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Hospital Catering and Patient Nutrition Follow-up Review

Aneurin Bevan University Health Board

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The team who delivered the work comprised Gabrielle Smith, Delyth Lewis and Carol Moseley.

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Aneurin Bevan University Health Board has made good overall progress in addressing the recommendations to improve catering and nutrition services. The Health Board now needs to focus on strengthening nutritional screening and documentation processes and board reporting, as well as ensuring that all patient areas are prepared for mealtimes and patients receive prompt help with eating.

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Summary report

Background

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

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

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

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

5. To support the implementation of the nutrition and catering 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 to ensure these meet the nutrition and catering standards, and a range of snacks that are compliant with standards and procured through all-Wales contracts.

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

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

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

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

Our main findings

7. Between March and June 2015, we undertook follow-up work at Aneurin Bevan University Health Board (the Health Board) to assess the extent to which it had implemented the Auditor General's national recommendations for securing improvements in meeting patients' nutritional needs and mealtime experiences, controlling catering costs and planning, monitoring and reporting[5]. In addition, we also assessed the extent to which the Health Board had addressed the recommendations made as part of the local audit in 2010.

8. We concluded that the Health Board has made good overall progress in addressing the recommendations to improve catering and nutrition services. The Health Board now needs to focus on strengthening nutritional screening and documentation processes and board reporting, as well as ensuring that all patient areas are prepared for mealtimes and patients receive prompt help with eating. We reached this conclusion because:

- Arrangements for meeting patients' dietary and nutritional needs are improving but screening and documentation processes need to be strengthened:
  - Patients are screened for nutritional problems but documented screening information is fragmented and incomplete.
  - Compliance with the nutritional care pathway is routinely monitored but compliance audits show scope for improvement.
  - Menu items are nutritionally assessed through the all-Wales menu framework and the Health Board is working towards full compliance.
  - Patients have access to food and beverages 24 hours a day with compliance regularly monitored.
  - Written information for patients on what to expect in hospital is available but not widely disseminated.

[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.

- There is scope to improve some aspects of the mealtime experience:
  - Patients are generally positive about food services.
  - Not all patients receive prompt help at mealtimes and there is more to do to prepare the ward environment prior to meal services.
  - Protected mealtime principles are increasingly applied but some hospitals are not yet fully compliant.
- Cost control mechanisms and IT systems are used to manage catering services and while costs compare favourably overall, food costs for patient catering are rising:
  - Cost control mechanisms and IT systems are used for managing the service and while patient meal costs are comparable with the Wales average, food costs for patient catering are increasing.
  - Food waste is regularly audited with wastage below the national target but monitoring at ward level is inconsistent.
  - Non-patient catering services operate at a small loss with the gap between income and costs reducing and one of the lowest in Wales.
- Arrangements for operational monitoring and oversight are robust but board assurance reporting needs strengthening:
  - Structures for oversight and scrutiny of catering and nutrition services remain robust at operational and sub-committee levels.
  - Performance is regularly monitored but board reporting is not comprehensive and relies on the annual Fundamentals of Care Audit.

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

Recommendations

10. The Health Board has fully achieved 35 of the 42 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 not completed, or where we consider insufficient or no progress has been made. 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)**.
Improving patients' mealtime experience	
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 **(national)**.
R10	Introduce protected mealtimes on all appropriate wards and establish arrangements that monitor compliance **(local)**.
Controlling the costs of the catering service	
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)**.
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 are improving but screening and documentation processes need to be strengthened

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. Meanwhile, not all NHS bodies regularly monitored compliance with the nutritional care pathway.

12. At the Health Board, there was scope to improve compliance with the nutritional care pathway. Nutritional assessments were not always completed within 24 hours, nursing staff were not necessarily confident using the nutritional screening tool, and nutritional care plans were not always in place. At that time, we recommended that the Health Board establish monitoring arrangements to assess compliance with the nutritional care pathway and the effectiveness of the process to review food charts.

13. Recent 'Dignity and Essential Care Inspections' by Healthcare Inspectorate Wales (HIW) on a number of wards at the Royal Gwent and Nevill Hall Hospitals identified a number of issues in relation to nutritional care. In particular, nutritional risk scores were not always recorded or oral health assessed. For those patients identified as at risk, care plans did not always reflect the help needed to eat and to drink, while food and fluid intake was recorded inconsistently. Where mechanisms were in place to identify patients at risk, these did not always have the desired effect.

