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Hospital Catering and Patient Nutrition Follow-up Review

Hywel Dda University Health Board

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Status of report

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Summary report

Background

1. Hospital catering services are an essential part of patient care given that good-quality, nutritious meals play a vital part in patients' rehabilitation and recovery. Effective catering services are dependent on sound planning and co-ordination of a range of processes involving menu planning, procurement, food production and distribution of meals to wards and patients. Good communication is also required across the range of staff groups involved, including managers, catering staff, dieticians, nurses, support staff and porters.

2. Patients' nutritional status needs to be properly assessed and monitored, and arrangements put in place to help patients enjoy their meals in an environment conducive to eating. The desired outcome should be a flexible, cost-effective catering service that provides a good choice of nutritious meals that can accommodate patients' specific dietary requirements.

3. In 2010, we undertook local hospital catering and patient nutrition audits across Wales, to follow up work previously carried out by the Audit Commission in 2002[1]. In March 2011, the Auditor General published a report[2], which summarised the findings from this work. The Auditor General's report concluded that catering arrangements and nutritional care provided to patients had generally improved and that patient satisfaction remained high. However, more needed to be done to ensure recognised good practice was more widely implemented, particularly in relation to nutritional screening and care planning, and to ensure that food wastage was minimised. In 2012, we undertook a follow-up audit at Hywel Dda University Health Board (the Health Board), and reported on the progress made in relation to the local recommendations we made in 2010.

4. In autumn 2011, the Welsh Government published the All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients. These standards supersede the 2002 nutrition and catering framework and provide technical guidance for staff responsible for meeting the nutritional needs of patients[3]. The standards also specify the nutrient content needed to provide for the diverse needs of the hospital population. NHS bodies were required to be fully compliant with the standards by April 2013.

5. To support the implementation of the standards, caterers and dieticians across Wales worked together to produce the All Wales Hospital Menu Framework, which was launched at the end of January 2013. The Framework consists of a database of an agreed set of menu items, a standardised set of recipes and cooking methods, nutritional analysis of each menu item and a range of snacks that are compliant with the standards and procured through all-Wales contracts.

[1] Audit Commission in Wales, **Acute Hospital Portfolio – A review of national findings on catering**, March 2002.

[2] Wales Audit Office, Hospital Catering and Patient Nutrition, March 2011.

[3] The nutrition and catering standards are aimed at meeting the nutritional needs of patients who are capable of eating and drinking. Patients receiving parenteral or enteral nutrition, that is nutrients delivered intravenously or directly into the gastro-intestinal system, are not covered by these standards.

6. The Public Accounts Committee has maintained a keen interest in the issues highlighted by the Auditor General's work, taking evidence from witnesses and publishing its own report in February 2012[4]. In 2014, the Auditor General gave a commitment to the Public Accounts Committee that he would undertake appropriate follow-up work to monitor how NHS bodies have taken forward his national and local recommendations. This commitment included taking account of the findings of any subsequent follow-ups undertaken in NHS bodies since 2010.

Our main findings

7. Between March and June 2015, we undertook follow-up work at the Health Board to assess the extent to which it had implemented the Auditor General's national recommendations[5]. We also assessed the extent to which the Health Board had addressed the recommendations made as part of the local audit in 2010 and again in 2012.

8. We concluded that the Health Board has made improvements to catering and nutrition although the pace of change has been slow in some areas. There is scope to further improve aspects of the mealtime experience, strategy implementation, monitoring of the pathway and Board reporting. We reached this conclusion because:

- Arrangements for assessing and meeting patients' dietary and nutritional needs are improving slowly and there is no mechanism for regular monitoring of the full nutritional care pathway:
  - nutritional screening rates vary and are much lower at Withybush although oral health assessment has improved significantly;
  - a comprehensive assessment of the nutritional care pathway took place in 2013-14 but has not been repeated;
  - compliance with standards for patient snacks, hot beverages and water replenishment is limited by a lack of financial and staffing resources;
  - menu items are nutritionally assessed through the All Wales Menu Framework with which the Health Board is largely compliant; and
  - written information for patients on what to expect in relation to food and snacks is limited.
- An appropriate range of menu choices is available to patients although there is scope to improve aspects of the mealtime experience:
  - an appropriate range of menu choices is available to patients although procedures to help patients choose are inconsistent;
  - levels of nursing support and supervision at mealtimes vary; and
  - further improvements are needed to embed protected mealtimes.

[4] National Assembly for Wales, **Hospital Catering and Patient Nutrition**, February 2012.
[5] Our audit approach is set out in Appendix 1. The scope of the audit work relates specifically to adult inpatients capable of eating and drinking normally.

- Patient catering costs are reducing and there has been some progress towards managing food waste consistently although income from non-patient catering services is insufficient to cover the cost:
  - patient catering costs are reducing although costs per patient meal are more than the Wales average;
  - there has been some progress towards a whole system approach to managing food waste although more needs to be done; and
  - non-patient catering services still run at a loss but the gap between income and cost is reducing.
- The implementation of nutrition and hydration strategy is impeded by a lack of operational infrastructure and there is little Board reporting on nutrition and catering:
  - lines of accountability for nutrition and catering are clear but the operational infrastructure through which to implement strategic actions lacks clarity;
  - there is little reporting to the Board on nutrition and catering; and
  - there are effective mechanisms in place to capture and act upon patient feedback.

9. Detailed findings from the audit work are summarised in the main body of this report.

Recommendations

10. The Health Board has fully achieved 24 of the 45 recommendations previously set out in our national and local reports and is on track against 18 others. The Health Board needs to maintain focus on implementing the remaining recommendations where progress is reported to be on track but is not yet completed, or where we consider insufficient or no progress has been made. The key issues identified in 2015 are summarised in Exhibit 1 together with the references to the relevant recommendations. A full list of the national and local recommendations, along with the status of each is set out in Appendix 2.

Exhibit 1: Local, national and follow-up recommendations still to be achieved at July 2015

Recommendation	Key issues in 2015
Ensuring patients' nutritional needs are met	
2010 R11	Improve nutrition-related information recorded in the nursing notes for patients.
2011 R1b	Ensure nutritional screening effectively identifies all patients who have nutritional problems, or are at risk of developing them, and that appropriate care plans and monitoring activities are instigated.
2011 R1c	Regularly audit compliance with all aspects of the nutritional care pathway across all their hospital sites and share the results of these monitoring exercises with all the relevant staff groups involved in catering and patient nutrition services.
2011 R1d	Establish the reasons for poor compliance with nutritional care pathway requirements and implement clear plans of action to address the problem and include provision of necessary training to staff.
2011 R1e	Ensure that patients have access to food 24 hours a day including the provision of snacks.
2012 R4	Ensure the effective provision and monitoring of staff training on nutrition and hydration, particularly the national e.learning programme.
Improving patients' mealtime experience	
2010 R7, 2011 R3c	Ensure that the importance of protected mealtimes continues to be communicated and that compliance with the policy is regularly reviewed.
2010 R8, 2011 R3b	Ensure that patients are given the opportunity to wash their hands before meals are served.
2010 R9	Ensure appropriate nutrition into the training programme for ward-based catering staff to improve their awareness of its importance and the need to follow ward procedures.
Controlling the costs of the catering service	
2010 R4, 2011 R7a, 2012 R2	Ensure that there is a clear plan to reduce further and eliminate, as far as possible, the subsidy on non-patient catering services.
2011 R4b	Introduce computerised catering information systems, and ensure in the meantime that there is timely good-quality information for planning and delivery decisions.
R011 R5b	Continue to work towards full compliance with the All Wales Menu Framework at the time of our fieldwork and consider the use of a budget/allowance per patient to prevent cost variations between sites and patient groups.

Recommendation	Key issues in 2015
Effective service planning and monitoring	
2010 R1	Strengthen planning arrangements for catering to ensure a clear and consistent agenda for the catering service across the Health Board.
2010 R3	Improve the Board scrutiny arrangements for monitoring catering and nutrition risks and performance
2011 R8b	Ensure that business plans can be progressed to standardise catering and nutritional services.
2011 R10a	Ensure that the Board receives EFPMS and other performance data regarding catering services and patient nutrition.
2011 R10b	Systematically collate the information from nutritional screening so that the wider organisation can understand the scale of the problem and its likely impact on catering and nutrition services in order to meet patients' needs.

