

Hospital Catering and Patient Nutrition Follow-up Review

Cwm Taf University Health Board

Audit year: 2015

Issued: October 2015

Document reference: 502A2015

Status of report

This document has been prepared as part of work performed in accordance with statutory functions.

In the event of receiving a request for information to which this document may be relevant, attention is drawn to the Code of Practice issued under section 45 of the Freedom of Information Act 2000. The section 45 Code sets out the practice in the handling of requests that is expected of public authorities, including consultation with relevant third parties. In relation to this document, the Auditor General for Wales and the Wales Audit Office are relevant third parties. Any enquiries regarding disclosure or re-use of this document should be sent to the Wales Audit Office at info.officer@audit.wales.

The person who delivered the work was Sara Utley.

Contents

The Health Board has made good progress in addressing recommendations to improve catering and nutrition services and has significantly reduced the subsidy for non-patient catering. There is further scope to strengthen some aspects of nutritional screening, ensure timely nursing support at mealtimes and reduce the costs of patient catering.

Summary report

Background	4
Our main findings	5
Recommendations	6

Detailed report

Arrangements for meeting patients' dietary and nutritional needs continue to improve but not all patients are regularly assessed and documentation processes need to improve	9
Mealtime experiences have improved, but nursing support at mealtimes was not always timely	14
The level of subsidy for non-patient catering services has reduced significantly and is the lowest in Wales but patient catering costs do not compare favourably with Wales	17
Arrangements for planning, monitoring and reporting on hospital catering and nutrition services are largely robust	23

Appendices

Audit approach	26
National and local recommendations	28

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 the 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 2002¹. In March 2011, the Auditor General published a report², 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.
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 patients³. 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 <http://www.wao.gov.uk/publication/hospital-catering-and-patient-nutrition>

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 2012⁴. 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 Cwm Taf University Health Board (the Health Board) to assess the extent to which it had implemented the Auditor General's national recommendations⁵. We also assessed the extent to which the Health Board had addressed the recommendations made as part of the local audit work in 2010 and again in 2013.
8. We concluded that the Health Board has made good progress in addressing recommendations to improve catering and nutrition services and has significantly reduced the subsidy for non-patient catering. There is further scope to strengthen some aspects of nutritional screening, ensure timely nursing support at mealtimes and reduce the costs of patient catering. We reached this conclusion because:
- Arrangements for meeting patients' dietary and nutritional needs continue to improve but not all patients are regularly assessed and documentation processes need to improve:
 - Although nutritional screening is undertaken on admission, not all patients at Ysbyty Cwm Rhondda are rescreened, assessment information is sometimes fragmented and care plans are not always in place.
 - Compliance with the nutritional care pathway is routinely assessed and reported both locally and corporately.
 - Current arrangements ensure patients have access to food and drinks 24 hours a day with compliance regularly monitored.
 - Menu items are nutritionally assessed through the all-Wales menu framework with which the Health Board is compliant.
 - Written information is provided for patients on what to expect in hospital.
 - Mealtime experiences have improved, but nursing support at mealtimes was not always timely:
 - Patients are positive about food services and menus are well presented demonstrating a strong patient focus.
 - Nursing support and supervision at mealtimes was not always timely.
 - Protected mealtime principles are more widely embedded than previously.

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.

-
- The level of subsidy for non-patient catering services has reduced significantly and it is the lowest in Wales but patient catering costs do not compare favourably with Wales:
 - Patient meal costs are rising along with increases in patient meals but across Wales costs and meal orders are falling.
 - There are clear guidelines about what constitutes un-served meals with un-served wastage the lowest in Wales.
 - The gap between the cost and income for non-patient catering services has reduced significantly and is the lowest in Wales.
 - Arrangements for planning, monitoring and reporting on hospital catering and nutrition services are largely robust:
 - There are well established arrangements through the Catering and Nutrition Group to ensure national policies and standards are implemented.
 - Corporate arrangements for monitoring the nutritional care pathway and food quality are well established.
 - There are good mechanisms in place to capture and act upon patient feedback about catering and nutrition.
9. Detailed findings from the audit work are summarised in the main body of this report.

Recommendations

10. The Health Board has fully achieved 25 recommendations previously set out in our national and local reports. 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. In addition, the Health Board needs to reconsider its governance and accountability framework for catering and nutrition services in light of interim arrangements for executive director portfolios. These recommendations are set out in [Exhibit 1](#). A full list of the national and local recommendations, along with the status of each recommendation is set out in [Appendix 2](#).

Exhibit 1: National and local recommendations still to be achieved at July 2015

Recommendations

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 (National).
- 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 (Local).
- 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 (Local).
- 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. (Local)

Controlling the costs of the catering service

- 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 (National).
- R7a We recommend 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 (National).
- 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 (National).
- R1 Differences in patient catering costs between Royal Glamorgan Hospital (RGH) and Prince Charles Hospital (PCH) remain, while non-patient catering services have yet to break even. The Health Board should continue to monitor the difference in patient catering service costs and ensure that non-patient services break even as quickly as possible. (Local)

Recommendations

Effective service planning and monitoring

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. (National).

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. (National).

Detailed report

Arrangements for meeting patients' dietary and nutritional needs continue to improve but not all patients are regularly assessed and documentation processes need to improve

- 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 quality of the nursing records. Not all NHS bodies regularly monitored compliance with the nutritional care pathway. At the Health Board, we found that at that time, patients were not always screened on admission in relation to nutritional risk, and the information recorded as part of the screening process was not always comprehensive. Nutritional care plans were not always in place for all patients. Follow-up audit work in 2013 found that there had been improvements with patients nutritionally screened upon admission but again care plans were not always in place.