Patients are screened for nutritional problems but documented screening information is fragmented and incomplete

14. We reviewed a set of case notes on each of the four wards that we visited as part of this audit, 20 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 and rescreened patients using the MUST nutritional screening tool[6] and weighed patients within 24 hours of admission.

15. The all-Wales nutrition and catering standards make it clear that oral health and communication are part of nutritional care. Ward staff told us that the 'All Wales Oral Health Risk Assessment' tool is not used routinely despite the importance of good dentition for eating and enjoying food. Our review found information on oral health recorded in 2 out of 20 case notes while 18 out of 20 case notes recorded

[6] 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. The tool also includes guidelines for introducing an effective and suitable treatment plan.

communication difficulties. Findings from the 2014 Fundamentals of Care audit, completed between October and November 2014, found that two-thirds of patients had a record of an oral health assessment.

16. The nursing assessment documentation was not easy to navigate and assessment information was often incomplete. There were gaps in information on appetite, usual dietary intake or the need for special or therapeutic diets, factors that we would expect to see as part of the admission and screening process. This may be due in part to a lack of prompts for a more detailed description of the problem and the help needed, and the different format of the admission documentation used depending upon where patients were admitted within the hospital. Minutes from meetings of the Food Interest Groups (FIG) indicated that MUST scores are not routinely recorded for patients admitted through A&E and the medical admissions unit. Our case note review found:

- although weights were recorded for all patients, height was not recorded for three patients, although the case notes recorded the body mass index;
- seven of the 20 case notes did not indicate whether a patient's swallowing ability had been assessed, even on the wards where nursing staff were trained to undertake swallowing assessments;
- while Step 2 of the MUST tool scores 'unplanned weight loss', 8 of the 20 case notes did not record information on the size or nature of any unintentional weight loss;
- two of the 20 case notes did not record a patient's usual appetite;
- eight of the 20 case notes did not record a patient's usual dietary intake while one case note did not record whether a patient had any special or therapeutic dietary requirements or restrictions due to allergies; and
- three of the 20 case notes did not record whether a patient's clinical condition might affect their nutritional needs.

17. Ward staff told us during our recent audit that the all-Wales standardised nursing documentation, including prompts for specific information about activities of daily living, such as eating and drinking, had yet to be introduced. Nursing staff were unclear about the timetable for the introduction of the standardised documentation but it should support improvements in the quality of information captured.

18. Dietetic staff have developed a poor appetite pathway setting out the nutritional care that nursing staff can provide to patients with a MUST score of one or more and no other complications. Our case note review found that nutritional care plans were in place for all patients with a MUST score of one or more. However, the poor appetite care plan template differed between the wards we visited. Our casenote review found that patients at nutritional risk had been referred for dietetic assessment and food intake was recorded on the all-Wales food charts for those patients at nutritional risk. On one ward that we visited, food intake was recorded for all patients irrespective of the MUST score. We did not observe the all-Wales fluid chart in use on the wards that we visited. Instead, ward staff were using fluid charts that they had adapted for their patient populations. We were told that the all-Wales fluid charts would be introduced when the 'stock pile' of old charts had run out.

19. The Health Board has a range of mechanisms in place to identify those patients who need help with eating and drinking. These include traffic light systems at the bedside that describe the level of assistance needed, patient status boards, 'intentional rounding' sheets that also identify the level of assistance needed and the 'handover document'. The 'handover document' is printed for individual nursing staff at the start of every shift to identify patients who are at particular risk, for example, those needing help with eating and drinking. On some wards, the red tray system is in use at mealtimes to identify patients needing help or for whom food intake should be recorded. This system is supported on some wards by a 'check before you collect' notice at the patient's bedside to alert staff that the patient's food intake needs to be recorded.

Compliance with the nutritional care pathway is routinely monitored but compliance audits show scope for improvement

20. Nutritional assessment within 24 hours of admission is one of three mandatory metrics on the all-Wales nursing and midwifery dashboard. Compliance with nutritional screening is monitored monthly with an audit of at least 50 per cent of the inpatient population. The dashboard is discussed at divisional nurse meetings and the Clinical Nutrition Steering Group monitors overall compliance. The Health Board's data show that compliance fluctuated around 90 per cent for the past year. It aims to achieve 95 per cent compliance.