Detailed report

Arrangements for assessing and meeting patients' dietary and nutritional needs are improving slowly and there is no mechanism for regular monitoring of the full nutritional care pathway

11. In 2010, many hospitals in Wales had improved their arrangements to ensure patients' nutritional needs were met but information was fragmented and did not allow for a quick overview of patients' nutritional problems or for reviewing nutritional status easily. The lack of standardised nursing documentation to record key assessment information may have contributed to the variation in the quality of the nursing records. Not all NHS bodies regularly monitored compliance with the nutritional care pathway.

12. At the Health Board in 2010, we found that not all patients received nutritional screening within 24 hours of admission. Information associated with nutritional assessment and needs was recorded in separate documents while there was little information on patients' oral health needs. In addition, there were substantial differences in the format of documentation in use across the Health Board.

Nutritional screening rates vary and are much lower at Withybush although oral health assessment has improved significantly

13. As part of our 2015 work, we reviewed five sets of case notes on each of the four wards that we visited as part of the audit, 20 case notes in total. We assessed whether nursing staff screened patients on admission using a validated nutritional assessment tool and repeated the process at least weekly, as well as assessing the quality of the nutritional screening process. We looked specifically for information that we would expect to see as part of the admission and screening process such as weight, recent unintentional weight loss, current appetite, 'normal' dietary intake, special dietary requirements, the ability to eat independently, difficulties eating or drinking and problems with oral health and hygiene, including dentition. The Health Board's Adult Nutritional Screening Tool (ANST) uses a different approach to the Malnutrition Universal Screening Tool (MUST) and does not include measures of height or body mass index (BMI).

14. The Health Board has used the ANST since 2010. The Welsh Government accepts the use of locally developed nutritional screening tools if they can be demonstrated to be at least as valid as the MUST. In August 2014, the Clinical Effectiveness and Audit Committee received the results of clinical audit work commissioned by the Nutrition and Hydration Steering Group[6] (NHSG), which provided some assurance regarding the validity of the local ANST. However, the Health Board recognises that progress in

[6] After the period of our fieldwork, the Nutrition and Hydration Steering Group was re-named the Nutrition and Hydration Task Group, and the terms of reference were revised.

fully validating the local ANST has been slow and is considering funding Swansea University to carry out further validation work.

15. All 20 patients included in our case note review had been screened on admission using the ANST and weighed. A nutritional risk score was not calculated for four of the 20 patients, although two of these four had arrived on the ward less than 24 hours previously. Seven patients had been in hospital for the relevant period following which there would be a repeat nutritional assessment, and all of these had been reassessed. However, in one of these, a reassessment was missed at one particular interval. The Health Board's own nutritional care pathway audit in 2013-14 (see below) found a lower proportion (70 per cent) of patients were nutritionally screened within 24 hours of admission but a higher proportion (77 per cent) had been rescreened.

16. Completion of functional assessments as part of the nutritional screening process were carried out consistently, although documentation does not readily lend itself to distinguishing between a patient's cognitive and physical ability to eat and drink, and the extent of their mobility to sit up unaided to do so.

17. The All Wales Nutrition and Catering Standards make it clear that oral health and communication are part of nutritional care. Our latest case note review found notable improvements in the assessment of oral health compared with our findings in 2010. Of the 20 patient case notes reviewed, 19 included an assessment of oral health, which is also better than the findings from the Health Board's 2014 Fundamentals of Care audit that found 69 per cent of patients (on 75 participating wards) had received an oral health assessment. The previous year only 36 per cent of patients had documentary evidence of an oral health assessment.

18. Nutritional screening indicated that 12 of the 20 patients required a nutrition care plan. However, only 10 care plans were in place. Eleven of these patients had been referred to a dietician, but one had not. For patients identified as at high risk, nutrition and hydration charts were used consistently but there were some gaps in entries and signatures. The 2014 Fundamentals of Care audit also found gaps in signatures on food and fluid charts. In some cases, patients' food and fluid intake was monitored based on the professional judgement of nursing staff, when the ANST had not indicated monitoring intake was necessary.

19. None of the patient case notes that we reviewed contained information about patient's dietary preferences and requirements or usual dietary intake. Staff told us this information was shared during the handover process. This issue was highlighted as being an area of poor compliance in the Health Board's own audit of the nutritional care pathway in 2013-14 (see below).

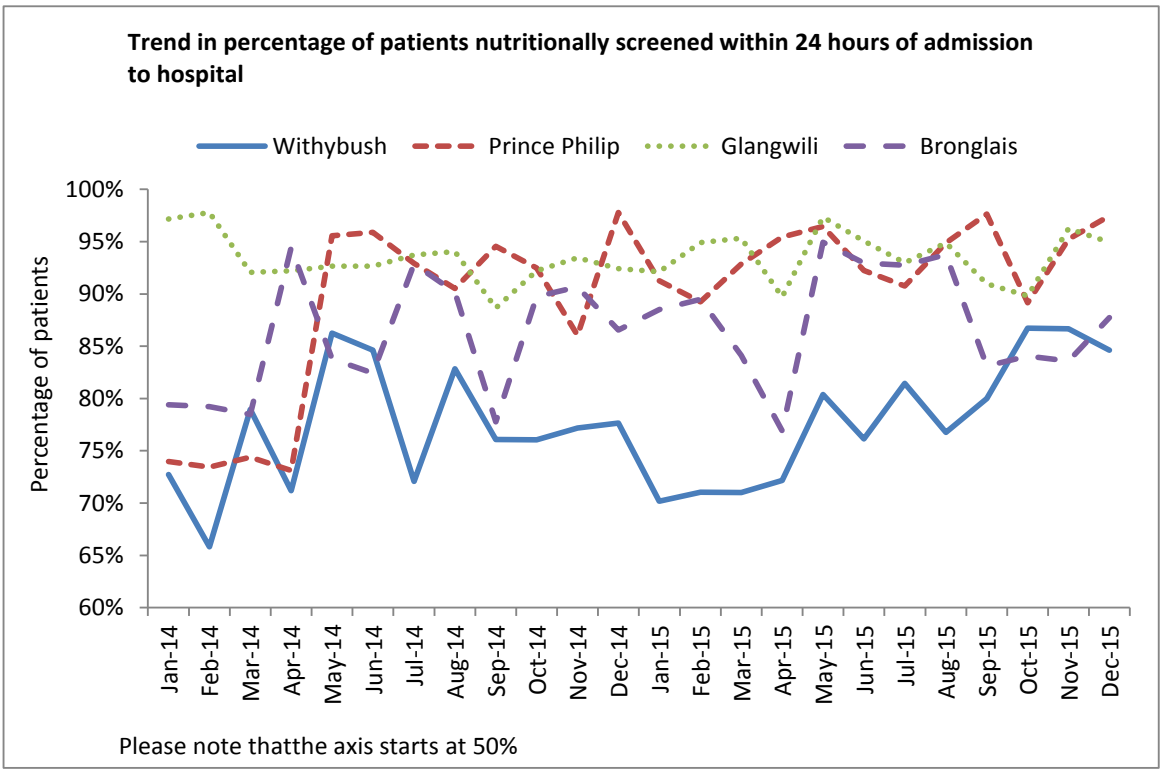
20. Nutritional assessment within 24 hours of admission is one of three mandatory metrics on the all-Wales nursing and midwifery dashboard. Compliance with nutritional screening is monitored monthly and performance presented in the Nursing Performance Monitoring Report. Exhibit 2 shows that compliance with nutritional screening has varied considerably between hospitals. The data suggests that in the second part of 2015, compliance improved at Withybush but levelled off towards the end of the year and, despite promising signs of improvement at Bronglais, performance once again deterioriated. There is no clear indication from recent NHSG

meeting minutes as to how this poor compliance is being addressed. The Health Board indicated that compliance data are reviewed monthly by the Director of Nursing and clinical areas called to account for any poor performance.

21. The annual Fundamentals of Care audit requires each ward, and the Health Board as a whole, to develop an action plan in response to its findings. These are monitored through the operational nursing structures, and reported to the NHSG.

22. Since our audit fieldwork, the Health Board has begun piloting Care Indicator Scrutiny and Improvement groups. These groups are comprised of a lead nurse and ward sisters at each site. The groups will be locally accountable for the detailed review of compliance with care indicators, including nutritional screening and record keeping standards (such as the appropriate use of care plans).