Although nutritional screening is undertaken on admission, not all patients at Ysbyty Cwm Rhondda are rescreened, assessment information is sometimes fragmented and care plans are not always in place

- 12.** As part of our 2015 work, we reviewed a set of case notes on each of the two wards that we visited as part of the audit, 10 case notes in total. We assessed whether nursing staff nutritionally screened patients on admission and repeated it at least weekly, as well as the quality of the nutritional screening process. We found that nursing staff routinely screened patients on admission using the MUST nutritional screening tool.⁶ However, not all patients were rescreened according to their risk score and care plan. At Ysbyty Cwm Rhondda (YCR), none of the five patients had an up-to-date nutritional risk score and we were unable to locate one of the five nutritional care plans. At the Royal Glamorgan Hospital (RGH), there were up-to-date nutritional risk scores for the five case notes that we reviewed but one of the five nutritional care plans was also missing.
- 13.** Measures of height were estimated for all 10 patients because neither ward had height stadiometers. The 2014 Fundamentals of Care audit found that only 78 per cent of wards had access to height measuring tools. At RGH, nursing staff calculated the body mass index (BMI) using patients' self-reported height, while at YCR, nursing staff used appropriate alternative estimates of height.

⁶ The Malnutrition Universal Screening Tool (MUST) is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

-
14. The All Wales Nutrition and Catering Standards make it clear that oral health and communication are part of nutritional care. Our review found information on oral health recorded in all case notes and eight out of ten case notes recorded communication difficulties. Findings from the 2014 Fundamentals of Care audit also support high levels of compliance with oral health and an improvement in the assessment and management of communication needs.
 15. When patients are admitted, nursing staff complete an initial assessment, in addition to the nutritional screening, that is supposed to capture information on any swallowing difficulties, as well as dietary preferences. Our case note review found that swallowing had not been assessed in two out of the ten case notes reviewed. The 2014 Fundamentals of Care audit identified that only 80 per cent of patients identified as having swallowing problems had an up-to-date plan of care. We also found that there were gaps in information on appetite, usual dietary intake or the need for special or therapeutic diets. There was no record of patients' current therapeutic, lifestyle or cultural requirements in relation to food and fluids for two out of the ten case notes, while two out of ten case notes did not record a patient's usual dietary intake. Whilst undertaking our case note review, we had to look at a number of different sources to locate information relevant to patients' nutritional assessments, which was time consuming.
 16. Nursing staff used template nutritional care plans but we were unable to locate two of the ten care plans for the case notes reviewed. We also found that nursing staff were using the all-Wales food charts to record patients' fluid intake instead of the all-Wales fluid charts. The Health Board's lead nurse for the Fundamentals of Care standards, who helped us with the case note review, also identified patients that should have had their fluid intake monitored but were not.
 17. The Health Board has mechanisms in place to identify those patients who need help with eating and drinking. These include the meal bed plan, the 'intentional rounding' sheet which identifies the level of assistance needed, the drink a drop logo, the butterfly scheme for those patients with a cognitive problem and the 'at a glance' patient boards located near nursing stations. The Health Board does not use the red tray system to identify patients at mealtimes who need help with eating or for whom food intake should be recorded, because it believes this compromises patient dignity. We observed the other mechanisms in operation during our ward visits.

Compliance with the nutritional care pathway is routinely assessed and reported both locally and corporately

18. In 2010, not all NHS bodies monitored compliance with the nutritional care pathway and we recommended that the Health Board establish arrangements for routine assessment of compliance. By 2013, the Health Board was undertaking regular spot-check audits of dignity, protected mealtimes and nutritional screening.
19. The Health Board's 'Hospital Nutrition and Catering Policy' indicates that nutritional screening is important and the Health Board has continued to develop its arrangements. It established a Nutrition and Audit Group, which supports the delivery

of good nutritional care by reviewing national policies and guidelines, and providing advice and guidance to ensure the successful implementation of the All Wales Nutritional Pathway. This multi-disciplinary group is accountable to the Catering and Nutrition Group.

- 20.** Members of the Nutrition and Audit Group support the delivery of the Patient Catering and Nutrition Audits, which includes the lead Fundamentals of Care Nurse. Recently the Patient Catering and Nutrition Audits identified reduced compliance with nutritional assessments. In response the Nutrition and Audit Group has developed a focused (Malnutrition Universal Screening Tool) MUST audit tool to be used at ward level to improve compliance and raise the profile of nutritional assessment. The MUST audit assesses whether:
- nutritional screening is undertaken within 24 hours of admission;
 - weights are recorded;
 - appropriate actions are taken depending on the MUST risk score;
 - nutritional screening is repeated at appropriate intervals;
 - special dietary or functional requirements are reflected in care plans;
 - patients' hydration needs are met and fluid balance charts are used appropriately; and
 - patients' dietary needs are communicated to catering staff.
- 21.** The MUST compliance is now assessed monthly, across all wards by ward staff while the lead nurse for Fundamentals of Care standards also carries out spot checks. The results are collated by the lead nurse for Fundamentals of Care standards, who submits a quarterly report to the Quality and Safety Committee.
- 22.** Compliance with nutritional screening is one of three mandatory metrics on the all-Wales nursing and midwifery dashboard with regular reporting to the Welsh Government. This metric is also included in the Health Board's Integrated Performance Dashboard which is presented at each meeting of the Board. Data presented to the Board in July 2015 shows that compliance with nutritional screening is generally at or above 95 per cent but in March compliance dipped to 93 per cent.
- 23.** In 2010, there were no regular training programmes or refresher training for ward staff to maintain awareness on using the nutritional screening tools and assessment documentation. The Welsh Government introduced an e-learning training 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 training package within 12 months of this date while new staff should complete it within 12 months of appointment. Our follow-up review in 2013 found that compliance with the e-learning training package was poor. Our recent audit work has found that 14 per cent of new starters have undertaken the e-learning module and overall compliance was 77 per cent for all staff. The Health Board is working to increase achieving full compliance by March 2016. It set up classroom-based sessions delivered by the lead nurse for Fundamentals of Care standards. Although attendance at these sessions was high initially, attendance has deteriorated due to heavy

