WALES AUDIT OFFICE
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Follow-up Review of Hospital Catering Services

Cwm Taf Health Board

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Contents

Cwm Taf Health Board has made good progress in implementing our recommendations in relation to catering and patient nutrition services.

Summary report

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 April 2010, we carried out work at Cwm Taf Health Board (the Health Board) to examine whether the Royal Glamorgan (RGH) and Prince Charles (PCH) 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. At that time, we concluded that the arrangements for catering services were generally sound, although the cost of catering services was considerably higher than average, and while patient satisfaction was high, aspects of the patient experience and nutritional screening needed to improve. We reached this conclusion because:

- the redesign of catering services was progressing well;
- the arrangements for food production and cost control were generally robust, however, poor recovery of non-patient catering costs in 2008-09 resulted in higher-than-average net costs, with those for RGH the highest in Wales;
- the arrangements for delivery of food to wards and patients was generally effective but there was scope to provide simple guidance on basic food hygiene [for nursing staff] and to improve certain aspects of patients' experience at mealtimes;
- the Health Board's catering service was flexible and innovative to ensure most patients received the nutrition that they required but nutritional screening on admission and care plans to manage nutritional risks were not comprehensive; and
- patients' views were actively sought and overall satisfaction with catering services was relatively high.

4. We made a number of detailed recommendations at that time[1], which were also reflected in our national report[2] published in March 2011. Our 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. Between October and November 2012, as part of our programme of local audit work, we examined whether the Health Board had made progress against our recommendations. We concluded that the Health Board has made good progress in implementing the recommendations in relation to catering and patient nutrition services. We reached this conclusion because:

- the historically high costs of catering services is reducing but there continues to be a marked difference in catering costs at the two main hospitals, due in part to the ongoing roll-out of the cook-freeze model at Prince Charles;
- the Health Board is recovering a much bigger proportion of the costs of non-patient catering services but it may be some time before these services breakeven;
- the Health Board has reduced food waste and is now comfortably complying with the wastage target set by the Welsh Government;
- ward staff continue to comply with basic food hygiene practice but poor compliance with the MUST[3] e-learning package means that nursing staff are not making use of general guidance on food hygiene;
- the Health Board has taken positive steps to improve patients' mealtime experiences; compliance with protected mealtimes has improved, and nursing staff are generally available to help patients at the right time; and
- there are improvements in nutritional care with patients being screened on admission but nutritional care plans are not always in place and compliance with the MUST e-learning package is poor.

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

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

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

[3] The Malnutrition Universal Screening Tool (MUST) was designed by the Malnutrition Advisory Group of the British Association for Parenteral and Enteral Nutrition, as an effective way of identifying adults (particularly the elderly) who are malnourished, at risk of malnutrition, or obese.

Recommendations

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

R1	**Differences in patient catering costs between RGH and PCH remain while non-patient catering services have yet to breakeven**. The Health Board should continue to monitor the difference in patient catering service costs and to ensure that non-patient services breakeven as quickly as possible.
R2	**Nutritional care plans are not always in place**. The Health Board should include a review of a sample of care plans when carrying out spot check audits of dignity, protected mealtimes and nutritional screening.
R3	**Compliance with the e-learning package introduced in 2011 to support improvements in the application of MUST and all-Wales food charts is poor**. The Health Board should: • investigate the amount of time needed to complete the e-learning package; • ensure incumbent nursing staff are either given adequate time to complete the e-learning package in one sitting, or remind nursing staff that it can be completed over subsequent days; and • include the e-learning package in induction training for new starters.

Appendix 1

Detailed audit findings

Issues	Detailed findings from follow-up audit work
Have the reasons for higher-than-average catering costs been identified and addressed?	**The historically high cost of catering services is reducing but there continues to be a marked difference in catering costs at the two main hospitals, due in part to the ongoing roll-out of the cook-freeze model at Prince Charles** ***Ongoing action by the Health Board to review the cost effectiveness of catering services is helping to bring down the high cost per patient day at the RGH*** The Welsh Government took the decision to implement a costed model for catering services in 2012, which is supported by a new set of data definitions for the Estates and Facilities Performance Management System (EFPMS). We relied on the EFPMS for the most up-to-date comparative information on catering service costs for our follow-up work. Exhibit 1 shows that the total cost of patient catering services at the RGH and PCH rose by 14 per cent from £3.17 million in 2008-09 to £3.62 million in 2011-12. The rise in costs seems to be due in part to the increase in 'other' costs ie, consumables, although it is not clear why these 'other' costs increased so sharply. Changes in costs for provisions and staff have impacted differently on both hospitals over the last four years with provision costs increasing substantially more at RGH compared with PCH, while staff costs reduced at RGH and increased at PCH.