Exhibit 2: Compliance with nutritional screening is consistently poorer at Withybush



Source: Hywel Dda University Health Board Fundamentals of Care Findings

A comprehensive assessment of the nutritional care pathway took place in 2013-14 but has not been repeated

23. In 2010, not all NHS bodies monitored compliance with the nutritional care pathway and we recommended that the Health Board establish arrangements to assess compliance. In 2012, we found that routine monthly audits of patient records had recently been established, to enable compliance reporting on various aspects of content, including nutrition-related content.

24. In 2013-14, the NHSG commissioned a multi-disciplinary audit of the full hospital nutritional care pathway audit across the Health Board. The audit evaluated compliance with the protocol underpinning the All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients. The subsequent report covered a number of themes:

- Meal Delivery
- Beverages
- Meal Clearing And Food Waste
- Oral Nutritional Supplements
- Level Of Nutritional Risk
- Ordering Of Meals
- Catering Provision
- Snacks

25. Amongst a range of issues to be identified, the audit found the following: poor completion of the ANST; little recording of patient needs and preferences; provision of beverages not compliant with the standards; portions not matching what had been requested in menu order (where meals were plated in the kitchen); and poor co-ordination and communication during protected mealtimes. The report recommended updating the Health Board's Nutrition Action Plan accordingly. It also recommended repeating the audit for all, or part of, the pathway but there is no evidence from our work that the audit was repeated. While some aspects of the nutritional care pathway are audited twice annually using the Fundamentals of Care audit tool, it does not cover all of the nutritional care pathway or all of the issues highlighted by the NHSG nutritional care pathway audit.

26. The Health Board recognises that it is not compliant with the All Wales Nutrition and Catering Standards. Its audit work and observations show that some clinical areas find it challenging to deliver consistently a robust pathway of nutritional care. These areas are the target of support from dieticians and clinical nurse specialists (for nutrition), training, and other initiatives. Senior staff told us that there is an ongoing focus on this agenda so that it remains a high priority at ward level. Ward teams are required to carry out nutritional improvement work to embed in practice.

27. In 2010, there were no regular training programmes, or refresher training events, for ward staff to maintain awareness on using the ANST and assessment documentation. The Welsh Government introduced an e.learning package in the use of the all Wales nutrition care pathway and all-Wales food and fluid charts in September 2011. All ward-based nursing staff were required to complete the e.learning within 12 months of this date while new staff should complete it within 12 months of appointment.

28. The NHSG monitors staff uptake of the e.learning package. Senior nursing staff told us that the intention behind the e.learning is good and that the quality of the content is high. However, they also indicated that content of the training needs to be updated to reflect recent changes to the size of water jugs and beakers. The Health Board has indicated that it is difficult to evaluate the number of staff who have completed the e.learning modules on nutritional screening and on food and fluid charts, since the

modules were placed on a new web platform in July 2014. This makes it difficult to monitor the numbers of staff still to be trained, and to report on overall compliance.

29. The Health Board provides a range of other types of training in relation to nutritional care. The NHSG commissioned a review by dieticians of all nutrition training in order to identify gaps, issues around accessibility and to standardise and accredit the training. Training on adult nutritional care for acute, community and diabetes staff has been fully mapped, while further mapping is needed of the training received by hotel, catering and facilities staff, health promotion staff, mental health staff and paediatric staff.

30. Findings from the mapping exercise to date have been reported to the NHSG and provide the basis for further action. Each type of training is listed against each of the care areas above, and is categorised using a traffic-light system. The findings also show that while training is delivered on a regular basis in a number of areas, there are a range of areas categorised as orange and red where there is a training deficit.

Compliance with standards for patient snacks, hot beverages and water replenishment is limited by a lack of financial and staffing resources

31. In 2010, we found that most hospitals had arrangements in place to provide snacks but many patients indicated that snacks were unavailable between meals. The All Wales Nutrition and Catering Standards indicated that snacks should be offered two to three times a day with evening snacks offered to all patients because of the long gap between the evening meal and breakfast.

32. During 2011, the Health Board began to implement its policy 'Guidelines and operational system to ensure the provision of access to nutritionally balanced foods across 24 hours for all inpatients'. Implementation was through each of the county nutrition groups, supported by the Menu Planning Sub Group (MPG), with reporting to the NHSG. The policy document provides guidance regarding availability of food for all inpatients 24 hours a day, and defines the processes that staff should follow to access food for patients outside of core catering service hours. The policy implementation plan recognised that there would be food cost implications associated with the level of uptake out of hours.

33. In the 2013 All Wales Patient Menu Survey, 45 per cent of Health Board patients who responded said that they had not been offered a snack after their evening meal and before 10 pm. The all-Wales average was 35 per cent. The Health Board's 2013-14 nutritional care pathway audit found that 28 per cent of patients required snacks as part of their nutritional care but only a small proportion of these patients (five per cent) had been offered snacks. The audit suggested 'training to ensure staff screen, act on, and care plan to address nutritional risk and focus on the 'Food First' approach to optimising nutrition care'. There has been no audit relating to the provision of snacks since.

34. The Quality and Safety Committee's 2013-14 annual report recognised that the lack of availability of snacks for patients was a key challenge and that a significant part of the challenge was the increasing cost associated with wide-scale enhancement of food

provision and that to effectively implement 'Food First', nutritional care required adequate resources. It suggested that work on minimising food waste might support improved availability of snacks if the efficiencies from reducing waste could be ring fenced for reinvestment in meeting the All Wales Nutrition and Catering Standards.

35. The Health Board's 2014 Fundamentals of Care report seems to show improvement with 93 per cent of patients reporting that they were always or usually provided with nutritious food and snacks. The report also indicated that all staff audited responded positively that a range of snacks was available for patients who had missed a meal or who were hungry between meals. Nonetheless, during our latest audit work staff told us that snacks were not available everywhere and funding for snacks was an ongoing challenge.

36. During 2015, the use of ambient snack boxes on ward beverage trolleys was piloted at Prince Philip Hospital. This work helped to demonstrate what typical snack uptake might be and enabled testing of a process to deliver snacks to patients. Also during 2015, the 'Nutrition and Hydration Week' clearly emphasised the importance of 'Food First' particularly through the availability of snacks between meals, especially for patients at risk of malnutrition or with a poor appetite.

37. The standards for patient food and fluid identify that seven to eight hot and cold beverage rounds should take place each day and that water in jugs should be changed three times a day. Non-compliance is an ongoing issue for the Health Board and staff told us that this is largely because of insufficient staffing levels. The Director of Nursing Sub-Committee Exception Report presented to the NHSG in August 2014, referred to recent 'Trusted to Care' follow-up spot check visits which found that almost all in-patient areas were non-compliant with these standards. The report also indicated that the introduction of new NHS patient water jugs holding a smaller volume of fluid could exacerbate hydration problems further.

38. The Health Board's 2014 Fundamentals of Care audit findings show that 73 per cent of wards changed water jugs three times a day and that 57 per cent of wards carried out a minimum of seven beverage rounds.

39. The Health Board's non-compliance with water-jug changes, beverage rounds and snacks is identified and reported to the Quality and Safety Committee on the corporate nursing risk register. An update from the January 2015 Nutrition and Hydration Steering Group to the February Quality and Safety Committee states that it is a matter of concern that the all-Wales standards in relation to numbers of beverage rounds and water-jug replenishment will still not be complied with in most acute service areas. Further work between Heads of Nursing and Catering was agreed as urgent at the meeting with an update to be provided to the September Quality and Safety Committee. However, during our recent work, staff told us that compliance with these standards remains a concern and to the end of October, the Quality and Safety Committee (now the Quality, Safety and Experience Assurance Committee) had not received an update.

Menu items are nutritionally assessed through the All Wales Menu Framework with which the Health Board is largely compliant

40. In 2010, we found that there was assessment and validation of all menus by dieticians and other clinicians. However, staff commented that processes for menu development and change took much longer than they would like. Since then, the Welsh Government has published the All Wales Nutrition and Catering Standards, which specify the 12 minimum nutrients for analysis.

41. The Health Board operates a two-week cycle standard menu framework at each of its district general hospitals. The majority of the recipes used are from the All Wales Menu Framework (AWMF). Where local recipes are used, these are analysed in-house to ensure that they meet the All Wales Nutrition and Catering Standards.

