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Follow-up Review of Hospital Catering Services

Abertawe Bro Morgannwg University Health Board

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The person who delivered the work was Philip Jones.

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Abertawe Bro Morgannwg University Health Board has made progress towards implementing our recommendations in relation to catering and patient nutrition services but a number of significant issues still need addressing.

Summary report

Summary

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 required across the range of staff groups involved, including managers, catering staff, dieticians, nurses, support staff and porters.

2. 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. 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.

3. In May and June 2010, we carried out work at Abertawe Bro Morgannwg University Health Board (the Health Board) to examine whether Singleton, Morriston, Neath Port Talbot and Princess of Wales hospitals provided efficient catering services that met recognised good practice. We considered the whole of the hospital catering 'food chain' from planning and procurement, through to the delivery of food to the ward and patients, and the management of mealtimes.

4. At that time our overall conclusion was that the local catering services were reasonably effective in meeting patients' needs but there was scope to do more to standardise catering services and improve the patient experience. We made a number of detailed recommendations at the time of our original work[1], as well as a number of recommendations in our subsequent national report[2] published in March 2011. These recommendations were aimed at improving compliance with nutritional screening and care planning and food safety procedures, as well as improving systems for controlling catering costs and improving the patient experience.

5. More r*ecently, Trusted to Care*[3] (May 2014) was published following an independent review into aspects of care and practice at the Princess of Wales and Neath Port Talbot Hospitals by the Dementia Services Development Centre and The People Organisation. Amongst other things, it found significant shortcomings in relation to the provision of fluids and food to patients.

[1] The recommendations can be found in *Hospital Catering* at:
www.wao.gov.uk/assets/Local_Reports/Abertawe_Bro_Morgannwg_LHB_Hospital_Catering.pdf

[2] The recommendations can be found in *Hospital Catering and Patient Nutrition* at:
www.wao.gov.uk/assets/englishdocuments/HC_Report_ENG.pdf

[3] The *Trusted to Care* report can be found at:
www.wales.gov.uk/docs/dhss/publications/140512trustedtocareen.pdf

6. Between February and April 2014, as part of our programme of local audit work, we carried out fieldwork to examine whether the Health Board had made progress against our recommendations. As part of this work we visited four wards across Morriston, Singleton, Neath Port Talbot and Princess of Wales hospitals to observe one mealtime and review of a sample of case notes. We concluded that the Health Board has made progress towards implementing our recommendations in relation to catering and patient nutrition services but a number of significant issues still need addressing.

7. We reached this conclusion because:

- while there have been developments in the monitoring and benchmarking of local and national indicators and other measures, there are concerns that the Board is not in a position to give sufficient scrutiny to performance on catering and nutrition;
- the Health Board is making progress towards a single approach to food production and has improved the ward catering model in some areas, although these arrangements are not yet standardised, and nutritional assessment of all locally developed recipes and menus has not been completed;
- there is a clearer understanding of the cost of food production and delivery, including the need to effectively manage the cost implications of All Wales Contracts for food and the financial impact of competition from non-NHS food outlets;
- compliance with the Welsh Government's nutritional assessment e-learning tool for nurses, and the take-up of food safety training by nursing staff is poor;
- while there has been progress with some aspects of nutritional screening and planning, the Health Board needs to sustain its focus on improving rates of compliance, particularly for follow-up screening; and
- protected mealtimes are important and most staff work to maintain them, although we observed variable practice, and there is a need to improve patient information about food and nutrition.

8. Detailed findings from our follow-up work are summarised in Appendix 1. The recommendations from our original audit are summarised in Appendix 2.

Recommendations

9. A number of recommendations have arisen from the follow-up review. These are listed below.

R1 **There is still scope to improve the framework to develop, monitor, and report catering and nutrition issues. The Health Board should:**

- develop appropriate indicators to monitor the hydration, mobility and feeding of all older people;
- review, clarify and streamline the arrangements for groups and committees associated with catering and nutrition in the Health Board to minimise duplication and ensure effective communication;
- review the information received by the Board in relation to catering and nutrition, and it's performance management role for those areas;
- further develop the format of the Annual Nutrition Report, particularly in light of the recommendations in *Trusted to Care*;
- revise the reporting of ward care metrics to always include actual patient numbers; and
- ensure that catering and nutrition are key elements in the Health Board's new arrangements for patient, carer and service user engagement.