21. Dietetic staff also regularly audit the 'poor appetite pathway' across hospital sites with audit findings discussed at the relevant hospital FIG and the Clinical Nutrition Steering Group. The audit assesses whether:

- patients are screened within 24 hours of admission;
- a MUST score is calculated;
- patients with a MUST score of 1 or more are placed on the poor appetite pathway and associated care plan;
- patients on the poor appetite pathway have their food intake recorded on the all-Wales food chart;
- patients on the poor appetite pathway are offered regular snacks and prescribed nutritional supplements;
- patients with a MUST score of 1 or more and clinical complications are referred for dietetic assessment; and
- patients on the poor appetite pathway are easily identified with a nutritional risk alert sign or symbol at the bedside or elsewhere.

22. Findings from these audits generally show lower proportions of patients with a MUST score compared with the compliance rate reported as part of the nursing metrics, or as part of our case note review. On one ward, dietetic staff found a MUST score recorded for only one in three patients compared with full compliance on other wards. Unlike our case note review (see paragraph 18), dietetic staff found that patients with a MUST

score of one or more were not always on the poor appetite pathway, nor did they have a poor appetite care plan. Not all patients with a MUST score of one or more and clinical complications were referred to the dietician.

23. In 2010, there were no regular training programmes or refresher training for ward nursing 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.

24. In July 2014, the e-learning modules on both the nutritional screening and food and fluid charts were placed on a new web platform. The Health Board indicated that it no longer has access to information on the number of staff completing these modules prior to July 2014 making it difficult to monitor numbers of staff still to be trained and to report on overall compliance. Recent data show that between July 2014 and July 2015, 445 staff completed the nutritional screening and food chart e-learning module and 40 staff completed the fluid chart e-learning module. Senior nursing staff report that the e-learning platform is difficult to access and that the site is difficult to navigate. Others reported that it was not always possible to complete the training uninterrupted because of the time needed to complete it.

25. The Health Board recognises the importance of training in helping to improve compliance with the nutritional care pathway. It is putting in place plans to improve overall compliance with the e-learning modules, with the work led by the divisional nurses. On one ward visited, the ward manager indicated that nursing staff would work with dietetic colleagues to develop bespoke nutrition training if needed. On this ward, dietetic staff had established, and were maintaining, an information board with dietary and nutritional advice for patients, which also acted as a learning resource for nursing staff.

26. In 2010, we recommended that the Health Board introduce basic nutrition into the training programme for ward-based catering staff to improve awareness of its importance and the need to follow ward procedures. Our recent audit found ward-based catering staff had been given information on good nutrition and more recently, a high proportion of these staff had been trained on allergen legislation to a level commensurate with their role.

Menu items are nutritionally assessed through the all-Wales menu framework and the Health Board is working towards full compliance

27. In 2010, dieticians were involved in menu planning at all hospitals but not all hospital menus had been nutritionally assessed. At that time, we recommended that the Health Board nutritionally assess all menu items before implementing menu changes. Since then, the Welsh Government published the all-Wales nutrition and catering

standards, which specify the 12 minimum nutrients for analysis. In January 2013, the all-Wales menu framework was launched to support implementation of these standards.

28. The Health Board is working towards full compliance with the all-Wales menu framework by March 2016. At the time our fieldwork, it was compliant with all soup recipes and 84 per cent of the recipes for the main course. More work was needed to increase compliance with dessert recipes and the Health Board aimed to increase compliance from 48 per cent to 90 per cent by autumn 2015. Meals are also coded for the 14 allergens that must be labelled on foods as part of the Food Information Regulation.

29. The Health Board also contributes to the all-Wales commodity advisory group, working with the procurement dietician based within the NHS Shared Services Partnership, to ensure food suppliers provide nutritional information about their products to assess compliance with nutritional standards.

Patients have access to food and beverages 24 hours a day with compliance regularly monitored

30. 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 indicate that snacks should be offered two to three times a day. Evening snacks should be offered to all patients because of the long gap between the evening meal and breakfast.