Issues	Detailed findings from follow-up audit work

Exhibit 1: Change in component costs of patient catering services

Hospital		2008-09	2009-10	2010-11	2011-12	Per cent change between 2008-09 and 2011-12
RGH	Staff	£1,378,430	£1,525,862	£1,230,271	£1,348,371	-2%
	Provisions	£711,006	£758,165	£746,092	£825,638	16%
	Other costs	£67,086	£66,103	£78,024	£139,231	108%
Total		**£2,156,522**	**£2,350,130**	**£2,054,387**	**£2,313,240**	**7%**
PCH	Staff	£604,316	£720,928	£681,442	£835,677	38%
	Provisions	£395,445	£355,395	£391,838	£398,840	1%
	Other costs	£17,984	£14,619	£43,960	£71,639	298%
Total		**£1,017,745**	**£1,090,942**	**£1,117,240**	**£1,306,156**	**28%**

Source: Wales Audit Office analysis of data from NHS Estate in Wales Facilities Performance Report 2011-12 and data provided as part of the original audit in 2010

In 2010, we reported that RGH's catering costs per patient day were highest in Wales. We hypothesised that the higher costs at RGH were due to the staff costs associated with the long-established, ward-based catering service and that in the future differences in costs might narrow when changes to pay bands for catering staff took effect at PCH and the roll out of the ward-based catering service model was complete. The rise in staff costs at PCH over the last four years may reflect this impact. At the time of our follow-up work, PCH was still operating its traditional fresh-cook/plated service for those wards which were still being refurbished. The rise in staff costs at PCH may reflect the cost of running both models.

Issues	Detailed findings from follow-up audit work

As part of our follow-up work, we recalculated the cost of patient catering services per bed day using information on average occupied bed days for each hospital. [Information on bed days for 2011-2 has not yet been published for individual hospitals; we have assumed that there has been no change in average occupied bed days.] Exhibit 2 shows that the costs of patient catering services per bed day have narrowed between both hospitals with costs increasing year on year at PCH and reducing at RGH that is until 2011-12. The increase in patient catering costs per bed day at RGH in 2011-12 is not easily explained, particularly as the percentage increase in patient catering costs was higher at PCH between 2010-11 and 2011-12.

Exhibit 2: Trend in the costs of patient catering services per bed day

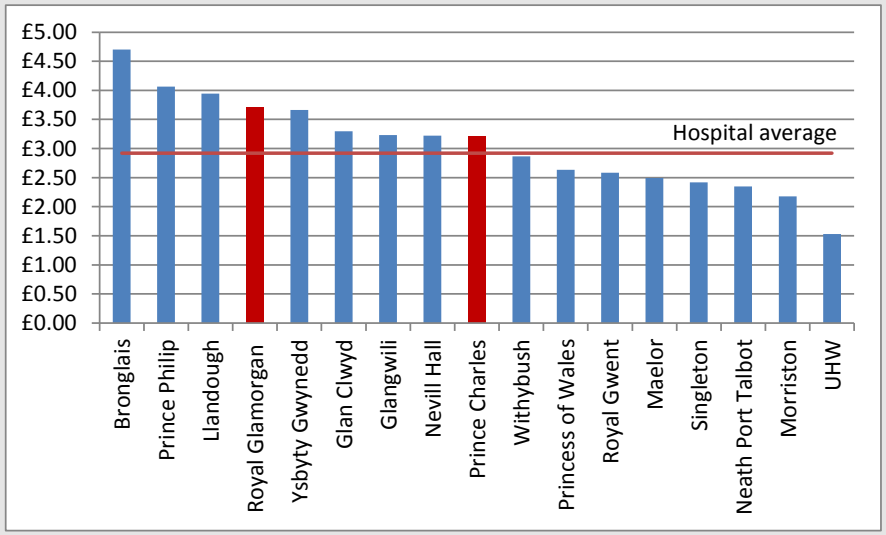
Hospital	2008-09	2009-10	2010-11	2011-12
RGH	£16.62	£15.34	£12.84	£14.42
PCH	£8.23	£9.15	£9.82	£11.45