R2 **Some aspects of food provision need standardisation and evaluation. The Health Board should:**

- ensure, as a matter of urgency, that the nutritional assessment of local recipes and menus is carried out, and that the funding used is not diverted from any important aspects of patient nutrition;
- ensure that there is full compliance with standards for measuring food temperatures on wards;
- review the impact of snacks and cooked breakfasts on individual patient nutrition, and on food wastage; and
- review the financial impact of competition from private food outlets to ensure that the Health Board is obtaining best value in relation to the income from its own services.

R3 **Compliance with the e-learning package introduced in 2011 to support the nutritional evaluation of patients remains poor, and the roll-out of food safety training is proving challenging. The Health Board should:**

- progress the uptake of e-learning on patient nutrition as a matter of priority; and
- reinforce the need for ward staff, and other staff, to attend food safety training.

R4	**Compliance with nutritional assessment and protected mealtimes needs continual reinforcement and patient information across the Health Board regarding food needs to be improved. The Health Board should:** • review patient nutritional assessment procedures in light of the findings in this report; • reinforce protected mealtime requirements on all wards in light of the findings in this report; • improve the provision of information to patients across the Health Board regarding food and nutrition; and • work together with the Abertawe Bro Morgannwg Community Health Council and its Food and Nutrition Sub-Committee, to address the range of concerns raised through its work, and highlighted in this report.

Appendix 1

Detailed audit findings

The following table sets up our findings from the 2014 follow-up review examining progress against the issues identified in the 2010 audit.

Issues	Detailed findings from follow-up audit work
Has the Health Board developed a range of indicators to monitor, benchmark, and report the performance of its catering and nutrition services?	**While there have been developments in the monitoring and benchmarking of local and national indicators and other measures, there are concerns that the Board is not in a position to give sufficient scrutiny to performance on catering and nutrition** ***Trusted to Care*:** This recent high-profile report found that the Health Board failed to perform in relation to key aspects of patient hydration and feeding. It recommended that the Health Board should *'address hydration, mobility and feeding practice for all older patients and publish audited results on a quarterly basis'.* The Health Board needs to ensure that it is achieving the appropriate standards as a matter of urgency, and sustain these standards over time. This will require clear and robust indicators, trend reporting and comparative information to show the relative performance of the Health Board compared to other organisations. It will also need to ensure that there is effective scrutiny of the performance associated with these aspects of care. **Board Scrutiny:** Our review of Board papers over a 12-month period found that catering and nutrition issues do not have a high profile at Board meetings. While the Board received various assurances from the Quality and Safety Committee, such as the Annual Nutrition and Catering Report, and Fundamentals of Care reporting, this was largely high-level summary information. During our review it was reported to us that there is a lack of detail and robustness in the information received by the Board in these areas, as well as a lack of agreement about the extent of the Board's role in relation to the monitoring of performance. The need to review the overall performance role of the Board was commented on by the Chairman at the Health Board meeting of 23 May 2014.

Issues	Detailed findings from follow-up audit work
	Nutrition Steering Committee: The Nutrition Steering Committee (NSC) functions as a sub-group of the Quality and Safety Committee and provides the overall focus for catering and nutrition. It receives periodic reports on Fundamentals of Care, Point Prevalence Surveys and themes from patient satisfaction surveys. It has four sub-groups: • Food and Nutrition Development Group • Clinical Nutrition Support Group • Paediatric Nutrition Group • Community Nutrition Group These groups meet at various intervals and their terms of reference are said to be distinct, However, their responsibilities appear to overlap in practice. The Health Board needs to review their terms of reference to clarify and streamline arrangements where possible. The groups do not all function effectively. For example, at the time of our fieldwork, the Acting Director of Nursing recognised that the Clinical Nutrition Support Group needs to be revitalised in order to be fully effective. A number of other groups also address aspects of patient nutrition and catering. For example, the: • Patient Nutrition Group • ABMU Health Board Menu Planning Group • Catering Strategy Project Group • Hotel Services Modernisation Board Existing forums are used where multi-disciplinary or cross-departmental working is required to achieve agreed actions and outcomes. We recognise that many groups have common membership to ensure consistency of approach and effective communication. As above, with so many groups and forums acting on this agenda, the Health Board must ensure that the need for each one is clear, and that there is a streamlining of arrangements where possible.