workloads with wards unable to release staff to attend. During our ward visits, ward staff told us of problems accessing the e-learning system because of problems obtaining passwords and physical access to a computer, which affects compliance.

- 24.** At the Health Board in 2010, we found that ward staff complied with basic food hygiene practice, but there was scope to provide simple guidance. By 2013, the Health Board's ward-based catering staff were undertaking refresher training in food hygiene every two years. Our latest audit found that these arrangements have been maintained, and there are ongoing discussions about training ward-based catering staff to complete the all-Wales food charts.

Current arrangements ensure patients have access to food and drinks 24 hours a day with compliance regularly monitored

- 25.** 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.
- 26.** At the Health Board, snacks are available between meals and for patients who miss a meal. A range of snacks, such as biscuits, fresh fruit, yoghurts, cheese and crackers and sandwiches, as well as staples like bread, cereal and milk, are stored in ward kitchens. Snacks are offered during the mid-morning and mid-afternoon beverage rounds but patients can request snacks from nursing staff and ward-based catering staff at any time of the day. During our visit to RGH, ward staff were unsure about the availability of snacks.
- 27.** The Health Board monitors the availability of snacks through the Patient Catering and Nutrition Audits.
- 28.** In addition to snacks, staff can access hot and cold vending machines for patients who need meals out of hours because they were a late transfer into the hospital or missed a mealtime. Access to the vending machines is with tokens. The hot and cold vending machines are also available for patients – in the accident and emergency Departments – who require a hot meal.
- 29.** The 2014 Fundamentals of Care audit found ward areas complied fully with providing 'a range of snacks for patients who missed meals or were hungry between meals with 94 per cent of patients always or usually provided with nutritious food and snacks. The Health Board also monitors availability of snacks through the Patient Catering and Nutrition audits which are undertaken bi-monthly across the Health Board.
- 30.** The standards for patient food and fluid identify that seven to eight beverage rounds offering hot and cold drinks should take place each day, and that water in jugs should be changed three times a day. The 2014 Fundamentals of Care audit found that drinking water was available and within patients' reach, however, only 52 per cent of wards achieved seven or more beverage rounds a day, and water jug replenishment

three times a day. During our ward visits, ward managers and ward-based catering staff told us they provide seven to eight drinks per day and that, typically, water jugs were changed three times a day.

Menu items are nutritionally assessed through the all-Wales menu framework with which the Health Board is compliant

31. In 2010, we found that dieticians were involved in menu planning at all hospitals but not all hospital menus had been nutritionally assessed. At the Health Board, dieticians and clinicians were involved in developing strategy and policy through the Catering and Nutrition Group. Dieticians had also been heavily involved in menu planning and nutritional analysis of recipes. Since then, the Welsh Government published the All Wales Nutrition and Catering Standards, which specify the 12 minimum nutrients for analysis. The Health Board indicated that it is fully compliant with the all-Wales menu framework using the recipes in the database to design the patient menu. All food items in the vending machines have also been nutritionally assessed.
32. The multidisciplinary operational menu group works to design menus to meet energy and minimum nutrient requirements. The Health Board contributes to the all-Wales menu framework group where compliance with the menu framework and catering and nutrition standards is discussed, as well as how it is integrated into current reporting mechanisms with NHS organisations. The Health Board also contributes to the all-Wales commodity advisory group, working with the procurement dietician based with the NHS Shared Services Partnership, to ensure food suppliers provide nutritional information about their products to assess compliance with nutritional standards.

Written information is provided for patients on what to expect in hospital

33. 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 provision 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**. In 2010, we found that the Health Board's patient information booklet set out what patients could expect in relation to their care, such as being provided with prompt assistance at mealtimes to ensure they were able to enjoy a warm appetising meal. Our follow-up work in 2013 found that this message was reinforced through its Dignity Pledge, with 4 of the 16 pledges relating to mealtimes. The 'Dignity Pledge' was prominently displayed on wards and included in bedside documentation. These arrangements remain in place.
34. The Dignity Pledge is integrated into all packs of adult nursing notes and staff are encouraged to discuss it with patients/families. In addition, information on the patient menu is available on the Health Board's website should patients want to access it.

Mealtime experiences have improved, but nursing support at mealtimes was not always timely

35. 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, our 2010 work showed that overall satisfaction with hospital catering services was high but some aspects of the mealtime could be improved, in particular, compliance with the protected mealtime policy and ensuring that all patients had the opportunity to prepare for their meals.
36. In 2013, we found that the Health Board had taken positive steps to improve patients' mealtime experiences and that compliance with protected mealtimes had improved with nursing staff generally available to help patients at the right time. A new seasonal menu had also been introduced which offered patients a greater range of dishes and meals, which complied with the all-Wales nutrition and catering standards. Mealtime guidelines were also developed for nursing staff. These guidelines set out the expectation that meal bed plans would be produced on a daily basis to provide information to catering staff on patients' nutritional requirements, while a designated nurse should accompany catering assistants when meals are served.