Source: Wales Audit Office analysis of data from NHS Estate in Wales Facilities Performance Report 2011-12, information on NHS beds available on StatsWales and data provided as part of our original audit in 2010

One of the new EFPMS indicators is the 'cost of a patient meal', which replaces the previous 'cost of a patient meal day' indicator. The indicator is calculated by dividing the costs of patient catering services (ie, provision costs, production costs, costs of ward-based catering assistants and non-consumable costs) by the total number of meals requested (ie, breakfast, lunch, dinner and sandwiches). In 2011-12, the cost per patient meal at RGH and PCH was £3.71 and £3.21 respectively, both higher than the average (£2.92) for other acute hospitals (Exhibit 3). However, Welsh Health Estates acknowledges that the data submitted to the EFPMS included some implausibly wide variations in patient meal costs, between and within other health boards, which distorts the hospital average. Welsh Health Estates anticipates that the accuracy of the data will improve as difficulties with using the new data definitions are overcome.

Issues	Detailed findings from follow-up audit work

Exhibit 3: Cost per patient meal in 2011-12



Source: Wales Audit Office analysis of data from NHS Estate in Wales Facilities Performance Report 2011-12

Our original audit in 2010 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 facilities management group has developed a balanced scorecard to track expenditure against budget, as well as levels of income generated, sickness absence and overtime. These data are helping managers to more easily review the establishments needed to provide high-quality catering services for patients across all its sites.

Issues	Detailed findings from follow-up audit work

The Health Board is recovering a much bigger proportion of the costs of non-patient catering services but it may be some time before these services breakeven

Our previous audit in 2010 found that RGH and PCH did not generate enough income to recover the costs of providing non-patient catering services. Exhibit 4 shows that the cost of non-patient catering services at RGH rose steadily between 2008-09 and 2010-11 before falling in 2011-12, while at PCH costs fluctuated year on year. Both hospitals generated increases in income from non-patient catering services helping to reduce the gap between income and costs. Staff that we interviewed indicated that it may take up to three years to close the gap and break even.

Exhibit 4: Trend in the percentage difference in income and costs for non-patient catering services at RGH and PCH

Year	RGH			PCH		
	Income	Costs	Gap	Income	Costs	Gap
2008-09	£770,722	£1,114,600	-31%	£364,451	£813,153	-55%
2009-10	£812,844	£1,208,083	-33%	£382,356	£658,645	-42%
2010-11	£828,382	£1,338,092	-38%	£496,756	£779,170	-36%
2011-12	£953,306	£1,251,532	-24%	£554,865	£665,521	-17%

Source: Wales Audit Office analysis of data from NHS Estate in Wales Facilities Performance Report 2011-12

Issues	Detailed findings from follow-up audit work
	A review by Internal Audit in summer 2012 found that the profit or loss made by individual hospital restaurants could not be accurately quantified because unique cost codes were not maintained for individual restaurants. Cost codes were maintained on a per-hospital basis for catering services. Income and expenditure, including staff costs relating to the restaurants, in-patient meals and snacks were all reported together with the catering management team apportioning costs for patient and non-patient catering services when submitting information to the EFPMS. Internal Audit recommended that individual cost centres be created and maintained for each hospital restaurant to ensure accurate reporting on costs and profitability and to identify opportunities for improvement. At the time of our follow-up work, the Health Board had established separate cost centres, which is enabling better monitoring of profit and loss across non-patient catering services. The Health Board continues to take action to review the most profitable opening time of the restaurants at RGH and PCH. The Health Board is using the Electronic Point of Sale (EPoS) system to monitor the number of transactions at particular times of the day, as well as reviewing the most profitable product lines. At RGH, this would mean that the restaurant should open later and close earlier. Before any change in operating hours, alternative arrangements to access hot food will need to be in place for those staff eg, junior doctors, working overnight. At the time of our follow-up work, the Health Board was exploring alternatives to the current system. In addition to providing alternative access to hot meals, the Health Board will have to make arrangements to redeploy any catering staff affected by changes in operating hours. ***The Health Board has continued to invest in hospital catering services*** The Central Production Unit (CPU) has recently been expanded and upgraded to meet the needs of all the Health Board's hospitals. The upgrade also includes investment in new IT systems, such as Menumark, which will provide real-time information on recipe costs, nutritional content and stock control. The Health Board reports that Menumark brings big improvements to real-time information and efficiencies for the CPU, particularly in producing nutrient labels for food products. The CPU has been separated from the patient catering and restaurant services, and now operates as an 'independent business unit'. All cook-freeze products supplied to RGH and PCH are priced to reflect the cost of the provisions and production costs (ie, staff costs and consumables like the food containers). Like the patient and non-patient catering services, the CPU's performance is closely monitored by the Facilities management group using a balanced scorecard. To remain competitive, the CPU plans to market test its products with other well-known brands.