42. Health Board staff actively participated in the development of the AWMF through the AWMF Group, and the head chef at Bronglais Hospital was involved in developing and piloting recipes. Staff continue to engage in discussions about compliance with the AWMF, and implementation and compliance reporting of the All Wales Nutrition and Catering Standards.

Written information for patients on what to expect in relation to food and snacks is limited

43. The 2011 All Wales Nutrition and Catering Standards make it clear that information should be provided to patients and their carers on what to expect in relation to meals and snacks while in hospital. In 2012, the Chief Medical Officer and Chief Nursing Officer for Wales issued a joint letter in relation to hospital catering and food provisions asking NHS bodies to provide patients with the information set out in the Auditor General's leaflet **Eating Well in Hospital – What You Should Expect**.

44. On sites where plated meals are provided from the kitchen (Bronglais Hospital and Withybush Hospital), patients receive a menu to choose their meals from and there are specific menus for patients requiring therapeutic diets. However, ward staff told us that patients do not always receive information about how their nutritional or dietary needs or preferences will be met and staff were not always familiar with the **Eating Well in Hospital** leaflet. Some catering information was in place on notice boards in some wards, but this varied from ward to ward.

An appropriate range of menu choices is available to patients although there is scope to improve aspects of the mealtime experience

45. In 2010, most hospitals provided an appropriate choice of meals and patients were generally satisfied with the food they received. However, not all patients got the help they needed at mealtimes and more could be done to embed protected mealtime principles on some wards. At the Health Board, catering services generally provided adequate choice and responded effectively to meeting individual needs with patients helped at mealtimes. However, there were variations in how protected mealtime principles were applied.

46. Our follow-up work in 2012 found that the Health Board was ensuring protected meal times operated fully. Family and carer feedback also led to the Health Board revising protected mealtime notices at ward entrances to encourage families to support patients at mealtimes. Previous notices were seen as unintentionally discouraging this type of support. Furthermore, the Health Board had introduced a schedule of audits using the Royal College of Nursing protected mealtime observation tool with findings used to drive improvement.

An appropriate range of menu choices is available to patients although procedures to help patients choose are inconsistent

47. As mentioned above, the Health Board operates a two-week menu cycle. Systems for patient menu ordering vary. At Withybush and Bronglais, patients choose from a menu form, which is returned with their food tray when meals arrive from the kitchen. At Prince Philip and Glangwili, patients choose their meal on the same day from a list which is read out to them by staff. Although a choice of portion size is available at each hospital, the bulk food service at Prince Philip and Glangwili allows for greater flexibility in terms of the portion size and the choice of vegetables which are served with the meal.

48. Menus for patients with special and therapeutic diets are also available. Texture modified meals for patients with swallowing difficulties have been adapted to ensure compliance with texture and nutrition standards (see paragraph 82).

49. The NHSG reviews patients' menus. At the time of our fieldwork, the All Wales menu framework group had conducted a questionnaire survey of inpatients across all NHS bodies about the choice and quality of food. While an analysis of the findings was expected later in 2015, it was not available to us at the time of our work.

Levels of nursing support and supervision at mealtimes vary

50. We observed the lunchtime meal service on four wards – one ward at each of the four district general hospitals (Glangwili, Withybush, Prince Philip and Bronglais). In general, we found that support with eating for patients was variable across and within wards. A designated lead on each patient bay of Ward 9, Prince Philip (rehabilitation ward) assists patients at mealtimes and we observed that this particular arrangement worked very well. However, there were some instances where patients had to wait to receive support. On Meurig Ward at Bronglais, qualified nurses were carrying out non-mealtime activities and not focussing sufficiently on the protected mealtime process.

51. The Health Board has introduced the red tray system across acute and community hospitals to act as visual prompt for staff to indicate the patient is at nutritional risk and may require support to eat or to monitor food intake.

52. Exhibit 3 sets out the differences we observed between mealtime practices across the four wards. Our observations are based on the activities that we expected staff to undertake and whether these actions applied to all patients, most, some or none.

Exhibit 3: Key actions observed as part of the lunchtime service

Observations of the lunchtime service	**Bronglais**	**Withybush**	**Glangwili**	**Prince Philip**
Ward	**Meurig**	**1**	**CDU**	**9**
Patients helped to prepare for mealtimes, including using the toilet, washing hands and sitting up or getting out of bed	All	Some	Some	All
Bedside areas/tables tidied before meals served	All	None	All	All
Bedside areas/tables cleared of clinical waste before the meal service	All	Some	All	All
Staff providing food service wear protective clothing	All	All	All	All
Temperatures of meals are recorded before service begins[1]	All	All	All	All
Nursing staff accompany ward-based catering/hotel staff during the service	None	All	All	All
Patients needing help with eating are easily identified	All	All	All	All
Meals are left within reach of patients	All	All	Most	All
Help is given to cut up food or to remove packaging	Some	Some	Some	All

Observations of the lunchtime service	Bronglais	Withybush	Glangwili	Prince Philip
Ward	**Meurig**	**1**	**CDU**	**9**
Patients needing help receive it promptly	Some	All	Some	All
Nursing staff supervise and encourage patients with eating throughout mealtimes	Some	All	All	All

Source: Wales Audit Office observations of lunchtime services

53. The Health Board's nutritional care pathway audit, 2013-14, found that nursing staff were focussed on the protected mealtime service in only 17 per cent of instances. Patients were offered the opportunity for hand hygiene prior to the protected mealtime in only 25 per cent of instances.

54. The 2014 Fundamentals of Care audit found that nearly all (99 per cent) wards had systems in place to allow family or friends to assist with meal times. On the four wards that we visited, nursing staff told us that they actively welcome and encourage family and friends to help patients at mealtimes. During our ward visits, we observed families helping their relatives with eating.

Further improvements are needed to embed protected mealtimes

55. There is a protected mealtime policy in place and the NHSG has a programme of work to ensure that protected mealtime principles are embedded across wards. Internal reviews have identified areas where practice can improve. The Health Board's nutritional care pathway audit identified that various aspects of protected mealtimes needed improvement (Exhibit 4).

Exhibit 4: Health Board nutritional care pathway audit suggests the need for improvement in a number of areas

	Yes	No	Unknown / N/A
	%	%	%
Was the mealtime protected?	58	42	0
Is there a protected mealtime post at the ward entrance?	50	33	17
Is there ward level co-ordination of the protected mealtime?	25	58	17
Are nursing staff focussed on the protected mealtime service?	17	58	25

Source: Hywel Dda University Health Board nutritional pathway audit, 2013/14

56. Our observation of lunchtime services found that there were variable levels of focus on protected mealtime arrangements at ward level. Ward managers we spoke to were confident that protected mealtimes work well with professional colleagues generally supportive of the principles. However, there was also recognition that it is more difficult to apply protected mealtime principles on some wards because of the clinical needs of patients. For example on Ward 1 at Withybush Hospital, nursing staff needed to transfer patients to the operating theatre during the lunch service.

57. In particular, we found that:

- signage at ward entrances explained the times and purpose of protected mealtimes but varied in content and prominence;
- cleaning activities were generally completed prior to the meal service and where these activities did continue it was generally in areas away from patients' bedsides; however, on Meurig Ward at Bronglais, cleaners were clearing waste bags from patient areas before the meal service was completed;
- instances where the food waste collection trolley was taken into ward bays before all patients had finished eating, potentially signalling the end of the mealtime and discouraging patients from finishing their food;
- one instance on Ward 9 at Prince Philip, where left over food was scraped from plates into a bin immediately in front of patients, one of whom had not finished eating; and
- routine medical and medicine rounds stopped at the start of the meal service and healthcare professional staff for the most part left patient areas and if they remained, interactions with patients and nursing staff were minimised; however, five doctors were carrying out various tasks on Ward 1 at Withybush, during the mealtime including the review of patients and talking to nursing staff.

Patient catering costs are reducing and there has been some progress towards managing food waste consistently although income from non-patient catering services is insufficient to cover the cost

58. In 2010, financial information on catering services was typically poor and where it existed, it showed significant variations in costs within and between NHS organisations. Few hospitals generated enough income to recover all the costs of providing non-patient catering services and few NHS bodies had an agreed policy on subsidy. The Auditor General recommended that a clear model for costing patient and non-patient catering services should be developed. NHS bodies in Wales jointly agreed in 2012 to implement a new costed model for catering services as part of the Estates and Facilities Performance Management System (EFPMS) supported by revised data definitions. Little progress had been made in computerising hospital catering systems and most of the current catering information management systems relied on manual paper processes.