Patients are positive about food services and menus are well presented demonstrating a strong patient focus

37. The Health Board's 'Hospital Nutrition and Catering Policy' indicates that catering services should provide a menu that allows patients choice, as well as supporting their nutritional and cultural needs. Currently, the Health Board operates a one-week menu cycle. The Health Board is striving to ensure good levels of choice, and has continued to use seasonal menus to increase variety for patients. Menus contain a mix of lighter options, as well as traditional meals. In the 2014 Fundamentals of Care report patients' comments about the quality and quantity of diet and fluids provided in hospital have been positive, with 95 per cent of responses indicating that they felt that they were always or usually provided with nutritious food and snacks throughout their stay. Monitoring of patients' satisfaction is also undertaken through the Patient Catering and Nutrition Audits with high levels of satisfaction being reported corporately of around 90 per cent.
38. Patient menus are well presented and always available at ward level for patients to make their meal choice. These menus have an anti-bacterial coating to prevent the spread of infections. Work is also currently underway to design pictorial menus to help patients with communication difficulties make their meal choice.

Nursing support and supervision at mealtimes was not always timely

39. The 2014 Fundamentals of Care audit found that all wards helped patients to prepare for mealtimes, bed tables and communal areas were tidied, and all meals were placed within easy reach. As part of our latest audit, we visited one ward at RGH and one ward at YCR to observe the lunchtime meal service. We found that:
- Ward-based catering staff were knowledgeable about patients' nutritional needs and dietary preferences and would help to cut up food and open packaging. They also encouraged patients to eat, tempting them with different meal options when they refused to eat a hot meal.
 - At RGH, nursing and catering staff worked well together to ensure an effective meal service. All ward staff were notified when the meal service was ready to start and each area of the ward had dedicated staff to support patients.
 - At YCR, the ward-based catering assistant did not appear as well supported. Although nursing staff accompanied the ward-based catering assistant during the meal service, there were not enough nursing staff to ensure all patients received timely assistance with their meals at the point of service.
40. The 2014 Fundamentals of Care audit found that all wards had systems in place to allow family or friends to assist with meal times. On the two wards that we visited, nursing staff told us that they welcomed and encouraged family and friends to help patients at mealtimes. At the time of our visit, we did not observe families or friends helping patients with eating.
41. **Exhibit 2** sets out the differences we observed between RGH and YCR. Our observations are based on the activities that we expected to see and whether these activities applied to all, most, some or no patients. On the day that we visited the wards at YCR, the ward manager was absent, which may account for some of the differences observed in practice.

Exhibit 2: Key actions observed as part of the lunchtime service

Observations of the lunchtime service	RGH	YCR
Patients helped to prepare for mealtimes, including using the toilet, washing hands and sitting up or getting out of bed	All	Some (times)
Bedside areas/tables tidied before meals served	All	Some (times)
Bedside areas/tables cleared of clinical waste	All	Most
Ward-based catering staff wear protective clothing	All	All
Temperatures of meals are recorded before service begins	All	All
Nursing staff accompanied the ward-based catering staff during the service	All	Most

Observations of the lunchtime service	RGH	YCR
Patients needing help with eating are easily identified	All	All
Meals are left within reach of patients	All	All
Help is given to cut up food or to remove packaging	All	All
Patients needing help receive it promptly	All	Some (times)
Nursing staff supervise and encourage patients with eating throughout mealtimes	All	Most

Source: Wales Audit Office observations of lunchtime services

42. The Health Board uses bi-monthly Patient Catering and Nutrition audits to ensure compliance with food hygiene, expected meal service practice and the patient experience. These audits look at compliance against a checklist of factors such as, monitoring patient choice, protected mealtimes, observing food hygiene and monitoring staff engagement in mealtimes. Catering and nursing staff, dieticians, and speech and language therapists are encouraged to participate in the audit process to ensure a multi-disciplinary approach to monitoring standards.

Protected mealtime principles are more widely embedded than previously

43. The standard for protected mealtimes is set out in the Health Board's 'Patients Protected Mealtimes Policy'. Our 2010 audit identified some issues with compliance with the protected mealtimes policy, however, our follow-up work in 2013 found that this had improved. Compliance with protected mealtimes is monitored by the Fundamentals of Care nurse, as well as forming one of the questions on the Patient Catering and Nutrition audits.
44. On the two wards where we observed the lunchtime meal service, signage was in place at the ward entrance to explain the purpose of protected mealtimes and the times it operated but the signage was not consistent. It could also be more explicit about encouraging relatives to support mealtimes.
45. For the most part, protected mealtimes were observed with non-essential clinical activity 'winding down' just before the meal service commenced. Staff were confident protected mealtimes worked well with professional colleagues supportive of the principles. At RGH, we observed a ward manager challenging a porter who had come to collect a patient. During our ward visits, we found:
- ▮ Healthcare professional staff for the most part left the ward areas at the start of the meal service, and, if they remained, interactions with patients and nursing staff were minimised.

-
- Ñ Cleaning activities continued in ward corridors during the meal service at the YCR ward but cleaning activities were not carried out at or near patients' bedsides and cleaning activities did not impede the food trolley.
 - Ñ On one ward at YCR, a porter arrived to deliver some medication but he was not observed in patient areas, did not stay long, and his presence did not affect the mealtime service.