Issues	Detailed findings from follow-up audit work
Have the systems for the monitoring and recording of food waste been reviewed to ensure their effectiveness?	**The Health Board has reduced food waste and is now comfortably complying with the wastage target set by the Welsh Government.** In 2010, we found that not all un-served meals were recorded on the 'ward temperature sheet' after each meal service. Our observation of the lunchtime meal service found that the number of un-served portions was very low but the number of un-served portions was not recorded afterwards. When we enquired why not, we were told that the new ward-based catering model meant that only the right number of meals was regenerated and that the volume of un-served food items was negligible. The Health Board needs to assure itself that even where there is perceived to be no waste that this information is captured.
Have arrangements for ensuring compliance with food safety procedures been strengthened?	**Ward staff continue to comply with basic food hygiene practice but poor compliance with the MUST e-learning package means that nursing staff are not making use of general guidance on food hygiene.** Our report in 2010 found that although ward staff complied with basic food hygiene practice, there was scope to provide simple guidance. Findings from the 2011 Fundamentals of Care audit indicated that 35 per cent of nursing staff had received basic food hygiene training. The e-learning package on the application of MUST and the all-Wales food charts, which was introduced in 2011, includes a section on general food hygiene awareness for nursing staff. However, uptake of the e-learning package is poor, so nursing staff are not making use of the general guidance available. Meanwhile, the ward-based catering assistant undertakes regular refresher training in food hygiene every two years. Our observation of one meal service found that the ward-based catering assistant and nursing staff followed safe food hygiene practices at mealtimes by hand washing and wearing protective clothing ie, aprons and gloves as appropriate with the temperature of each food product recorded before the service commenced. Each hospital catering service is given a 'hygiene rating' when it is inspected by a food safety officer from the local authority. The hygiene rating shows how closely the catering services are meeting the requirements of food hygiene laws. The catering service receives one of six scores, zero to five: • 0 – Urgent improvement needed • 1 – Major improvement necessary • 2 – Improvement necessary

Issues	Detailed findings from follow-up audit work
	• 3 – Generally satisfactory • 4 – Good • 5 – Very good The food hygiene ratings are now collected routinely as part of the EFPMS submissions, which enables hospitals to easily compare performance. The catering services at RGH and PCH are rated as 'good'.
Have steps been taken to ensure that the patient mealtime experience on all wards is a positive one?	**The Health Board has taken positive steps to improve patients' mealtime experiences; compliance with protected mealtimes has improved and nursing staff are generally available to help patients at the right time** Our previous audit work showed that overall satisfaction with hospital catering services was high but that some aspects of the mealtime could be improved, in particular compliance with the protected mealtime policy and ensuring all patients had the opportunity to prepare for their meals. The catering department continues to seek regular feedback from patients about the food service and the feedback collected by the catering service indicates that patients are generally satisfied. Nursing staff also indicated that over the last two years, the number of complaints about food from patients on the ward seems to have reduced with the choice and quality of meals improving. The Health Board has also introduced a new seasonal menu offering patients a greater range of dishes and meals, which comply with the revised all-Wales nutrition and catering standards for food and fluid for hospital in-patients, which were published in October 2011. The menu now offers lighter meals at lunchtime where the gap between breakfast and lunch is relatively short (four hours), and a more substantial meal in the evening where the gap between supper and breakfast is more than 14 hours. This small change addresses the concerns raised by patients about the long gap between supper and breakfast highlighted in our previous audit. On the ward that we visited, the ward-based catering assistant, in collaboration with nursing staff, will help patients choose a suitable meal option from the seasonal menu based on choice and nutritional needs. Although the new menu is laminated and remains at the patients' bedside, ward staff perceive that most patients do not look at it.