59. At the same time, NHS bodies were adopting measures to control the costs of catering services. There was scope, however, to make more use of standard costed recipes, agreeing food and beverage allowances for patients, standardising local catering contracts and reducing levels of food waste, which was unacceptably high. The Auditor General recommended that NHS organisations should aim to ensure that wastage did not exceed 10 per cent. The Welsh Government subsequently set a 10 per cent food waste target for un-served meals for achievement by the end of 2012-13.

Patient catering costs are reducing although costs per patient meal are more than the Wales average

60. In 2010, the Health Board's food production and cost control systems varied across each hospital with different ways of constructing the ledgers. Cost comparisons were difficult because the definitions used to monitor and record costs differed. By 2012, the Health Board was standardising food production and cost control systems and changing the way in which it compiled the ledgers enabling better benchmarking across hospitals.

61. The Health Board's EFPMS data submissions show small fluctuations in the cost of patient catering services with costs increasing by 1.5 per cent from £4.2 million in 2011-12 to £4.23 million in 2103-14 (Exhibit 5). Across Wales, these costs reduced by five per cent. Meanwhile at the Health Board, the number of patient meals requested reduced by 1.2 per cent (or 14,300 meals) over the same time compared with a four per cent reduction across Wales.

Exhibit 5: Patient catering service costs are reducing

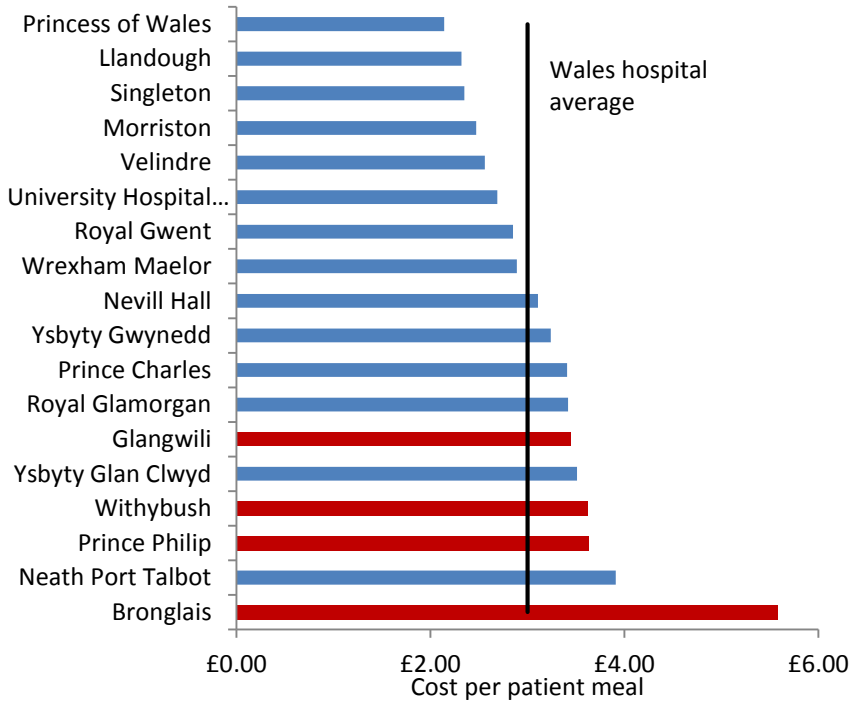
Year	Cost of catering services (£ million)	
	Hywel Dda	Wales
2011-12	4.20	38.95
2012-13	4.17	37.26
2013-14	4.23	36.97

Source: Wales Audit Office analysis of NHS Estates in Wales Facilities Performance Report 2012-13 and the 2013-14 supplementary data

62. The Health Board's 2013-14 EFPMS data show that the cost per patient meal across all its hospitals was £3.70 having increased from £3.60 in 2011-12. During this period, catering services absorbed the costs associated with introducing the All Wales Menu Framework, including the cost of moving from packet soups to homemade soups, and implementing hot desserts at suppertime. Across Wales, the cost per patient meal was £3.29 in 2013-14 with costs ranging from £2.56 at Velindre to £6.23 at Powys.

63. Exhibit 6 shows that costs per patient meal at the Health Board's four district general hospitals were greater than the Wales hospital average (£3.00). Bronglais Hospital had the highest cost in Wales and was almost double the Wales hospital average.

Exhibit 6: Costs per patient meal are above the hospital average with costs at Bronglais nearly double the hospital average and the highest in Wales



Source: NHS Estates in Wales Facilities Performance supplementary data 2013-14

64. In 2010, the Health Board's food production arrangements relied heavily on manual paper systems rather than an IT solution. In his national report, the Auditor General recommended that NHS bodies should introduce computerised catering information systems. The Health Board still relies on the paper-based systems.

65. The NHS Wales Informatics Service and NHS Shared Services Partnership have developed an outline business case to procure a national catering IT solution but progress has been slow. Our latest audit found that NHS bodies, including the Health Board, had commented on the outline business case. The Health Board is awaiting a decision but in the meantime, it will need to ensure it has timely good quality information for planning and delivery decisions.

66. To support the implementation of the 2011 nutrition and catering standards, the All Wales Hospital Menu Framework (AWMF) was launched in January 2013. Recipes within the menu framework are costed. All health boards jointly funded the appointment of a procurement dietician working in the NHS Shared Services Partnership – Procurement Service to support the development of all-Wales procurement contracts to source provisions commodities for the dishes on the menu framework. The Nutrition and Hydration Group members have been actively involved with the AWMF group and with the All Wales Nutrition Co-ordinators Group, helping to ensure that nutrition work in the Health Board informs, and is informed by, national developments.

There has been some progress towards a whole system approach to managing food waste although more needs to be done

67. In 2010, the Health Board had systems in place to monitor waste with wastage exceeding 10 per cent. By the time of our follow-up work in 2012, the Health Board had introduced regular audits of un-served food waste with the MPG targeting wards with the highest levels of waste in order to establish the reasons and to address them. In addition, improvements were being made to meal ordering processes to reduce waste.

68. In June 2014, the NHSG accepted a series of recommendations put forward in an SBAR[7] paper relating to the need to reduce food waste. The paper recognised that while the issue had been on the agenda of the Menu Planning Group (MPG) for some time, a more robust, consistent and whole system approach was needed to manage food waste. The recommendations included:

- establishing executive approval to work in partnership with the Waste Resources Action Programme (WRAP) to reduce waste;
- agreement and implementation of a consistent audit and monitoring methodology for unserved patient meal waste and plate waste across the Health Board;

[7] Situation, Background, Assessment, Recommendation

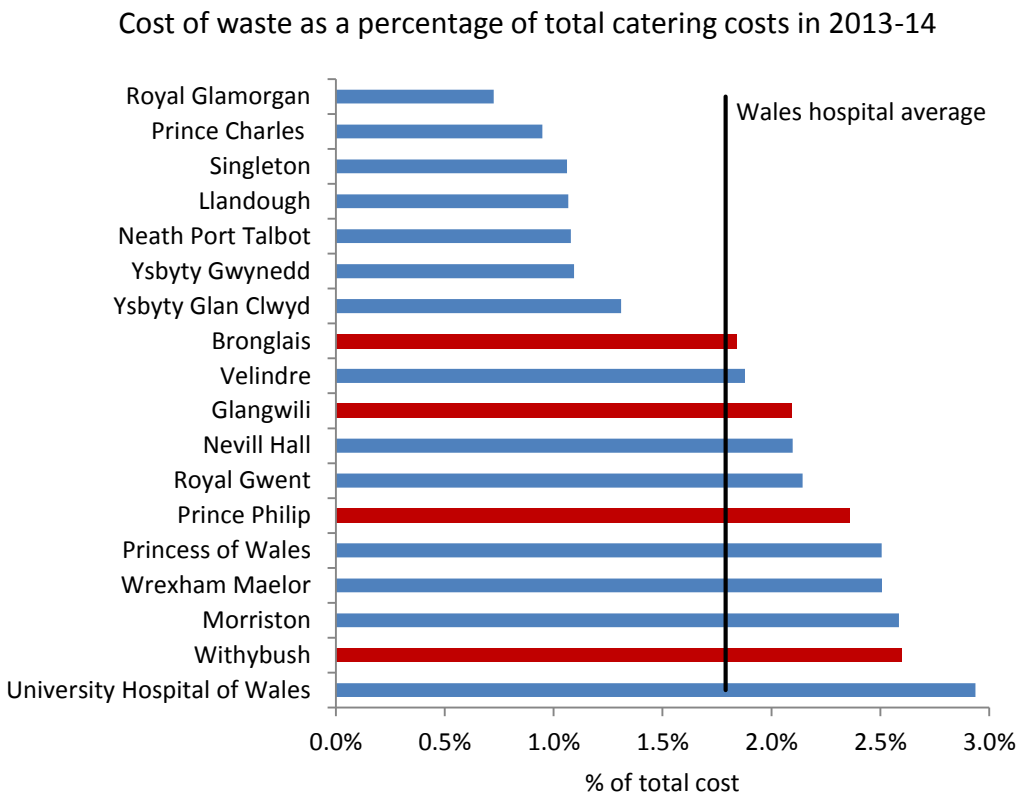
- reporting and scrutiny of food waste levels at every County Nutrition Group meeting, as an ongoing agenda item;
- presentation of county reports on food waste at the MPG for cross-county scrutiny, with formal quarterly reporting to the NHSG;
- setting of targets to reduce waste incrementally over a three-year period (to commence following receipt of the SBAR);
- development and implementation of a consistent approach to calculating non-patient food waste by catering leads in each county; and
- comprehensive promotion of waste reduction initiatives.