31. At the Health Board, snacks are available between meals and for patients who miss a meal. Staples like bread, cereal and milk, are stored in ward kitchens. Nursing staff on the wards that we visited told us that they could request a limited range of snacks (yogurt, cheese and biscuits and a cake) using a snack request form. Other food items had to be authorised by a dietician. Snacks are delivered to the ward with the food trolley and stored on patients' lockers. If the food item is perishable, it will be stored in the ward kitchen fridge. At Nevill Hall, not all kitchens provided secure storage to enable larger quantities of snacks to be stored safely. A programme of ward kitchen refurbishment is underway.

32. Dietetic staff indicated that different snack ordering systems are in place across hospital sites. However, wards do not order snacks in the quantities that they would expect, given the poor appetite care plan provides a prompt for it. Dietetic staff would always like to offer snacks to patients between meals and to record when patients refuse the offer. At the time of our audit fieldwork, St Woolos Hospital was piloting a new snack system while Ysbyty Ystrad Fawr has been operating a successful snack system since 2014 with 84 per cent of patients always offered snacks.

33. The Health Board's nutrition, catering and food-quality audit tool assesses whether staff offer patients a bedtime snack and throughout the day. The Health Board's audits found good compliance, which mirrored the 2014 Fundamentals of Care audit which found that 93 per cent of ward areas complied with providing 'a range of snacks for

patients who missed meals or were hungry between meals. Most patients (91 per cent) reported being 'always or usually provided with nutritious food and snacks'.

34. The standards for patient food and fluid identify that seven to eight hot and cold beverage rounds should take place each day and that water in jugs should be changed three times a day. The 2014 Fundamentals of Care audit found that drinking water was always available and within patients' reach but not all wards (82 per cent) achieved seven or more beverage rounds or replenished water jugs three times a day (75 per cent). The multidisciplinary nutrition, catering and food quality audits also found that only five hospitals replenished water jugs three times a day. During our ward visits, ward managers and ward-based catering staff told us it was challenging to provide seven to eight drinks per day and that, typically, water jugs were changed twice a day.

35. Meanwhile, a 'glass full' scheme was introduced on one ward to improve hydration levels amongst ward patients. A drinking glass symbol is used to identify those patients at risk of dehydration and who require help to drink fluids. The drinking glass symbol at the patient's bedside shows visitors and staff that this patient needs more encouragement and help. At the time of our audit work, the Health Board was working to roll out the scheme more widely.

Written information for patients on what to expect in hospital is available but not widely disseminated

36. The 2011 all Wales Nutrition and Catering standards made it clear that information should be provided to patients and their carers on what to expect in relation to meals and snacks while in hospital. In 2012, the Chief Medical Officer and Chief Nursing Officer for Wales issued a joint letter in relation to hospital catering and food provisions. This letter asked NHS bodies to provide patients with the information set out in the Auditor General's leaflet **Eating Well in Hospital – What You Should Expect**. Although this leaflet was available on the Health Board's intranet at the time of our follow-up audit, along with guidelines for patients and visitors on bringing food into hospital, these were not widely known about. At the time of our fieldwork, the dietetic department was developing its public-facing website to improve accessibility. This website is now live and these leaflets are accessible to the public.

37. The Health Board's 'Protected Mealtime Policy' includes an informative patient information leaflet about protected mealtimes and 'quiet time', the dedicated rest period after lunch. This leaflet sets out what patients should expect in relation to the ward environment and preparations to help them prior to and during mealtimes. However, it was not evident from our ward visits that this leaflet was used routinely, and ward staff were unaware of it. We did observe information boards with dietary and nutritional advice for patients on one ward (see paragraph 25). Since our audit fieldwork, the Clinical Nutrition Steering Group has agreed to display this leaflet on ward information boards or provide laminated copies at the patient's bedside.

38. Dietetic staff have developed a poor appetite leaflet to provide ideas and practical tips on how to get extra nourishment for patients with a MUST score of one or more and for those patients being discharged from hospital. Ward staff referred to this leaflet, which they downloaded for patients from the Health Board's intranet.

There is scope to improve some aspects of the mealtime experience

39. In 2010, most hospitals across Wales 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. In Nevill Hall at that time, we found that the meal ordering system was not as well developed as that at the Royal Gwent. This meant that patients in Nevill Hall did not always receive the meal they chose nor the portion size requested. We recommended that the Health Board improve communications between wards and catering departments at Nevill Hall so patients would receive the right meal for their dietary needs.