The level of subsidy for non-patient catering services has reduced significantly and is the lowest in Wales but patient catering costs do not compare favourably with Wales

46. 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 has been made in computerising hospital catering systems and most of the current catering information management systems relied on manual paper processes.
47. 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 were 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. Our follow-up audit in 2013 found that the Health Board had reduced waste and was comfortably complying with the wastage target set by the Welsh Government.

Patient meal costs are rising along with increases in patient meals but across Wales costs and patient meal orders are falling

48. The Health Board's EFPMS data submissions show that the cost of patient catering services increased by 23 per cent, from £4.93 million in 2011-12 to £6.07 million in 2013-14 (**Exhibit 3**). Meanwhile, these costs reduced by five per cent across Wales. Our analysis of the EFPMS data suggests patient catering costs have increased because of increasing provision and staff costs. However, the number of patient meals

requested increased by only five per cent from 1.62 million meals in 2011-12 to 1.70 million meals in 2013-14, while across Wales, meals requested reduced by four per cent.

49. The Health Board indicated the central production unit (CPU) is failing to recover approximately £50,000 of its running costs. Currently, the CPU recharges the catering manager for the cook-freeze products supplied, which are priced to reflect the cost of the provisions and production costs (ie, staff costs and consumables like the food containers). However, the pricing does not include the 'losses'. Furthermore, the Health Board's current budgetary arrangements for catering services mean that the CPU's 'losses' are not reflected in the EFPMS data. In future, the service model will change whereby the CPU will manage the provisions budget as well as the production budget.

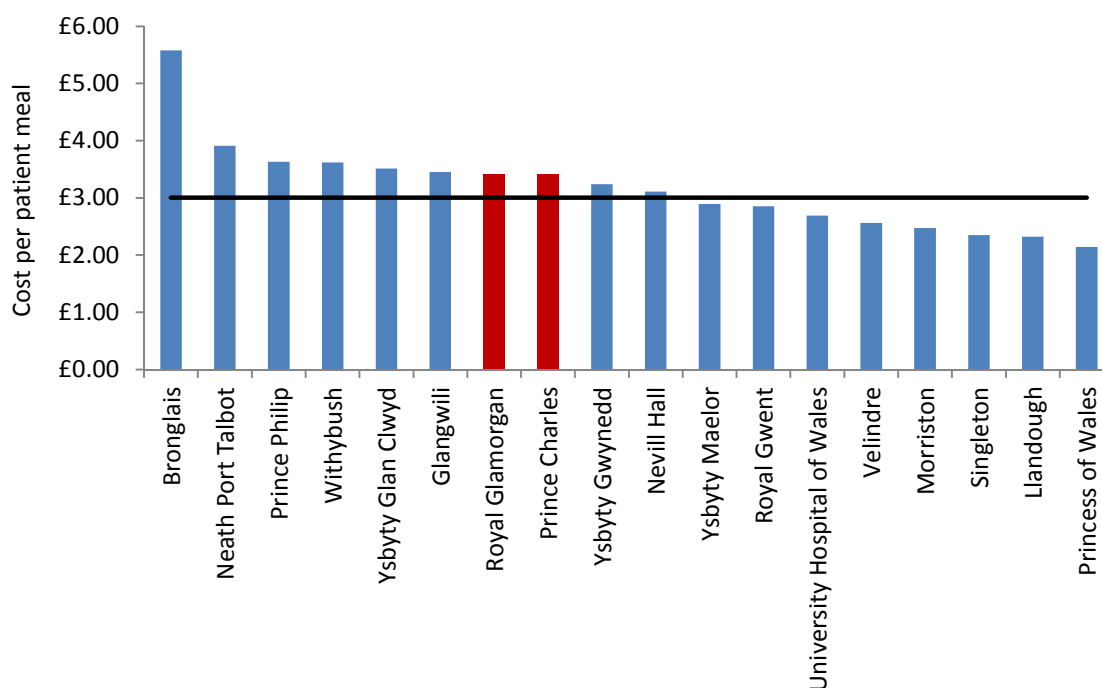
Exhibit 3: Patient catering service costs are increasing

Year	Cost of catering services (£ million)	
	Cwm Taf	Wales
2011-12	4.93	38.95
2012-13	6.05	37.26
2013-14	6.07	36.97

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

50. The Health Board has not set a daily target meal cost per patient. The Health Board acknowledges that patient catering services are relatively more expensive than most other health boards when comparing costs per patient meal. The EFPMS data for 2013-14 show that the cost per patient meal was £3.55 across all the Health Board's hospitals, having increased from £3.03 in 2011-12. The costs per patient meal at PCH and RGH are both above the acute hospital average (**Exhibit 4**).