69. By the time of our latest audit, work with the WRAP has been given executive approval, and initial discussions between the Health Board and WRAP had taken place. There has also been some movement towards a whole-system approach to reduce waste, although more work was needed. In 2014, the county catering leads implemented a new standard operating procedure to measure and monitor un-served food waste consistently while continuing to target ward areas where wastage is too high. However, the MPG noted that none of the county nutrition groups reported food waste levels and the Health Board indicated that reporting was now taking place.

70. A food waste audit was carried out at Bronglais Hospital, covering a three-week period during August and September 2014. The audit measured both un-served and plate waste using the weights of waste buckets. This provided a practical approach to the task. During this audit the total waste recorded was up to 39.8 per cent. Since the audit, the focus on waste has supported a reduction to under 10 per cent of un-served food waste.

71. Analysis of the 2013-14 EFPMS data shows that the cost of un-served meals was £110,400 for the Health Board's four district general hospitals. This equates to 2.2 per cent of total catering costs, which was at or above the hospital average in Wales (1.8 per cent) with Withybush having the second highest proportion (2.6) overall (Exhibit 7).

Exhibit 7: The cost of waste as a percentage of total catering costs is greater than the Wales hospital average at the Health Board's district general hospitals



Source: NHS Estates in Wales Facilities Performance supplementary data 2013-14

Non-patient catering services still run at a loss but the gap between income and cost is reducing

72. In 2010, the Health Board did not have a subsidy policy for non-patient catering services but there was an expectation that services should break even. Its restaurant services were running at a loss of £551,000. At that time, we recommended that the Health Board should introduce a clear policy on subsidy to set the framework for delivering non-patient catering services. By the time of our follow-up audit in 2012, the Health Board was taking action to reduce the subsidy, particularly at hospitals where the level of subsidy was very high.

73. Our latest audit work found that the Health Board operates a single price tariff for all non-patient catering services to reduce the subsidy. Although there is still no formal policy in place to eliminate the subsidy, a report presented to the Integrated Governance Committee in October 2014, regarding 'Hotel Services and Facilities Key Performance Indicators', indicates that the contribution to non-patient catering services

needs to be reduced. Further progress will depend on the pace at which the strategic business case of catering services is progressed (see paragraph 84).

74. The income generated by the Health Board's non-patient catering services is insufficient to recover operating costs but the gap is reducing, despite the increase in 2012-13 (Exhibit 8). In 2013-14, the total income generated was enough to recover 83 per cent of the £1.4 million costs, which equates to a subsidy of £239,000.
Only Glangwili and Withybush hospitals were profitable. Across Wales, no NHS organisation recovered the cost of non-patient catering services in 2013-14 but the Health Board's performance is comparatively better than some health boards (Exhibit 9).

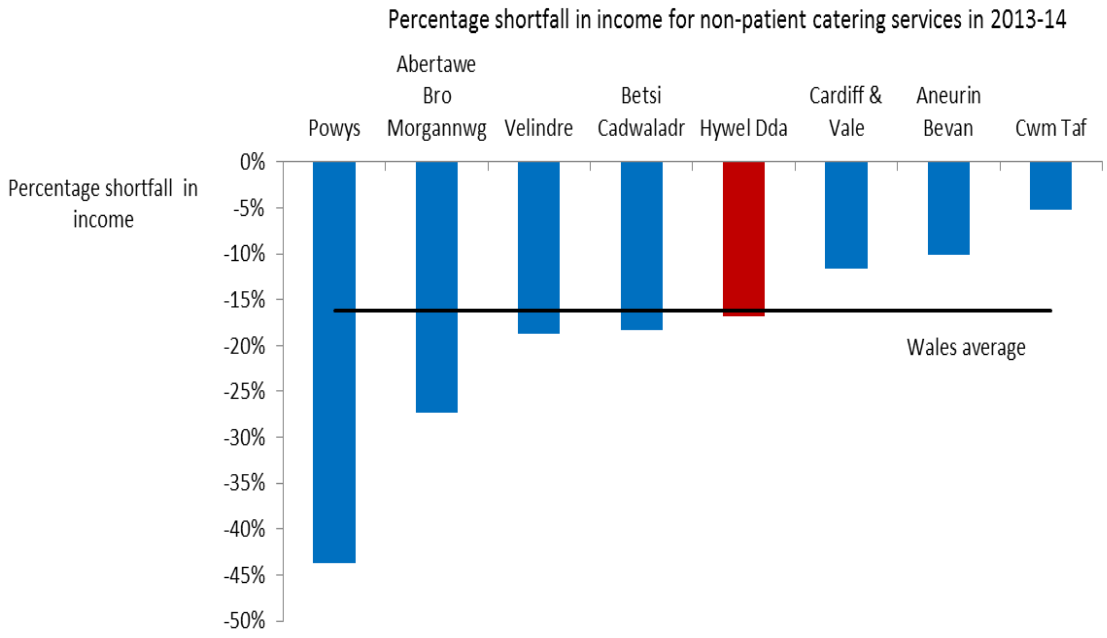
Exhibit 8: The gap between income and costs of the Health Board's non-patient catering service is reducing

Year	Cost of non-patient catering services	Income achieved	Percentage gap in costs and income
	(£ millions)		%
2011-12	1.63	1.26	-23
2012-13	1.75[1]	1.30	-26
2013-14	1.43[1]	1.20	-16

[1] Includes rental costs for vending machines

Source: Wales Audit Office analysis of NHS Estates in Wales Facilities Performance Report 2012-13 and the 2013-14 supplementary data

Exhibit 9: NHS organisations do not generate enough income to recover the cost of non-patient catering services; there is a 17 per cent shortfall in Health Board income



Source: Wales Audit Office analysis of NHS Estates in Wales Facilities Performance supplementary data 2013-14

The implementation of nutrition and hydration strategic actions is impeded by a lack of operational infrastructure and there is little Board reporting on nutrition and catering

75. In 2010, the existence of up-to-date strategies and plans to give effect to national policies in relation to hospital catering and patient nutrition was patchy, while in several NHS bodies arrangements needed to be harmonised following NHS re-organisation in 2009. A more comprehensive and co-ordinated approach was needed to seek the views of patients and families to inform plans and developments. NHS boards received limited information on the delivery and performance of catering services and issues relating to patient nutrition. There was no collation of information from nutritional screening to help understand the scale of the problem and likely impact on services. In some NHS bodies, executive accountabilities for catering and nutrition could be clearer.

76. In the Health Board in 2010, there was strong professional leadership and executive accountability in relation to patient nutrition. A single nutrition strategy was in draft, and was subsequently agreed and adopted across the Health Board. Local catering services were well-managed within the separate county locality structures. However, there was no single operational planning and business framework for the catering service, which created uncertainty about how the service would be developed and taken forward. At the time of our follow-up work in 2012, the Health Board was working to develop and implement a business plan for delivering consistent catering services across all hospitals.