Issues	Detailed findings from follow-up audit work
	HACCP (Hazard Analysis and Critical Control Points): Since our earlier work, the implementation of HACCP arrangements has provided a focus for more consistent food safety arrangements across hospital sites. The work helps to address the requirements of Environmental Health Officer (EHO) inspections by the various local councils. Following our work in 2010, the catering service appointed a quality assurance manager to enable the benchmarking of standards, implementation of HACCP arrangements, and the promotion of greater consistency between EHO inspections. Previously, catering policies varied across the Health Board and work has taken place to develop a single approach as far as possible eg the introduction of a Health Board-wide policy on the control of Listeria. **Annual Catering and Nutrition Report:** The Director of Nursing prepares an annual Catering and Nutrition Report for the Quality and Safety Committee. This type of report was introduced following our work in 2010, and focuses on patient nutrition rather than strategy relating to catering services. The Health Board should review and improve the format of this report, in light of the recommendations in *Trusted to Care.* **Patient and service user feedback:** The Health Board recognises that it needs to make substantial improvements to the way it enables service users to provide feedback. Strategic and organisational changes are underway which staff described as a move to gathering and using feedback 'on an industrial scale'. The catering service and nursing staff continue with existing patient feedback mechanisms in the meantime, and report their findings to the various groups indicated above.

Issues	Detailed findings from follow-up audit work
Has the Health Board significantly progressed its plans to standardise catering services across its hospitals?	**The Health Board is making progress towards a single approach to food production and has improved the ward catering model in some areas, although these arrangements are not yet standardised, and nutritional assessment of all locally developed recipes and menus has not been completed** In 2010 we identified a number of ways in which the Health Board needed to standardise catering practices across hospitals. Our current work has shown progress across some of these areas, as follows: **Agreeing the food production and ward catering model:** A standardised 'cook-freeze' service model is in place at three out of the four main sites. A consultation document is under consideration for the introduction of this model at the Princess of Wales Hospital, where the capital implications are larger than was the case elsewhere. Neath Port Talbot Hospital and Singleton Hospitals had introduced ward hosts at the time of our review in 2010. While the roles are ward-based, the catering service manages them. They take charge of the organisation of mealtimes, ordering and helping to serve food and the model appears to work well. A variation of this model was being piloted at the time of our fieldwork at Morriston Hospital on Angylsey F and Gower S and T wards. It involved ward housekeepers, managed as part of ward resources while accountable to the catering service for their role in relation to mealtimes. Achievement of this model has been through the combining of ward and catering resources. We understand that after our fieldwork took place, housekeepers were appointed permanently on these wards. A further housekeeper role has been agreed for Ward G at Morriston, although there is no clear plan yet to establish these roles elsewhere in that hospital. Introduction of the ward host model is under consideration at the Princess of Wales Hospital, where the findings of *Trusted to Care* have highlighted previous serious inadequacies relating to standards of patient nutrition and fluid intake. **Reviewing the nutritional content of recipes:** The Health Board has adopted a proportion of the recipes set out by the All-Wales Menu Planning Group. It has its own menu planning group to provide a focus for development and review of local recipes and menus. It is vital that there is nutritional assessment of the content of individual recipes and of their combination into menus. While the All-Wales menus are all nutritionally assessed, the Health Board has not completed assessment of its local recipes and menus, progress being limited by insufficient dietetic resource. The Quality and Safety Committee recently reported to the Board on the latter, following work by the Health Board's Older Person's Steering Group. The Health Board has been aware of this lack of nutritional assessment of local recipes for several years and has not