Exhibit 4: The Health Board's costs per patient meal are above the average cost for acute hospitals



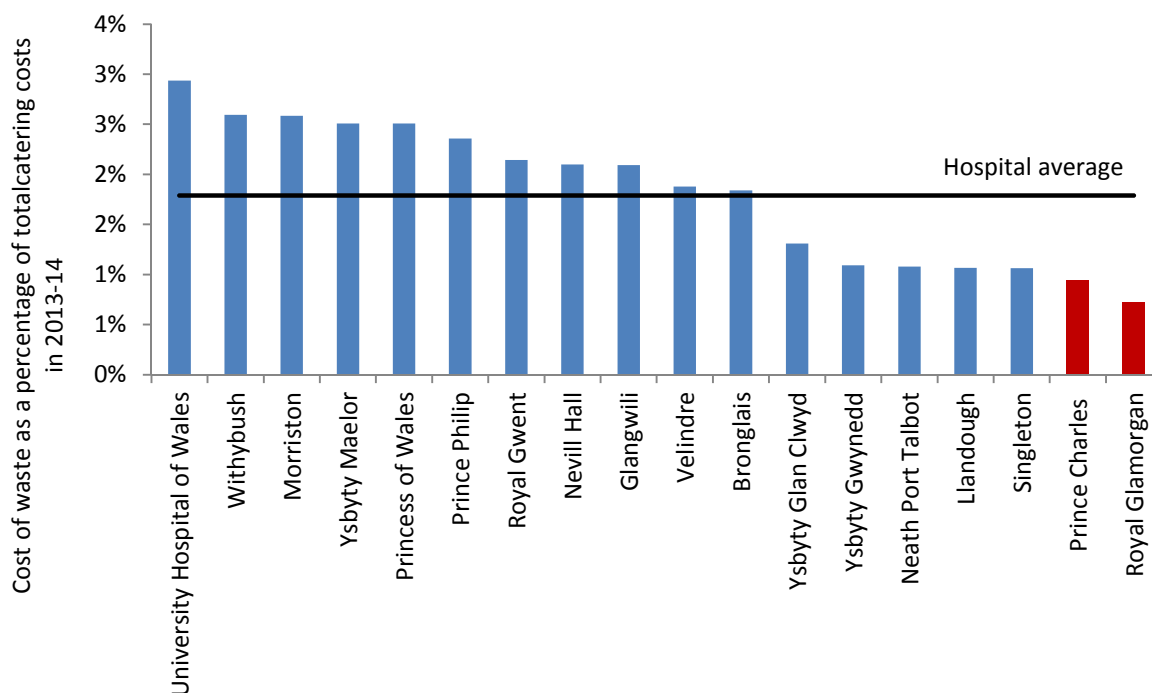
Source: Wales Audit Office analysis of NHS Estates in Wales Facilities Performance supplementary data 2013-14

51. In 2010, the Health Board's food production arrangements relied heavily on manual paper systems rather than on IT solutions. In his national report, the Auditor General recommended that NHS bodies should introduce computerised catering information systems. At the time of our follow-up work in 2013, the Health Board had invested in new IT systems, such as Menumark, to provide real-time information on recipe costs, nutritional content and stock control. The Health Board continues to use these systems. The Health Board continues to use the Electronic Point of Sales system to monitor the number of transactions at particular times of the day, as well as reviewing the most profitable product lines. Detailed profit and loss accounts are available for each area of catering expenditure, enabling detailed analysis of performance.
52. To support the implementation of the 2011 Nutrition and Catering standards, the All Wales Hospital Menu Framework 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 provision commodities for the dishes on the menu framework. The Health Board contributes to the all-Wales menu framework group and the all-Wales commodity group to progress procurement issues, including developing contracts to source local produce from local suppliers.

There are clear guidelines about what constitutes un-served meals with un-served wastage the lowest in Wales

53. In 2010, the Health Board actively monitored un-served food waste but gaps in information may have underestimated the full extent and its cost. By the time of our follow-up work in 2013, the Health Board had improved arrangements to monitor food waste, and wastage was reducing.
54. The Health Board has clear guidelines about what constitutes un-served meal waste. Un-served waste (known as trolley waste) is recorded at ward level for all meal items and collated by the catering teams. The Health Board does not currently record plate waste.
55. The Health Board continues to monitor food waste from un-served meals. In 2014-15, the volume of food waste from un-served meals was less than one per cent across all hospital sites compared with 3.78 per cent at the time of our 2010 audit. This is well below the national target of 10 per cent. The multidisciplinary approach to mealtime audits ensures waste issues are tackled collectively.
56. Analysis of the 2013-14 EFPMS data shows the cost of un-served meals was £68,845 at the Health Board, which equates to less than one per cent of total catering costs. There were small variations between hospitals but overall the Health Board has the lowest waste costs in Wales ([Exhibit 5](#)).