Issues	Detailed findings from follow-up audit work
	The Health Board published its *Dignity Pledge* in March 2011. The *Dignity Pledge* lists 16 pledges of which four are related to mealtimes, in particular ensuring protected mealtimes are in place, providing opportunities for patients to wash their hands prior to meals, assisting patients to get into a comfortable position for eating, as well as ensuring meals and drinks are within reach and providing assistance for those who need help eating, including welcoming relatives and carers to assist. The *Dignity Pledge* was prominently displayed on the ward that we visited as part of the audit. Patients are informed of the *Dignity Pledge* as part of the admission process and a copy of the pledge is kept with the nursing documentation at the patient's bedside. The Health Board has also adapted the Alzheimer Society's leaflet *This is Me* for use in the ward environment to ensure things like food preferences can be more easily shared between patient and ward staff. The Health Board has also developed guidelines for nursing staff at mealtimes. These guidelines set out the expectation that meal bed plans, which set out patient requirements eg, pureed diet, will be completed every morning by the nurse in charge and shared with the catering assistants as early as possible with changes to the bed plan communicated throughout the day. Interviews with ward staff also indicate this is the usual practice and the whiteboard was in use on the day of our ward visit. The guidelines also state that a designated nurse should accompany catering assistants when meals are being served to ensure that patients are ready to take their meal and that patients who need assistance with eating meals should not be given their meal unless a nurse is available to help. The Health Board has introduced nutrition care champions on the wards to ensure that these guidelines become embedded. Our observation of the meal service found that nursing and catering staff worked well together to provide an efficient meal service, in particular: • patients were helped to get comfortable in readiness for lunch, with patients offered the opportunity to wash their hands; and • all nursing staff were ready to assist the catering assistant once the meal trolley arrived on the ward, giving patients their meals and then immediately assisting those patients with eating difficulties or in need of encouragement.

Issues	Detailed findings from follow-up audit work
	There was full compliance with protected mealtimes with all other staff leaving the ward and not returning until after the meal service, approximately one hour later. The findings from the 2011 Fundamentals of Care audit indicated that most patients were given assistance and were not interrupted during their meals. Furthermore, the Health Board's own spot check audits of dignity, protected mealtimes and nutritional screening across a sample of wards in early 2012 showed that: • Patients were observed being helped to prepare for meals although not all patients had access to hand wipes before or after meals and alternatives were not provided. • On some wards, nursing staff were observed having a break during the meal service instead of working with the ward-based catering staff to give out meals. • Those patients who needed help or encouragement with eating were given it but sometimes meals would be served to patients who needed help before nursing staff were ready, or able, to assist them. Relatives and carers were observed helping patients with eating. • Full compliance with protected mealtimes was not always evident but ward environments, with the exception of the medical assessment units, were described as conducive to eating. The reason for less than full compliance was that other members of the multidisciplinary team – doctors, physiotherapists, etc – were on the ward during the meal service but interruptions were kept to a minimum. For those patients leaving the wards during mealtimes for tests or investigations, alternative arrangements were made for a replacement meal. And on some wards, nursing staff were carrying out medicine rounds during the meal service. The ward-based catering service continues to be rolled out at PCH as wards are refurbished. This new catering model was welcomed on the ward that we visited. Nursing staff indicated that this new model provided them with more time to help patients with eating as they no longer had to serve the meals. The new model also provides greater flexibility around the start of mealtimes to suit patients' needs because the 'regeneration' process is managed by the catering assistant on the ward, for example on the ward that we visited, the lunchtime service commenced half an hour after most other wards.