Issues	Detailed findings from follow-up audit work
	resolved the situation. It must address this as a matter of urgency. Although discussions have taken place, there is no agreement regarding the implementation of a dietetic resource or the funding required for it. We understand that some funding relating to the provision of snacks has been considered for use for a period of one year in order to help carry out this work. The Health Board must ensure that, using that funding in this way does not adversely affect snack availability for patients screened as high nutritional risk and needing this nutritional support. **Recording food temperatures:** The recording of food temperatures features in food standards and work is ongoing by the catering service to maintain awareness of its importance. However, the Health Board's Care Metrics data show instances where there is a lack of compliance with relevant procedures. Our ward observations, as part of this follow-up, suggested that practices need improving (see below). **Snacks and cooked breakfasts:** Patients with a nutritional score of 3 or above on the nutritional screening tool are provided with snacks, and those with a score of 7 or above receive a cooked breakfast. Patients below these thresholds can also have snacks if they wish. Both catering and nursing staff said that consumption of snacks and cooked breakfasts sometimes results in patients not being hungry at lunch and evening mealtimes, The catering service has evidenced an increase in food waste resulting from this. The Health Board must properly evaluate the impact on total nutritional intake of snacks and cooked breakfasts to ensure patients receive an overall nutritional balance, and take action where necessary to address the situation. It should continue to assess food waste linked to this issue, as a measure of the impact of any action taken.

Issues	Detailed findings from follow-up audit work
Has the Health Board strengthened its arrangements to better manage food production and to control costs?	**There is a clearer understanding of the cost of food production and delivery, including the need to effectively manage the cost implications of All Wales Contracts for food and the financial impact of internal competition from non-NHS food outlets** A number of key actions have been completed since our work in 2010: • a price review has been undertaken on each site, and the prices and food items purchased have been harmonised; • food contracts have been reviewed, although negotiation is ongoing with finance and procurement staff to agree the Health Board position on procurement and contractual issues for food purchasing; • customer numbers and average spend are counted every day at each meal service so that a profit and loss account can be generated for each meal service at each hospital; and • Singleton Hospital and Neath Port Talbot Hospital have reviewed non-patient catering service times and closed facilities where it is not financially viable for them to remain open. In 2010 we found that the Health Board subsidised non-patient catering services, with a gap between total costs and income of £711,204 (this did not include Neath Port Talbot Hospital, as the relevant financial information was not available). The Health Board has subsequently produced its own figures which include Neath Port Talbot Hospital and show that the overall gap across the Health Board between income and expenditure for non-patient catering services reduced by 20 per cent from £745,084 in 2010-11 to £595,045 in 2012-13. However, the gap for Neath Port Talbot Hospital increased slightly. These figures formed part of the Health Board's Estates and Facilities Performance Management System (EFPMS) submission (for a more detailed figures, see Appendix 3). Our original audit in 2010 also found that NHS organisations did not make sufficient use of the EFPMS data to review the cost effectiveness and quality of catering services. Our follow-up work found that the Health Board is making full use of the EFPMS data to manage and monitor catering and nutritional services across all its hospitals and to benchmark costs with other health boards. The Welsh Government has acknowledged that the only information it routinely collects about food waste relates to untouched plates of food. It will be carrying out a pilot exercise with Cardiff and Vale University Health Board to help understood more about the food waste that leaves wards. The Health Board catering service recognises that it could do more to understand the reasons for food waste and is building on its existing activities to measure untouched plates of food (see also *Snacks and cooked breakfasts*, above).