Exhibit 5: The cost of food waste for both RGH and PCH is the lowest in Wales

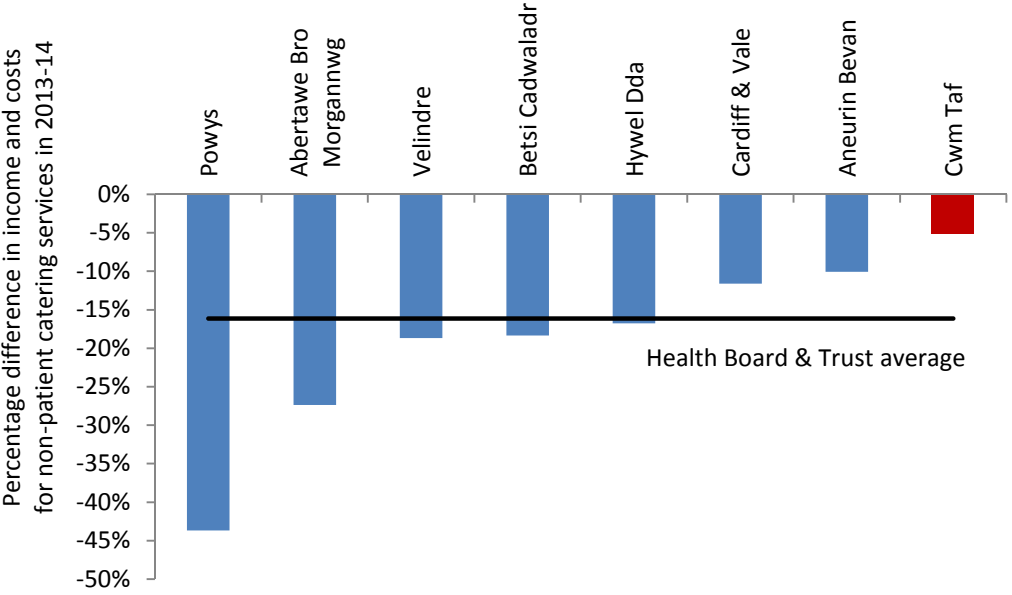


Source: Wales Audit Office analysis of NHS Estates in Wales Facilities Performance supplementary data 2013-14

The gap between the cost and income for non-patient catering services has reduced significantly and is the lowest in Wales

57. Our 2010 audit found that RGH and PCH did not generate enough income to recover the costs of providing non-patient catering services. At that time, we recommended that the Health Board should review the cost effectiveness of the opening hours of restaurants and check the robustness of the formulae to price products for staff and visitors. By the time of our follow-up audit in 2013, the Health Board was recovering a much bigger proportion of the costs of non-patient catering services but it was going to be some time before these services broke even.
58. Actions taken over the last two years include introducing profit and loss accounts for monitoring individual food outlets and reducing restaurant opening hours and numbers of catering staff. In addition, new services have been established, such as the Coffee Shop, which has increased sales.
59. Across Wales, the income generated from non-patient catering services was insufficient to recover operating costs ([Exhibit 6](#)). At Cwm Taf, the cost of non-patient catering services was £1.74 million in 2013-14 and the total income generated was enough to recover 95 per cent of these costs compared with a 26 per cent gap in 2011-12. This equates to a subsidy of £90,272, which is the lowest in Wales ([Exhibit 7](#)). Analysis of the EFPMS data suggest that staff costs for non-patient catering services reduced considerably between 2012-13 and 2013-14 from £1.28 million to £868,783 with the numbers of staff falling by over six per cent. At the time of our fieldwork, the Health Board was compiling the 2014-15 EFPMS data to submit to the NHS Shared Services Partnership; these data may show continued improvement.

Exhibit 6: NHS organisations do not generate enough income to recover the cost of providing non-patient catering services and the Health Board has the smallest gap



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

Exhibit 7: Costs of non-patient catering services continue to fall

Year	Cwm Taf		Wales	
	Cost of non-patient catering services	Income achieved	Cost of non-patient catering services	Income achieved
				(£ millions)
2011-12	2.27	1.67	15.05	11.20
2012-13	2.05	1.78	14.50	11.53
2013-14	1.74 ¹	1.65	13.431	11.26

¹ Includes rental costs for vending machines

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

Arrangements for planning, monitoring and reporting on hospital catering and nutrition services are largely robust

- 60.** 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. Information from nutritional screening was not collated to understand the scale of the problem and likely impact on services. In some NHS bodies, executive accountabilities for catering and nutrition needed to be clearer.
- 61.** In the Health Board at that time, executive accountability for catering and nutrition was clearly identified and sound strategies and policies, developed by appropriate multidisciplinary staff, were in place. The Board had not given detailed consideration to catering and nutrition other than those elements in the Healthcare Standards and Fundamentals of Care audits, with arrangements for performance monitoring and scrutiny in place locally and generally sound.

There are well-established arrangements through the Catering and Nutrition Group to ensure national policies and standards are implemented

- 62.** The Health Board's Nutrition and Catering Policy outlines how the nutrition and dietetic service will work in partnership to ensure patients' nutritional needs are met. In addition, all the legislative and NHS requirements are detailed to ensure that the

nutrition and catering services are compliant with national standards and statutory requirements. The Health Board supports a multidisciplinary approach to meeting patients' nutrition and hydration needs with assurance and oversight provided by the Catering and Nutrition Group. This Group, chaired by the Head of Hotel Services, includes a wide membership of staff from relevant disciplines and a member of the Community Health Council. The group has a broad programme of work, including producing and implementing policies that are ratified by the Board, monitoring compliance with inpatient nutrition and catering standards, implementation of the all-Wales menu framework and implementing the 10 key characteristics for good nutritional care in hospitals.⁷

- 63.** The Welsh Government introduced legislation to make it a mandatory requirement for all food businesses in Wales, including hospital catering, to display their food hygiene ratings. The Food Hygiene Rating (Wales) Act 2013 came into force from November 2013. All sites within the Health Board have a score of 4 and above, that is, good or very good hygiene standards, and a recent inspection at RGH resulted in a score of 5. Ratings are displayed prominently at Health Board sites.