40. HIW's recent Dignity and Essential Care Inspections on a number of wards at the Royal Gwent and Nevill Hall Hospitals also identified a number of issues in relation to mealtimes. In particular, patients were not always offered opportunities to wash their hands and there was poor compliance with protected mealtimes. Insufficient numbers of meals were provided with some patients not receiving the meal that they had ordered or having to wait for a replacement.

Patients are generally positive about food services

41. The Health Board operates a two-week menu cycle. The standard menu meets the needs of the majority of inpatients offering high-energy choices for those with poor appetites and healthier choices for those patients advised to follow a healthier lifestyle. Menu choices conform to the all-Wales Nutrition and Catering Standards and the menu offers lighter choices at each meal. All patients have the opportunity to choose from a daily selective menu and request preferred portion sizes.

42. Menus for patients with special and therapeutic diets are also available. Texture modified meals for patients with swallowing difficulties have been adapted to ensure compliance with texture and nutrition standards. The catering department has introduced an a la carte style menu for pureed meals with all meals and desserts purchased from the all-Wales contract. A two-week menu is in place for meals that are 'fork mashable' with these meals prepared in house.

43. The catering group reviews patients' menus and any changes considered are discussed with the Patients' Panel, Age Cymru and the Community Health Council (CHC). The Patients' Panel and the CHC are also assessors within the Food Quality Monitoring Programme. At the time of our fieldwork, the all-Wales menu framework

group had conducted a questionnaire survey of inpatients across all NHS bodies about the choice and quality of food. Across Wales, the survey response rate was 54 per cent compared with only 17 per cent at the Health Board. Analysis of the findings was expected at the end of the summer.

44. During our ward visits at Nevill Hall, patients were keen to tell us how much they appreciated the food and beverage services and the CHC's 'Bugwatch' report, which was presented to the Board at its July meeting and includes positive comments from patients about the hospital food. Overall numbers of formal complaints are very low with only one formal complaint about the food service received in 2014-15 compared with four compliments. The one complaint received was about food that was cold and unpalatable.

Not all patients receive prompt help at mealtimes and there is more to do to prepare the ward environment prior to meal services

45. In 2010, not all patients got the help they needed at mealtimes and mealtime preparations often took place at the point of service. At the Health Board, we found ward areas were not always well prepared for mealtimes, and at Nevill Hall, nursing staff were not always available to support patients at mealtimes.

46. As part of our latest audit, we visited two wards at Nevill Hall and two wards at the Royal Gwent hospitals to meet with ward staff and to observe the lunchtime meal service. Ward staff at Nevill Hall told us that since our audit in 2010, the number of nursing staff has increased. In addition, shift start times and break times were changed to ensure mealtimes were not interrupted and that nursing staff were available to help patients at mealtimes.

47. Exhibit 2 sets out the differences we observed between mealtime practices at Nevill Hall and the Royal Gwent hospitals. Our observations are based on the activities that we expected staff to undertake and whether these actions applied to all patients, most, some or none. Notable differences observed relate to checking food temperatures because of the different service models operating at the two hospitals. At the Royal Gwent, ward-based catering staff recorded temperatures before, during and at the end of the meal service. At Nevill Hall, food temperatures were checked before leaving the main kitchen but not taken when the food trolley arrived on the ward.

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

Observations of the lunchtime service	**Nevill Hall**		**Royal Gwent**	
Ward	**1/2**	**4/1**	**C5E**	**B3**
Patients helped to prepare for mealtimes, including using the toilet, washing hands and sitting up or getting out of bed	All	All	Some	All
Bedside areas/tables tidied before meals served	All	All	Most	All

Observations of the lunchtime service	Nevill Hall		Royal Gwent	
Ward	**1/2**	**4/1**	**C5E**	**B3**
Bedside areas/tables cleared of clinical waste	All	All	Most	All
Ward-based catering staff wear protective clothing	All	All	All	All
Temperatures of meals are recorded before service begins	None[1]	None[1]	All	All
Nursing staff accompany ward-based catering/hotel staff during the service[2]	All	All	All	All
Patients needing help with eating are easily identified	All	All	All	All
Meals are left within reach of patients	All	All	All	All
Help is given to cut up food or to remove packaging	All	All	Most	All
Patients needing help receive it promptly	All	All	Most	All
Nursing staff supervise and encourage patients with eating throughout mealtimes	All	All	Some	All

[1] Meals sent up to the wards plated up with temperatures recorded before the food trolley left the main kitchen.