Lines of accountability for nutrition and catering are clear but the operational infrastructure through which to implement strategic actions lacks clarity

77. There are clear and separate executive accountabilities for nutrition and catering. The Director of Nursing, Quality and Patient Experience is accountable for nutrition while the Director of Operations is accountable for catering. Operational lines of accountability for catering services are from the Director of Facilities up to the Director of Acute Services, who reports to the Director of Operations.

78. The NHSG provides the overall focus for planning for patients' nutrition and hydration needs. The Assistant Director of Nursing Practice chairs the group. It has a broad programme of work, including oversight and scrutiny of compliance with the All Wales Nutrition Pathway, the All Wales Menu Framework and healthcare standards relating to nutrition. The NHSG meets on a quarterly basis and receives routine updates from the MPG, and from the county operational nutrition groups. The NHSG provides a highlight report to the Quality and Safety Committee on a quarterly basis.

79. An organisational restructure came into effect in July 2014. Previously, the Health Board operated as three distinct counties with responsibility for acute, primary and community services managed in county. The new structure has an acute services directorate that spans the whole Health Board including the three counties. The aim of these new arrangements is to ensure that the acute services provide more cohesive and consistent care and improve performance and efficiency. The three counties now have a community and commissioning focus, maintaining their alignment to the local authority partners. Operational lines of accountability are now clearer and there is a stronger performance management framework underpinning delivery.

80. However, in January 2015, the NHSG was concerned that there was a lack of operational infrastructure to focus general discussions and operationalise strategic actions agreed in relation to nutrition and hydration following recent organisational changes. At the time of our follow-up review in the summer of 2015, staff told us that they still had concerns in this respect.

81. The MPG, supported by the county nutrition groups, has been responsible for progressing recommendations in our local and national reports on hospital catering. It reports key progress and challenges to the NHSG on a quarterly basis, and action plans from each MPG meeting are forwarded for NHSG scrutiny. However, we did not see any evidence that progress against the action plan(s) is monitored by the NHSG.

82. The Health Board's Quality and Safety Committee Report for 2013-14, summarised key NHSG achievements against its work plan, including:

- further roll out of the ANST and 'Food First' approach to managing risk;
- continued incremental implementation of the All Wales Menu Framework (AWMF), noting that the significant associated costs have determined and limited the pace;
- developing a paper to identify the potential costs and risks of not implementing the AWMF and working to explore ways of off-setting costs to enable further progress;
- implementing a pilot on three sites to offer snacks as part of enhancing nutrition at ward level as part of its Food First approach; and
- work to optimise the provision of texture modified (TMD) diets for patients with swallowing difficulties, which led to changes in local provision and menus.

83. In May 2015, following an external governance review earlier in the year, the Health Board approved a number of changes to its main and sub-committee structures. As a result the Quality and Safety Committee became the Quality, Safety and Experience Assurance Committee (QSEAC). The supporting sub-committee structures also changed with the NHSG becoming a task and finish group. It reports into three sub-committees, namely the Acute Services Safety and Quality Sub Committee, the Three Counties Quality, Safety and Experience Sub Committee for Primary Care and Community Services, and the Mental Health and Learning Disabilities Quality, Safety and Assurance Sub-Committee. Since the changes none of these sub-groups has provided an update on nutrition and hydration to the QSEAC, representing a gap in current assurance reporting (for example, see paragraph 39).

84. In 2011, the Health Board responded to our recommendation to strengthen planning arrangements to ensure a consistent agenda for catering services by appointing a strategic lead for these services. A considerable amount of work then took place to develop a strategic business case for catering across the Health Board, with the intention of developing a model for food provision and delivery that combined quality with value for money. In November 2013, the new Director of Facilities became responsible for, amongst other things, Hotel Services, which includes catering. Shortly after his appointment, the Director of Facilities reviewed the draft business case which outlined several options for the future of catering services and found that it lacked the necessary clarity to progress further. There followed an agreement to develop a new business case, the draft of which was almost complete at the time of our audit in 2015. Despite the Health Board's commitment and action to address our recommendation, it has taken some five years to reach a point where strategic options for catering services are likely to be ready for consideration. This has also affected the pace at which further progress could be made in reducing the cost of non-patient catering. The model for provision of the latter will depend on any decisions made on options contained in the strategic business case.

There is little reporting to the Board on nutrition and catering

85. In 2010, we found that reports to the Board highlighted the nutrition agenda, but there was no clear reporting of catering service operational issues. In 2012, arrangements to provide assurances to the Board on catering issues had been strengthened. However, in our current audit we found that there was little beyond the annual Fundamentals of Care report to highlight the nutrition agenda to the Board, and less with regard to catering service operational issues.

86. Although reporting to the Board on patient experience is routine at each of its meetings, we found little in relation to food and nutrition. At Cardiff and Vale University Health Board, patient feedback on food and mealtime experiences is presented to every Board meeting as part of its patient experience report, along with compliance with nutritional screening.

87. Performance is monitored and reported at an operational level. The dietetic service collates information on the numbers of patients at high nutritional risk. This information has been used to inform planning, for example, during recent medical bed changes across sites. However, it is not formally communicated up through the organisational structure, and there has been a failure to address the consistently poor performance at Withybush on nutritional assessment. Key performance indicators for catering services, such as waste, food provision costs and meal numbers are collated on a monthly basis. This information is reported periodically through the year to the Facilities management team.

88. The Health Board, as with other NHS bodies, has yet to collate information on a regular basis from nutritional screening to understand the number of patients identified with nutritional problems on admission.

There are effective mechanisms in place to capture and act upon patient feedback

89. The Health Board has continued to develop new ways to collect patient feedback on catering and nutrition. For example, the MPG sought views from the patient forum Siarad Iechyd on its proposals for food services for parents staying with their children while in hospital. This process has led the Health Board to identify further options to engage service users and carers.

90. In February 2014, the Health Board completed a summary of findings from the 2013 all-Wales patient menu survey, the 2013 Fundamentals of Care Audit and the 2013 Nutrition Pathway Audit to ensure action plans were aligned and informed service developments. We have not seen a more recent summary of this type.

91. The local CHC has been active in testing new dishes from the AWMF. As part of the Health Board's work on patient experiences, the Patient Experience Manager has introduced patient stories at MPG meetings.

92. As part of the 2015 Nutrition and Hydration Week, the Health Board invited staff and patients to suggest ideas for improving food and nutrition services.

93. At the time of our recent audit, the AWMF group was repeating its questionnaire survey of inpatients. The Health Board distributed surveys to 420 patients across its hospitals and there were 235 returns, which equates to a response rate of 56 per cent. At the time of our audit, the Health Board was waiting for the analysis of the survey findings, which would be shared in early autumn.

Appendix 1

Audit approach

The audit sought to answer the question: 'Has the Health Board implemented fully the Auditor General's recommendations for securing improvements in meeting patients' nutritional needs and their mealtime experience, in controlling catering costs and planning and monitoring. We carried out a number of audit activities in June 2015 to answer this question. Details of these are set out below.

Interviews and document review

We undertook a number of interviews with key individuals at the Health Board, including officers, an Independent Member, a patient representative and ward managers. We also reviewed a number of documents, including reports from other relevant external organisations and the Health Board's response to these reports.

Data analysis

We analysed the EFPMS data for 2012-13 and 2013-14, which is the most up to date. NHS bodies submitted the 2014-15 data to the NHS Wales Shared Services Partnership – Specialist Estates at the end of June. These data will be available at the end of November 2015.

Ward observations

We undertook observations of the lunchtime mealtime service on three wards, selected by the Executive Director of Nursing, Quality and Patient Experience, to assess whether:

- patients and the ward environment were prepared for mealtimes;
- patients received the right meal;
- patients were helped with eating if necessary; and
- protected mealtimes were complied with.

We visited the Meurig Ward, Bronglais Hospital; Ward 9, Prince Philip Hospital; Ward 1, Withybush Hospital; and the Clinical Decision Unit, Glangwili Hospital.

Case note review

We undertook a case note review on each ward where we observed the lunchtime service to assess whether:

- nutritional screening is undertaken using a validated screening tool when patients are admitted to hospital;
- information on weight, height, body mass index (BMI), recent unintentional weight loss, current appetite, 'normal' dietary intake, special dietary requirements, the ability to eat independently, difficulties eating or drinking and problems with oral health and hygiene, including dentition, had been recorded; and

- care plans were in place for those patients identified with, or at risk of nutritional problems and whether patients identified as at risk were referred for a dietetic assessment.

