the patient in question tended to fall out of bed so precautions were taken for his protection. For that reason, his table had been placed out of reach at the foot of his bed, as he could have hurt himself if the table was in the usual position. His drinking and toileting needs was checked every two hours, an arrangement that appeared to work well. The team was unable to speak directly to the patient as he was sleeping.

The team was unable to talk every patient, as some were not well enough to be bothered.

Harvest A Ward – speciality: care of the elderly

The team considered that meals were well presented, in reasonable portions and were appetising; they appeared to be nourishing and in accordance with patients' requests. Hot meals were checked for temperature constantly, and cold meals were pre-plated before arriving on the ward. These also appeared appetising and well presented.

Specific conditions and dietary needs were well signed above the beds.

Beds were adjusted at meal times to enable patients to sit in comfortable eating positions, although some tables needed renovation. Tables were

placed in position for meals. Sanitizer hand gel was available for all patients to use before meals, and water jugs were available and within easy reach of all patients, although some appeared over-full.

However, on the day of the visit, the meals were very late arriving at the ward; staff explained that there had been a problem in the kitchen and this had caused the delay. When questioned about effect of the delay in meals on patients, the team was told that snacks and fruit were available for patients if needed.

Although sufficient staff to were available to serve the meals to patients and help was given to those who required assistance with eating their meal, there was only one person dishing the meals onto the plates from the trolley. Both main meal and dessert were served at the same time and this took some time to reach the patients. Patients in single rooms were last to receive their meals and they seemed to have a long wait before being served.

The team was told that a new system of ordering meals was being trialled on this ward. The staff told the team that they were not happy with the system as it required a lot of staff time. The logic of experimenting with a new ordering system on a ward where patients needed assistance to make their choices was not immediately obvious.

The team spoke to many patients, all of whom said they were happy with the meals they were receiving, and with the quality and quantity of the meals. Visitors praised the meals that their relatives and friends had been receiving.

Sunrise B Ward – speciality: care of the elderly

The team arrived on the Ward at approximately 12 noon. They were met by the Matron, who was pleased to see them and very happy for them to be there. She felt mealtimes had improved a lot since she had originally joined the Trust.

The heated food trolley arrived just after 12.15pm and staff, all

of whom were wearing plastic aprons, were ready to serve and feed patients. There were six nurses to feed patients, with two staff serving the meals.

The team walked around the bays observing what was happening. The only food available was meatballs and mashed potato, which the team was told was classed as a "soft food". Dessert was also available on the trays but no patient appeared to eat theirs.

The team concluded that there were not enough staff available to feed every patient their food, which was becoming cooler and less appetising by the minute. One nurse to whom the team spoke appeared exasperated by the situation (her facial expressions said it all).

Meals are ordered during the morning of the day in which they will be served, by a kitchen assistant using a tablet computer app, who must go to up to 100 patients asking them what they want to eat for the day. As many of the patients are frail and elderly, they never seem to get what they order as the assistant guesses what they might eat.

Every patient had their meal served up on a red tray, and all had a water jug with a red lid, denoting they need help. Some jugs were out of patients' reach because they knock them over. The families that were there to help their relatives were not very happy with what was being served and a patient told the team that the food was unappetising and she would have loved something with a bit of flavour. The team spoke to the son of a patient waiting to be discharged after two weeks on the ward and he said that his mother had continually been served chicken, which she did not like, and that she had only had one meal that she had ordered during her entire stay on the ward!

All patients who were being fed had been propped up, although some were clearly very drowsy, which caused considerable problems for the nurses trying to feed them, and was very time consuming. The result was that no desserts were eaten. One patient was given two dinners and desserts as part of a plan to get him to put on

weight. It was also noted that some patients were given gluten-free cake for dessert even though they were not on a special diet.

To illustrate the problems staff had to contend with, some patients were observed with their arms tucked inside the bed sheets and were thus unable to wash their hands or feed themselves. The team was told that one patient in a side ward, who had dementia, tended to throw things and so her hands were permanently tucked down the bed. Her daughter told the team she was exasperated by the situation. Despite that, staff were unable to help all patients with their food as they did not have the time to do so.

Condiments were available on the trolley but not used (and were probably not appropriate for the type of patient on the ward). There was no evidence that indications of dietary requirements were within easy view of staff, such as discrete notices above the beds.

The portions of food served up appeared very small. Basic food is kept in the ward kitchen, such as bread and milk, which is not always brought up to the ward when ordered and staff must go down to get it. They also have Complan-type drinks to try and build patients up.

During the visit, the team saw no evidence of a comfort round being offered, and the levels in the water jugs suggested that not all patients were drinking sufficient water to remain properly hydrated. There appeared to be a very limited choice of food, restricted mainly to meatballs and mashed potato for the main course and rice pudding or Bakewell tart for dessert; small quantities of other foods were in evidence but too little to make any difference, and seemingly indifferently prepared.

The team gained the impression that choice was limited because this is an elderly care ward – but the consequence was that, because patients were not being fed the food of their choice, they were not eating what they were offered and wastage levels were accordingly high. The team was told that one family had complained about the lack of choice of food and were clearly not happy with the new system.

Although staff were enthusiastic about the meal time, there were too few of them to make a difference.