Issues	Detailed findings from follow-up audit work
	The catering service intends to carry out a further more detailed analysis of apportionment cost for non-patient catering, and has recently reported that vending income varies significantly across sites, ranging from around £9,000 (Neath Port Talbot Hospital) to £137,000 (Morriston Hospital). It identified vending as an area where more needs to be done to maximise income potential, and has set out an action to review vending policy and number of vendors on main sites. The catering service across the main sites has competitors including the Royal Voluntary Service (at Morriston and Neath Port Talbot Hospital), Brewbaker (at Princess of Wales Hospital) and Costa Coffee (at Singleton Hospital). It has reported that they tend to hold 'premium' sites within hospitals, maximising their income potential, and with a consequential impact on the takings in its own restaurants and coffee shops. The catering service has developed a new catering concept called 'Mwy Na' and is building coffee shop facilities in Princess of Wales and Morriston Hospitals. The new facilities will raise the quality of service offered and enable the catering service to compete more effectively with external competitors. The catering service would like to see internal competition contracts reviewed (when appropriate) to ensure the Health Board is obtaining best value in relation to the income of its own services.
Has the Health Board ensured the provision of appropriate training and guidance to nursing staff responsible for serving food to patients?	**Compliance with the Welsh Government's nutritional assessment e-learning tool for nurses, and the take-up of food safety training by nursing staff is poor** The Welsh Government introduced an e-learning package in September 2011, which is accessible via the NHS nursing portal. The focus of the e-learning package is on patient nutrition evaluation, in particular the Malnutrition Universal Screening Tool (MUST) and the use of the all-Wales food charts. The Health Board uses the WAASP4 tool for nutritional screening and while this accepted practice, it differs to the MUST focus of the e-learning package. All incumbent ward-based nursing staff were expected to complete the e-learning training package within 12 months of its introduction while new nursing staff would complete it within 12 months of commencing employment. Since September 2011, progress towards the introduction of this e-learning is recognised as having been highly variable and generally slow across Wales. In a systematic comparison provided by the Welsh Government to the Public Accounts Committee in September 2013, only 14 per cent of all relevant ward based staff in the Health Board had completed the e-learning nutrition package. The Welsh Government reported to the Public Accounts Committee meeting on 4 February 2014 that,

[4] Weight Appetite Ability to Eat – Stress Fractures and Pressure Sores/Wounds – the Health Board's nutritional assessment tool, which it adopted from the Cardiff and Value University Health Board.

Issues	Detailed findings from follow-up audit work
	across Wales, only 23 per cent of staff had trained by that time. The reasons cited for poor compliance are a lack of protected time to undertake the training and difficulty in accessing, and slow access speed, to the online training package. On one ward we visited as part of this review, only two nurses had completed the training, although the intention was to include the training as part of personal development plans going forward. We found similar positions on other wards visited. The Health Board recently introduced its own intranet site providing staff with information regarding patient nutritional care, although it is too early to evaluate its effectiveness. It has also introduced group-learning sessions in relation to the implementation of food and fluid intake charts, to increase support and improve compliance. The catering service provides food safety training to nursing staff and other staff who have roles involving the handling and serving of food. The catering service has reported to the Food Service and Nutrition Group on progress in rolling out the training, and indicated to us that with current levels of training uptake, attendance and funding, full training compliance by nurses is currently unachievable. It has pointed to the drop-out rates amongst staff who have signed up for places at training events, with staff reporting difficulty in attending training events because of other operational priorities. The result is that individual training events are under-attended, increasing the cost of provision, and training for other staff members can be delayed as a result. It regards the roll-out of an e-learning tool for food hygiene as essential for compliance with training uptake and as a potentially more cost effective option. Ensuring the training compliance of nursing staff at Princess of Wales and Morriston hospitals, where a ward host model has not been implemented, is particularly important given that these nurses are required to serve food, During our fieldwork we also observed inconsistent practice in recording food temperatures, further highlighting the need for training. Effective training in the nutritional assessment of patients and in safe handling of food is essential for supporting staff to deliver high quality care and consistent practice. Challenges for delivering nutritional assessment and food safety training as highlighted above need to be addressed and training up-take improved and monitored.