Corporate arrangements for monitoring the nutritional care pathway and food quality are well established

- 64.** The Health Board has arrangements to ensure that issues with catering and nutrition are brought to the attention of the Board. The Chair of the Catering and Nutrition Group reports to the Board level director responsible for facilities, including catering services. The Catering and Nutrition Group was established to co-ordinate catering and nutrition services on behalf of the Facilities Director. The Health Board may wish to update its terms of reference for the Catering and Nutrition Group in light of current interim changes to executive responsibilities.
- 65.** Supporting the Catering and Nutrition Group is the Nutrition and Audit Group. This multidisciplinary group supports the development of policies and procedures by the Catering and Nutrition Group, and it also undertakes the nutritional screening and compliance audits.
- 66.** The Catering and Nutrition Group reports to both the Corporate Risk Committee and the Quality and Safety Committee. In addition to updating the Catering and Nutrition Groups' terms of reference, the Health Board may wish to review and streamline the Catering and Nutrition Group's reporting lines. The terms of reference for the Catering and Nutrition Group suggest it also reports to the divisional integrated governance committee which in turn reports to the clinical governance group.
- 67.** The Catering and Nutrition Group produces quarterly and annual progress reports to provide visibility. A recent Catering and Nutrition quality safety audit report was produced which informed the Board of performance and progress against the all-Wales catering and nutrition standards; this highlighted that patient satisfaction was

⁷ Source: Council of Europe Resolution, Food and Nutritional Care in Hospitals, 2009

high, and low wastage levels across all sites as well as high levels of compliance with food hygiene training amongst catering staff.

- 68.** Information on costs of catering services is less visible at a corporate level, but is monitored and reported at departmental level by the facilities management team. The Health Board, as in other NHS bodies, has yet to collate information from nutritional screening to understand the number of patients identified with nutritional problems on admission, although compliance with nutritional screening is monitored regularly.
- 69.** The Quality and Safety Committee, through the Catering and Nutrition Group, monitored progress in implementing the recommendations from both local and national reports on hospital catering and patient nutrition. A comprehensive update on progress against each of the recommendations was provided to us by the Health Board.

There are good mechanisms in place to capture and act upon patient feedback about catering and nutrition

- 70.** Our work in 2010 reported on a number of formal and informal mechanisms which were in place to capture patients' views. Our recent work found strong arrangements for the measurement of patient experience.
- 71.** Patient experience is a key part of the Patient Catering and Nutrition Audits which are undertaken bi-monthly in wards across the Health Board. There are two parts to the Patient and Catering Nutrition Audit, the first focuses on compliance with catering standards, the second being a focus on patient satisfaction. Patients are asked a range of questions in relation to their experience of the food service which are then collated into a patient satisfaction score. This score forms part of the key performance indicators of the catering service. At the time of our review, patient satisfaction was high in 2014-15 for both community sites (87 per cent) and acute sites (94 per cent).
- 72.** The results from this are collated into a quarterly Catering and Nutrition Quality and Safety Audit Report, which is reported to the Catering and Nutrition Group, which in turn reports to the Corporate Risk Committee.
- 73.** The Health Board works collaboratively with the local Community Health Council (CHC) to assess and improve food and drink services for patients. The CHC representatives have been involved in taste-testing sessions in the past. More recently, CHC representatives worked with the catering department when it was introducing hot and cold vending machines.
- 74.** At the time of our fieldwork, the all-Wales menu framework group was conducting a questionnaire survey of inpatients across all NHS bodies about the choice and quality of food. The Health Board included additional questions on menu choice of relevance to its local services. Dietetic staff distributed 350 surveys to staff across its hospitals, which ensured a good response rate (63 per cent). The Health Board is waiting for the survey findings which are expected mid-summer, at which time it can begin revising the menu cycle and menu options.

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 between March and 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, 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 two wards, 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 wards D4 at YCR and Ward 19 at RGH.

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.

The five sets of case notes reviewed in each ward were selected by the ward managers.

Appendix 2

National and local recommendations

Table 1 sets out the six 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 recommendation⁸ is also set out in Tables 1, 2 and 3.

Table 1 – 2010 local recommendations

Recommendation		Status at July 2015
Controlling Costs		
R1	Examine the reasons for the higher-than-average catering costs by: <ul style="list-style-type: none">• 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.	O
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.	A
R3	Assess the systems for monitoring and recording waste by: <ul style="list-style-type: none">• 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.	A

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****Improving Patient Experience**

R4	<p>Improve the patient experience by:</p> <ul style="list-style-type: none">• 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.	A
R5	<p>Ensure compliance with food safety procedures by:</p> <ul style="list-style-type: none">• ensuring that all catering staff and food handlers receive the necessary training in food hygiene; and• develop guidance on basic food hygiene for ward staff that underpins policies and procedures in relation to ward-based catering services.	A
R6	<p>Improve compliance with nutritional screening and care planning by:</p> <ul style="list-style-type: none">• 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.	O

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.	0
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.	A
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.	A
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.	A
R2a	We recommend that NHS bodies take steps to ensure that all menus in use across hospital sites have been nutritionally assessed by dietitians.	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.	A
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.	A

Recommendation		Status at July 2015
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.	A
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
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 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.	O

Recommendation		Status at July 2015
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.	A
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
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
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 three 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 2013.

Table 3 – 2013 local recommendations

Recommendation		Status at July 2015
Controlling Costs		
R1	Differences in patient catering costs between RGH and PCH remain while non-patient catering services have yet to break even. The Health Board should continue to monitor the difference in patient catering service costs and ensure that non-patient services break even as quickly as possible	O
Ensuring patients' nutritional needs are met		
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.	O
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: <ul style="list-style-type: none"> 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. 	O

Wales Audit Office
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500

Fax: 029 2032 0600

Textphone: 029 2032 0660

E-mail: info@audit.wales

Website: www.audit.wales

Swyddfa Archwilio Cymru
24 Heol y Gadeirlan
Caerdydd CF11 9LJ

Ffôn: 029 2032 0500

Ffacs: 029 2032 0600

Ffôn Testun: 029 2032 0660

E-bost: post@archwilio.cymru

Gwefan: www.archwilio.cymru