Conclusions

The Healthwatch teams that carried out the visits had a mixed experience. The conduct of the mealtime at both the Bluebell and Harvest wards was satisfactory: food was served in adequate portions, seemingly in accordance with patients' orders and assistance with eating was available to those needing it. In Sunrise B ward, however, the story was very different: the food on offer was limited to "meatballs and potato", there were insufficient staff available to assist all patients with feeding, some patients' ability to move had been restricted for their own safety (but, by doing so, their ability to take food had been likewise restricted), and the food was indifferently served because the nursing and HCA staff were too stretched to attend properly to every patient.

Clearly, the hospital is conscious of the need to improve management of the patients' mealtime experience. The introduction of a new system to manage the ordering of meals is potentially a significant step but the evidence of the visit suggests that there is some way to go yet. More importantly, more needs to be done to address the problem of ensuring that those patients who are unable to feed themselves are helped to do so.

Moreover, whilst it is recognised that some patients lack the ability to order their own food – so some element of choice is unavoidably left to staff – it seems inappropriate simply to order a bland meal of "meatballs and potato" virtually automatically and that perhaps more effort could be made to encourage some at least of the patients to take a more active part in ordering their own food.

That said, it is also recognised that nursing and HCA staff are very busy and may not have time to spare to help every patient who needs it to order food. But good nutrition is a key part of recovery from illness or injury and there is always the possibility not only that some time spent with a patient

to organise the food they want would assist in reducing the amount of time they spend as an in-patient before being discharged, but also in promoting a better quality of life for them once they are discharged.

It is accepted that the food on offer meets all requisite standards for nutrition and hygiene; it is served hot when necessary and cold alternatives are available. But no matter how good the food may be, if the patient cannot or does not eat it for any reason, it will simply go to waste. The teams on the visit reported instances of patients not eating, or being able to eat, because they did not like what they were served or were unable to feed themselves and no one was available to help them.

There is clearly no simple answer. The hospital has used a "feeding buddy" scheme, with volunteers coming in to help patients who cannot feed themselves but such a scheme can only succeed if there is a ready supply of volunteers in sufficient numbers – but at the time of the visit, this did not seem to be the case. Nursing and HCA staff have numerous other tasks and duties to attend to and feeding is too easily overlooked (even though, as noted already, good feeding is one of the keys to prompt recovery).

It would not be feasible for Healthwatch to make specific recommendations about mealtimes. It is hoped, however, that the hospital will encourage staff to engage more with patients during mealtimes and, in particular, encourage patients who are have the ability to do so but for some reason are finding it hard, to feed themselves, and to respond to suggestions that a food is not liked or is not acceptable in a more positive way by taking action to ensure that something more to the patient's liking is made available to them. The greater use of volunteer "feeding buddies" would also help in that respect and the hospital is urged to develop that scheme further, as a matter of urgency.

Finally, since the visits were undertaken, comments have been received to the effect that the new food ordering scheme is not working as envisaged. The difficulties of managing the ordering of food in the quantities required

are obvious and the use of innovative solutions is to be encouraged. But new systems need to be bedded in over a period and closely-monitored to ensure that they are effective and working as expected.

The teams would like to thank all staff and patients who were seen during the visit for their help and co-operation, which is much appreciated.

Disclaimer

This report relates to the visit on 6 October 2016 and is representative only of those patients and staff who participated. It does not seek to be representative of all service users and/or staff.

Participation in Healthwatch Havering

Local people who have time to spare are welcome to join us as volunteers. We need both people who work in health or social care services, and those who are simply interested in getting the best possible health and social care services for the people of Havering.

Our aim is to develop wide, comprehensive and inclusive involvement in Healthwatch Havering, to allow every individual and organisation of the Havering Community to have a role and a voice at a level they feel appropriate to their personal circumstances.

We are looking for:

Members

This is the key working role. For some, this role will provide an opportunity to help improve an area of health and social care where they, their families or friends have experienced problems or difficulties. Very often a life experience has encouraged people to think about giving something back to the local community or simply personal circumstances now allow individuals to have time to develop themselves. This role will enable people to extend their networks, and can help prepare for college, university or a change in the working life. There is no need for any prior experience in health or social care for this role.

The role provides the face to face contact with the community, listening, helping, signposting, providing advice. It also is part of ensuring the most isolated people within our community have a voice.

Some Members may wish to become **Specialists**, developing and using expertise in a particular area of social care or health services.

Supporters

Participation as a Supporter is open to every citizen and organisation that lives or operates within the London Borough of Havering. Supporters ensure that Healthwatch is rooted in the community and acts with a view to ensure that Healthwatch Havering represents and promotes community involvement in the commissioning, provision and scrutiny of health and social services.

Interested? Want to know more?

Call us on **01708 303 300**; or email
enquiries@healthwatchhavering.co.uk

Healthwatch Havering is the operating name of
Havering Healthwatch Limited
A company limited by guarantee
Registered in England and Wales
No. 08416383

Registered Office:
Queen's Court, 9-17 Eastern Road, Romford RM1 3NH
Telephone: 01708 303300

Email: enquiries@healthwatchhavering.co.uk

Website: www.healthwatchhavering.co.uk