Issues	Detailed findings from follow-up audit work
Has the Health Board improved compliance with nutritional screening and care planning?	**While there has been progress with some aspects of nutritional screening and planning, the Health Board needs to sustain its focus on improving rates of compliance, particularly with the standard for follow-up screening** At the time of our original review the development and implementation of All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients was underway. The Health Board monitors progress in the implementation of these standards and reports them as part of its self-assessment returns on healthcare standard 14[5]. While the December 2013 progress report shows that most standards are in place, the Health Board had not achieved those relating to nutritional assessment of menus (see *Nutritional assessment of all recipes and menus* above). Although the timeframe for achievement had been set as 30 April 2013, Health Board staff indicated there are insufficient dietetic staff to carry out this work. In addition to these standards: • A Nutrition Care Pathway is monitored on a monthly basis at ward level and compliance is reported to the Quality and Safety Committee. • Ward sisters gather and monitor ward care metrics data, which include indicators about nutritional assessment and risk. These data are reviewed by the senior nursing team on a monthly basis. As part of our fieldwork, we reviewed a sample of the ward care metrics data, and observed that compliance with the standard for initial screening has shown some improvement, and is generally above 90 per cent. However, the percentage completion of follow-up screening at the appropriate interval is significantly lower, between around 80 per cent and 90 per cent. The Health Board indicated that it is continuing to work to raise compliance. • An annual Fundamentals of Care audit takes place in relation to patient eating and drinking and the findings are reported within the Health Board and submitted nationally. • Compliance with Protected Meal Times requirements is audited and reported to the Nutrition Steering Committee. In addition, some spot-checks are carried out by the Abertawe Bro Morgannwg Community Health Council (see below) and reported to the Health Board, which responds to the CHC with comments and any actions that result. The Health Board recognises the need to look across all sources of information at ward level in relation to nutrition and fluid intake in order to obtain assurance. For example, the Health Board has introduced ward care metrics relating to nutrition since our work in 2010. They are self-reported, based on small monthly samples of patients and therefore

[5] *Doing Well, Doing Better* – Standards for Health Services in Wales

Issues	Detailed findings from follow-up audit work
	cannot be relied on to give a fully accurate picture of service standards. . Furthermore, the way in which the data is reported could provide a false sense of assurance if viewed in isolation; because they are based on very small numbers reported as a percentage, with no indication of the sample size (see Appendix 4). We reviewed five sets of patient case notes on each of the four wards we visited to assess whether nutritional screening was undertaken when patients were admitted to hospital and if a validated screening tool was used. In addition, we compared the detail captured during the screening process against a checklist of items derived from guidelines on recommended practice. We found that while appropriate practice was frequently maintained, we also observed a number of instances of poor practice, for example: • in general, oral health evaluation is limited; • normal dietary intake is not part of nutritional assessment tools; • equipment to measure height was not always available, and consequently BMI was not measured; • some cases where nutritional scoring was incorrect; • one case where an old format of the nutritional assessment tool had been used; • instances where care plans were either in place but not needed, or not in place but should have been; • one ward where food charts had not been countersigned by nurses; and • one ward where the use of food supplements was recorded on white boards but not in patient notes. These issues are clearly a matter of concern, particularly as they emerged from just a small number of wards that we visited. In 2010, we recommended that the Health Board should compare the extent to which nurses and dieticians agree (inter-rater reliability) when scoring nutritional risk. Staff reported that there have not been sufficient resources to carry out this type of activity on a regular basis.

Issues	Detailed findings from follow-up audit work
Has the Health Board taken steps to ensure that the patient mealtime experience on all wards is a positive one?	**Protected mealtimes are important and most staff work to maintain them, although we observed variable practice, and there is a need to improve patient information about food and nutrition** Our ward visits found that most staff understand the importance of protected meal times. The use of white boards in many ward areas assists in identifying patient dietary needs. Use of red tray schemes also highlights particular nutritional needs, in line with good practice. Ward-based nutritional care champions are being introduced across the Health Board, and are said to help support this aspect of patient care. However, our ward meal time observations showed that compliance was not always consistent, in particular: • support for patients to maintain hygiene eg hand washing or the provision and use of hand wipes, was not always observed; • tables at beds were not always cleared before food was served, and in one instance a urine bottle was left on a table during mealtime; and • the recording of food temperatures before meal services did not always take place, and Ward G, Morriston Hospital, did not have a food thermometer. There is some information about food options and mealtimes for patients, although the Health Board recognises that provision is not consistent across all areas and needs to be improved. Practice in relation to the provision of menus to patients is variable and appears to have declined since our work in 2010. In most areas, nurses and catering assistants read out options to patients as opposed to presenting menu information to the patient in advance of mealtimes. At the time of our work, the catering service was developing bedside information for the Health Board as a whole, to contain a range of information of about food availability, including menus. Our ward observations suggested that the evaluation of patient experience of food is inconsistent. For example, on Ward G there had been no measurement of patient experience relating to food for at least two years. As mentioned above, the Health Board has recently started to implement fundamental changes to the way it captures vital patient, carer and service user information.