Ward managers selected the five sets of case notes reviewed on each ward.

Appendix 2

National and local recommendations

Table 1 sets out 14 local recommendations set out in our report, which summarised the findings from our 2010 audit work on hospital catering and patient nutrition services at the Health Board. The status of each recommendation[8] is also set out in Tables 1, 2 and 3.

Table 1 – 2010 local recommendations

Recommendation		Status at July 2015
Strategic planning and management arrangements		
R1	Strengthen planning arrangements for catering to ensure a clear and consistent agenda for the catering service across the Health Board.	O
R2	Reduce the time it takes to develop and establish new catering and nutrition processes.	A
R3	Improve the Board scrutiny arrangements for monitoring catering and nutrition risks and performance.	O
Procurement production and cost control		
R4	Introduce a clear subsidy policy to set the framework for delivering non-patient catering services.	O
R5	Develop consistent ledger arrangements across the Health Board to ensure that sufficient and robust catering business information is available.	A
R6	Improve the current food wastage monitoring arrangements to accurately reflect production efficiency and help identify the potential to improve existing systems.	A
Delivery of food to the ward		
R7	Introduce protected mealtimes at all mealtimes in all appropriate wards to meet the approach adopted in the best wards.	O
R8	Reinforce the need for patient hand cleansing.	O
R9	Ensure appropriate nutrition into the training programme for ward based catering staff to improve their awareness of its importance and the need to follow ward procedures.	O

[8] (A) indicates that the recommendation has been achieved, (O) indicates that the recommendation is on track to be achieved but is not yet completed and (N) indicates that insufficient or no progress has been made.

Recommendation		Status at July 2015
Meeting patients' nutritional needs and supporting recovery		
R11	Improve the format and types of nutrition-related information recorded in the nursing notes for patients.	O
R12	Develop practical methods to assist in the regular completion of food record charts and fluid intake/output charts.	A
Gathering views from patients and sharing information		
R13	Introduce effective arrangements for sharing information on patients' views of the service between ward managers and the catering service.	A
R14	Involve patients fully in developing the catering service, building on the recent positive experiences of patient engagement.	A

Table 2 sets out the 26 national recommendations set out in the Auditor General's 2011 report, which were relevant to NHS bodies providing patient catering services.

Table 2 – 2011 national recommendations

Recommendation		Status at July 2015
Ensuring patients' nutritional needs are met		
R1b	We recommend that NHS bodies use the results presented in our local audit reports as a basis for ensuring that they are effectively implementing the All Wales Nutritional Care Pathway, in particular, ensure that nutritional screening effectively identifies all patients who have nutritional problems, or are at risk of developing them, and that appropriate care plans and monitoring activities are instigated.	O
R1c	We recommend that NHS bodies regularly audit compliance with all aspects of the nutritional care pathway across all their hospital sites and share the results of these monitoring exercises with all the relevant staff groups involved in catering and patient nutrition services.	N
R1d	Where poor compliance with nutritional care pathway requirements is identified, we recommend that NHS bodies should establish the reasons for this, and implement clear plans of action to address the problem and include provision of necessary training to staff.	O

Recommendation		Status at July 2015
Ensuring patients' nutritional needs are met		
R1e	We recommend that NHS bodies have arrangements in place to ensure that patients have access to food 24 hours a day; provision of snacks should be part of these arrangements and patients should be made aware of what snacks are available to them, and when.	O
R2a	We recommend that NHS bodies take steps to ensure that all menus in use across hospitals sites have been nutritionally assessed by dieticians.	A
Improving patients' mealtime experience		
R3a	We recommend that NHS bodies ensure that their menus provide an appropriate choice of food and that the arrangements for ordering and serving food support adequate patient choice.	A
R3b	We recommend that NHS bodies review their practices at ward level to make sure that patients are helped to get comfortable in readiness for their meals, and are given the opportunity to wash their hands before the meal is served.	O
R3c	We recommend that NHS bodies continue to roll out the protected mealtime policy to as wide a range of wards as possible, communicating its importance to all the relevant staff groups working in the hospital, and regularly reviewing compliance with the policy.	O
Controlling the costs of the catering service		
R4b	We recommend that NHS bodies introduce computerised catering information systems, supported by clear cost benefit analysis in comparison to existing manual based information systems.	N
R5a	We recommend that NHS bodies review their current cost control mechanisms to ensure that they are making full use of standard costed recipes.	A
R5b	We recommend that NHS bodies review their current cost control mechanisms to ensure that they are making full use of daily food and beverage allowances for patients.	O
R5c	We recommend that NHS bodies review their current cost control mechanisms to ensure that they are making full use of standardised local catering contracts for the same or similar products across all their hospital sites.	A
R6a	We recommend that local and national targets are set for food wastage; as a guide NHS organisations should aim to ensure that wastage from un-served meals does not exceed 10 per cent.	A

Recommendation		Status at July 2015
Controlling the costs of the catering service		
R6b	We recommend that NHS bodies routinely monitor food wastage according to clear guidelines of what constitutes an un-served meal, and that this information is used to generate meaningful comparisons locally and nationally.	A
R6c	We recommend that monitoring of food waste should include identification of the reasons for the wastage that is observed, and this information should be used to identify priorities for improvements in systems and processes that are causing the waste.	A
R6d	We recommend that NHS bodies emphasise to their staff that controlling food waste is a collective responsibility and that catering and ward-based staff should work together to tackle the problem.	A
R7a	We recommend that set pricing policies and income generation targets that aim to ensure that non-patient catering services at least break even, or, if they do not, it is the result of a deliberate subsidy policy that is based on a detailed analysis of costs.	O
R7b	We recommend that NHS bodies regularly monitor income and expenditure of non-patient catering services to ensure that the financial performance of these services is as expected and that unacceptable deficits are not being incurred.	A
Effective service planning and monitoring		
R8b	We recommend that NHS bodies ensure that they have up-to-date plans and procedures that set out the local arrangements for implementing national policy requirements and to ensure that as far as possible, catering and nutritional services are standardised, particularly where NHS re-organisation has brought together a number of different service models under one organisation.	O
R8c	We recommend that NHS bodies ensure that executive director accountabilities for catering and nutrition are clearly defined, and where two or more executive directors are involved, there are well defined arrangements for the co-ordinated planning and monitoring of services.	A
R9c	We recommend that NHS bodies should ensure that they make full use of Estates and Facilities Performance Management System data as a tool in managing and monitoring their catering and nutritional services.	A
R10a	We recommend that NHS bodies develop a more comprehensive approach to reporting performance on catering services and patient nutrition to the Board, which brings together information on implementation of the nutritional care pathway, performance data on the costs of patient and non-patient services, food wastage and patient and relative feedback and this information should be presented to the Board at least annually and should make appropriate use of the EFPMS data.	O

Recommendation		Status at July 2015
Effective service planning and monitoring		
R10b	We recommend that NHS bodies systematically collate the information from nutritional screening on the number of patients identified with, or at risk of, nutritional problems to understand the scale of the problem and the likely impact on catering and nutrition services to meet these patients' needs.	N (Limited Progress)
R11a	We recommend that NHS bodies ensure that there are effective arrangements in place for sharing information on patients' views about catering services between ward sisters/charge nurses and the catering service.	A
R11b	We recommend that NHS bodies demonstrate how they have taken patients' views into account when developing catering and nutrition services.	A
R11c	We recommend that NHS bodies establish mechanisms to involve patients' in activities that assess the quality of catering and nutrition services.	A

Table 3 sets out the five local recommendations set out in our report summarising the findings from follow-up audit work on the Health Board's hospital catering and patient nutrition services in 2012.

Table 3 – 2012 local recommendations

Recommendation		Status at July 2015
Strategic planning and management arrangements		
R1	Formalise the management objectives for the Strategic Lead for Hotel Services and Facilities.	A
Procurement production and cost control		
R2	Formalise the Health Board policy on non-patient food subsidies.	O
R3	Maintain pressure on the active monitoring and reduction of food waste.	A
Ensuring patients' nutritional needs are met		
R4	Set SMART[9] targets for the provision of staff training on nutrition to be monitored by the Health Board.	O

[9] Specific/Measurable/Attainable/Realistic/Time-bound

Recommendation		Status at July 2015
Gathering views from patients and sharing information		
R5	Ensure that patient views on catering services are used to influence catering service provision and service development work.	A

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