[2] At Nevill Hall, hotel/domestic staff handed out the food trays and at the Royal Gwent ward-based catering staff plated patients' meals.

Source: Wales Audit Office observations of lunchtime services

48. Nursing staff told us that they actively welcomed and encouraged family and friends to help patients at mealtimes and we observed families helping during our ward visits. The 2014 Fundamentals of Care audit found that a registered nurse co-ordinated every mealtime on 86 per cent of wards while all nursing staff were engaged in the mealtime service on 95 per cent of wards. The Health Board also supports two volunteer schemes on some hospital wards – the Red Robin and the Mealtime Companion – to support patients at mealtimes. Mealtime Companions are staff volunteers, trained to support patients with eating and drinking as long as they do not have swallowing difficulties or allergies.

49. The Health Board's nutrition, catering and food quality audits tool assesses compliance with food hygiene practices at mealtimes, protected mealtimes and the nutritional care pathway. A bi-monthly schedule of audits is in place to ensure coverage across all hospitals. A multidisciplinary team composed of nursing, dietetic and facilities staff assesses compliance against a checklist of factors. The multidisciplinary team gives immediate verbal feedback to the senior nurse on duty.

50. These audits show that compliance was generally very good and patients receive the help they needed with eating. Where hospitals were non-compliant it was related to the following:

- patients were not always given the option to clean their hands prior to eating;
- bed tables and eating areas were not always clean or cleared before meal services;

- mealtimes were disrupted because of medical rounds, cleaning, visitors, etc;
- patients were not always provided with adapted cutlery or dementia-friendly crockery;
- temperatures of food were not always recorded at ward level;
- food temperature probes were not always in a suitable condition;
- water jugs were not always within a patient's reach at the bedside;
- the patient status board was not always used by nursing staff to visually highlight patients at risk; and
- the red tray system was not always in use.

Protected mealtime principles are increasingly applied but some hospitals are not yet fully compliant

51. In 2010, a substantial number of wards at the Health Board had yet to introduce protected mealtimes. Non-essential clinical and non-clinical activity was often still underway at the start of mealtimes. We recommended that the Health Board introduce protected mealtimes on all wards and establish arrangements for monitoring compliance, as well establishing whether waste bins had to be emptied during mealtimes.

52. The aim of protected mealtimes and responsibility for their application are set out in the Health Board's **Policy for Protected Mealtimes**. At Nevill Hall, there was signage at ward entrances explaining the purpose of protected mealtimes and quiet time, to encourage rest and recuperation. It also requested that clinical staff and friends and families refrain from visiting during these hours. At the Royal Gwent, protected mealtime signage was not visible at the entrance to the two wards that we visited. Information on 'quiet time' was posted on one ward.

53. The four ward managers that we met were confident protected mealtimes worked well with professional colleagues supportive of the principles. Ward managers reported that breakfast time was the most challenging meal to apply protected mealtime principles to because ward rounds started early. During our ward visits, we found that, for the most part, protected mealtimes operated effectively with non-essential clinical activity 'winding down' when the food trolley arrived on the ward. However, on one ward at the Royal Gwent, the medical ward round continued, nursing staff were administering medications and the cleaning trolley made it difficult to manoeuvre the food trolley in the narrow corridors. A visitor also arrived part way through the meal service to help a patient shave his beard rather than help with eating. The Health Board's regular audits of mealtime services in 2014-15 show that not all hospitals were fully compliant with protected mealtimes.

Cost control mechanisms and IT systems are used to manage catering services and while costs compare favourably overall, food costs for patient catering are rising

54. In 2010, we found that 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.

55. In addition, little progress had been made to computerise hospital-catering systems and most catering information systems relied on manual paper processes. The Auditor General recommended that NHS bodies should introduce computerised systems and the NHS Wales Informatics Service and NHS Shared Services Partnership have developed an outline business case to procure a national solution but no decision has been made.