Issues	Detailed findings from follow-up audit work
	Community Health Council: The Abertawe Bro Morgannwg Community Health Council (the CHC) is highly active in relation to reviewing the standard of catering, patient nutrition and fluid intake within the Health Board. This includes unannounced protected mealtime monitoring visits which have previously commended practice on some wards whilst highlighting matters of concern eg little evidence of hand hygiene prior to meals; lack of menu choice for some meals; the early timing of evening meals with consequent long gaps for patients before breakfast. Further examples of issues of concern to the CHC include: • a lack of effective communication of dietary and nutritional needs information gathered from surgical patients during pre-operative assessment to wards at the point of the inpatient episode; • a lack of understanding amongst nursing staff of the complex nutritional needs of patients; • a lack of knowledge by nursing staff about dietary options that are currently provided by the Health Board; • inability to time food provision on wards in support of individual patient medication regimes; • the need for wards to link patient self-medication plans with food provision; and • the ineffectiveness of existing mechanisms to capture patient concerns about food. In addition to being involved in routine food tasting exercises across Health Board sites, the CHC has recently set up its own Food and Nutrition Sub-Committee. The executive chair of the Sub-Committee is also a patient of the Health Board, with ongoing personal experience of the challenges faced by patients with specific dietary and nutritional requirements. The Sub-Committee is establishing a work plan to develop mechanisms that will help support better nutritional provision for patients. This work will provide a framework for the CHC, and other CHC's, to incorporate its feedback into Health Board work on food, nutrition and patient experience.

Appendix 2

Recommendations made in 2010

The table below sets out the recommendations from our original audit report published in 2010.

Strategic planning and management arrangements	
R1	Develop a range of indicators for monitoring and benchmarking the performance of the catering services and potential service risks, which are reported to the Board at least annually, such as, patient satisfaction, environmental health inspection issues, food waste, financial performance and the time taken to implement new initiatives.
R2	Progress plans for standardising catering practices across hospitals, including: • agreeing the production and delivery models; • reviewing the recipes used across each hospital; • nutritionally assessing all recipes and menus; • standardising ward practices at Princess of Wales and Morriston hospitals in relation to recording food temperatures prior to mealtimes and if necessary recording end of service food temperatures if there are complaints of cold meals; • undertaking periodic supervision of meal services at Princess of Wales and Morriston hospitals to assess the quality of the meal service and to improve efficiency if necessary; • establishing a schedule of taste testing sessions at Princess of Wales, Neath Port Talbot and Morriston hospitals, which mirrors that at Singleton hospital; • involving nursing staff and patients in taste testing sessions; and • engaging nursing staff more fully in meal services at Neath Port Talbot hospital like those at Singleton hospital.
R3	Expand the remit of the Nutrition Steering Group, or its subgroups, to include oversight of the emerging themes and issues from patient satisfaction surveys, the Fundamentals of Care audit and Point Prevalence Reviews.
R4	Find a mechanism to enable ward staff to contribute to the Food and Nutrition Development Group.

Procurement production and cost control	
R5	Seek to standardise local catering contracts for the same or similar products ie, one contract for all hospital sites.
R6	Review pricing structures in the staff/visitor restaurants and in doing so make a clear decision about the level of costs to be recovered from non-patient catering services.
R7	Work with catering and nursing staff to improve the meal ordering process for patients at Princess of Wales and Morriston hospitals.
R8	Improve arrangements for monitoring un-served food waste, particularly at Princess of Wales and Morriston hospitals and monitor reasons for waste.
Delivery of food to patients	
R9	Ensure all nursing staff responsible for serving patients have training and guidance on the following: • portion control; • basic food safety and hygiene; • appropriate protective clothing, including standardising the apron colour used during meal services; and • the need to comply with procedures for recording food temperatures and what to do if temperatures do not meet the required standards.
Meeting nutritional needs	
R10	Improve compliance with nutritional screening and care planning by: • recording comprehensive information about patients' nutritional health on the Unified Assessment/Nursing Assessment form, including information on oral health; • exploring the reasons for non-compliance with nursing staff; • changing the format of the WAASP monitoring tool to clearly show the score of each element when re-screening patients; • re-enforcing the threshold at which patients should be referred for dietetic assessment; and • reminding nursing staff about the importance of the all-Wales food and fluid charts and how these should be completed.
R11	Ensure all nursing staff have easy access to information about good nutritional care, including the different types of therapeutic diets.
R12	Compare the extent to which nurses and dieticians agree (inter-rater reliability) when scoring nutritional risk using the WAASP tool; if testing shows poor concordance then provide refresher training on the use of the WAASP tool.