Issues	Detailed findings from follow-up audit work
Has compliance with nutritional screening and care planning improved?	**There are improvements in nutritional care with patients being screened on admission but nutritional care plans are not always in place and compliance with the MUST e-learning package is poor** Our previous audit found that not all patients were screened on admission in relation to nutritional risk, the information recorded as part of the screening process was not always comprehensive and nutritional care plans were not in place for all patients. As part of our follow-up work, we reviewed the case notes of five patients to assess whether nutritional screening was undertaken and whether a nutrition care plan was in place. In 2010, we found that the nursing assessment documentation did not prompt nursing staff for a detailed description of the problems identified. Revised nursing documentation – *nursing assessment on admission* – has been rolled out and according to nursing staff that we interviewed has standardised the process. However, the lack of prompts for more detailed information remains, particularly in relation to 'nutrition'. Nursing staff continue to circle yes or no to a series of short questions, such as 'is assistance is required for eating' but there is no prompt to record a description of the assistance needed. Although there are a number of prescribed nursing actions on the MUST care plan that include identifying the help needed, it is not clear where this information is recorded. The review of the five case notes indicated that all patients had been screened on admission using the MUST tool and there was evidence that all patients had been rescreened at the appropriate intervals. Irrespective of the MUST score, a nutrition care plan should be in place. We found that a care plan was in place for only three of the five case notes reviewed which is broadly similar to our findings in 2010. The two patients who did not appear to have a nutrition care plan in place had been nutritionally assessed as at high risk; however, there was evidence that their food intake was being monitored and recorded. The findings from the 2011 Fundamentals of Care audit show that performance in relation to Standards 9 – Eating and Drinking – continued to improve between 2009 and 2011, and that better access to speech and language therapists is needed to undertake swallowing assessments for patients on admissions although plans were being developed to provide training to registered nurses to enable them to undertake the assessments. Basic food hygiene training for nursing staff was also highlighted as an area for improvement. The Health Board's own spot check audits of dignity, protected mealtimes and nutritional screening across a sample of wards in early 2012 showed that: • nutritional assessments using the MUST tool were generally carried out on every patient, but in some cases, not all patients were weighed on admission or weighed as frequently as required when assessed as medium or high risk; and • food charts were completed appropriately.

Issues	Detailed findings from follow-up audit work
	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, in particular the MUST tool and the use of the all-Wales food charts. 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. However, the Health Board has indicated that only 10 per cent of nursing staff have registered and/or completed the e-learning package. The reasons cited for poor compliance were a lack of protected time to undertake the training and slow access speed to the online training package. The uptake of the e-learning training is reported at each meeting of the catering and nutrition group (which reports to the corporate risk committee and the divisional integrated governance committee) but with little follow-up action evident. The Welsh Government has brought together all relevant policy guidance on hospital catering and patient nutrition into an intranet website called the *Hospital Nutrition and Catering Framework*. The website should be accessible to all wards via the All Wales Nursing Information Zone but the nursing staff that we met told us trying to access the site took too long – ie, the speed of connection – but once they were connected to the website, they did not experience any problems.

Appendix 2

Recommendations made in 2011

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

The Health Board should ensure its arrangements for catering and nutrition services address the following:	
R1	Examine the reasons for the higher-than-average catering costs per patient day by: • benchmarking numbers and costs of catering staff; • assessing the cost effectiveness of the opening hours of the staff/visitor restaurant at RGH; • checking the robustness of the formula used to price products for staff and visitors; and • reviewing pricing structures in the staff/visitor restaurant, and in doing so, making a clear decision about the level of costs to be recovered from non-patient catering services.
R2	Review the assumptions underpinning the roll out of the cook-freeze model at PCH to compare projected costs with those presented in this report.
R3	Assess the systems for monitoring and recording waste by: • improving the completion of ward temperature sheets for all food products and not just those regenerated on the ward; and • examining reasons for regenerating too much if wastage levels exceed an agreed threshold.
R4	Improve the patient experience by: • ensuring bed plans are completed at least daily; • continuing to promote the protected mealtime policy amongst wider groups of staff; • ensuring ward staff make time to help prepare patients for their meals; • rolling out the enhanced role for ward-based catering staff if the pilot scheme is successful; • ensuring patients have access to the patient information booklet and understand the information setting out arrangements for catering services, such as the use or otherwise of menu cards, and the availability of snacks; • revising the patient information booklet in due course to reflect the reasons why patients are discouraged from bringing in their own food; and • taking account of, and addressing, the less favourable views expressed by patients responding to our survey.

R5	Ensure compliance with food safety procedures by: • ensuring that all catering staff and food handlers receive the necessary training in food hygiene; and • developing guidance on basic food hygiene forward staff that underpins policies and procedures in relation to ward-based catering services.
R6	Improve compliance with nutritional screening and care planning by: • exploring the reasons for non-compliance with nursing staff; • providing simple guidance on how to use the nutritional risk screening tool; • recording more detail about patients' nutritional health on the Admission/24-hour Nursing Assessment Form; and • considering regularly auditing compliance with nutritional screening and the comprehensiveness of care plans.

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