Patient experience	
R13	Improve the patient experience by: • continuing to promote the protected mealtime policy amongst wider groups of staff; • ensuring patients are treated with dignity by serving meals on plates where appropriate; • working with the patient liaison representatives and patients to assess the quality of catering services; and • taking account of, and addressing, the less favourable views expressed by patients responding to our survey.
R14	Provide explicit information about catering and nutrition services for patients that sets out the following: • the arrangements for ordering meals at the different hospitals, including the use of menus; • the availability of snacks and how these can be ordered; • why patients are discouraged from bringing their own food into hospitals; and • why some food items are not routinely available, like skimmed milk or toast.

Appendix 3

Cost of non-patient catering services and income generated

The tables below shows an overall reduction in the subsidy to non-patient catering services between 2010-11 and 2012-13.

Table 1: Cost of non-patient catering services and income generated 2010-11

Costs and income	Princess of Wales	Morriston	Singleton	Neath	TOTAL
Staff	371,139	546,712	566,672	223,516	1,708,039
Provisions	137,251	358,297	261,489	196,832	953,869
Other consumables	21,544	84,747	55,227	22,474	183,992
Total costs	**529,934**	**989,756**	**883,388**	**442,822**	**2,845,900**
Income	**250,822**	**814,519**	**670,522**	**364,953**	**2,100,816**
Gap	**279,112**	**175,237**	**212,866**	**77,869**	**745,084**

Source: ABMUHB Catering Subsidy Report, February 2014

Table 2: Cost of non-patient catering services and income generated 2012-13

Costs and income	Princess of Wales	Morriston	Singleton	Neath	TOTAL
Staff	390,721	527,117	490,555	311,280	1,719,673
Provisions	133,736	427,172	213,058	132,140	906,106
Other consumables	38,098	46,444	63,280	20,519	168,341
Total costs	**562,555**	**1,000,733**	**766,893**	**463,939**	**2,794,120**
Income	**324,095**	**864,467**	**633,389**	**377,120**	**2,199,071**
Gap	**238,460**	**136,266**	**133,504**	**86,819**	**595,049**

Source: ABMUHB Catering Subsidy Report, February 2014

Appendix 4

Ward care metrics reporting – nutrition scoring example

The table below shows an example of the reporting format for ward care metrics relating to nutrition scoring, as used by the Health Board. The percentages relate to a small sample of patients from the ward each month. The absence of actual numbers of patients in this format has the potential to mislead the reader regarding the level of assurance provided.

Singleton Hospital, Ward 7

	Percentage of Nutrition Score Completed and Appropriate Action Taken within 24 hours of admission	Percentage of repeat nutritional risk assessments being undertaken within identified timescale (out of no of patients looked at in sample)	Percentage of patients assessed as being a moderate or high risk with a food chart in place and care plan
Apr 2013	100.00%	100.00%	100.00%
May 2013	100.00%	75.00%	100.00%
Jun 2013	100.00%	100.00%	100.00%
Jul 2013	100.00%	100.00%	100.00%
Aug 2013	93.33%	100.00%	100.00%
Sep 2013	100.00%	100.00%	100.00%
Oct 2013	100.00%	100.00%	100.00%
Nov 2013	100.00%	100.00%	100.00%
Dec 2013	100.00%	100.00%	100.00%
Jan 2014	100.00%	100.00%	100.00%

Source: ABMUHB Ward Care Metrics, February 2014

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