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

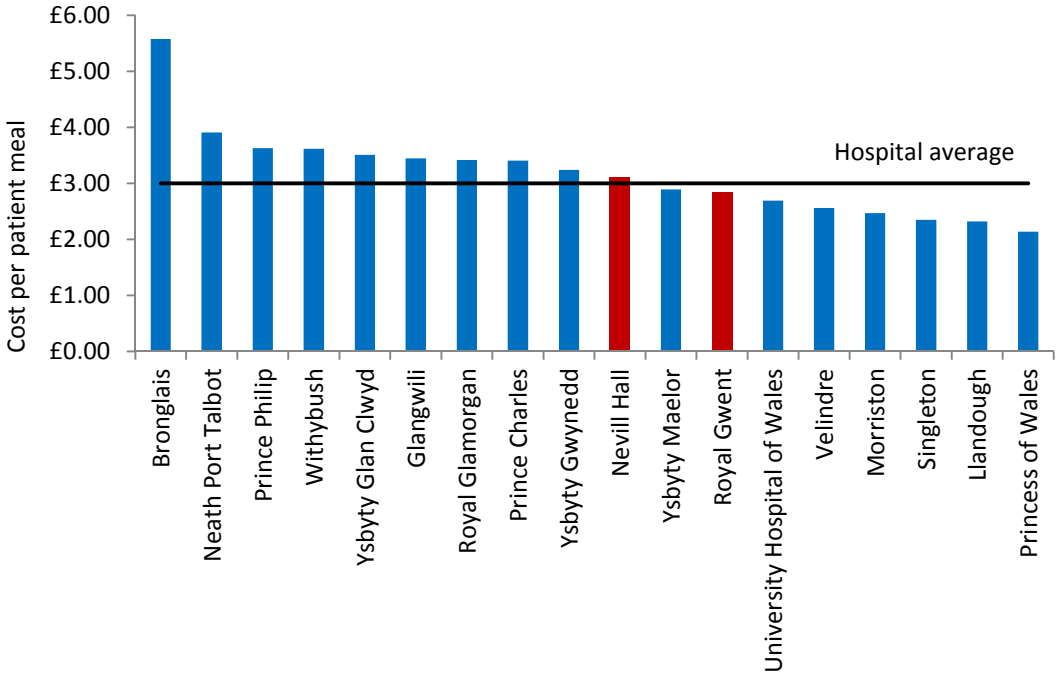
Cost control mechanisms and IT systems are used for managing the service and while patient meal costs are comparable with the Wales average, food costs for patient catering are increasing

57. In 2010, the Health Board had a well-established, paper-based menu selection process, which was collated manually through the Menumark IT system to produce production schedules. Since then, the Health Board has invested in the Menumark system to manage inpatient production and is now piloting the use of computer tablets to take patient meal orders. There is ongoing work at the all-Wales menu framework group, to which the Health Board contributes, to ensure all recipes in the database are costed. The Health Board inputs these costed recipes into the Menumark system, along with the commodity/ingredient prices, which are updated in line with all-Wales procurement contract prices. The Menumark system enables the Health Board to calculate the average daily main meal cost by hospital site.

58. All health boards jointly funded the appointment of a procurement dietician working in the NHS Shared Services Partnership (Procurement Service) to support the development of all-Wales procurement contracts to source provisions for the dishes on the menu framework. The NHS Shared Services Partnership is also working to streamline and standardise products, as well as helping NHS bodies develop contracts to source local produce. The Health Board indicated that it holds no local contracts for food products, with all products supplied through the all-Wales contracts.

59. At the time of our audit in 2010, the Health Board used a patient daily food allowance of £3.85. Our latest audit shows that the Health Board has maintained this daily food allowance for standard meals with small increments for some community hospitals and patient groups. Analysis of the EFPMS data for 2013-14 shows that the average cost per patient meal was £3.34 across the Health Board's hospitals, 15 per cent below the daily allowance. The cost per patient meal at the Nevill Hall and Royal Gwent hospitals is at or both below the Wales hospital average (Exhibit 3).

Exhibit 3: The cost per patient meal compares favourably with the Wales hospital average



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

60. Across Wales, the total cost of patient catering services reduced by five per cent between 2011-12 and 2013-14 compared with the 15 per cent increase at the Health Board (Exhibit 4). This increase appears to be due to increasing service provision costs, up by 16 per cent over the last two years compared with seven per cent across

Wales, while the number of patient meals requested increased by one per cent. Despite the increase in service provision costs and patient meal requests at the Health Board, the average cost per patient meal shows only small fluctuations year on year (Exhibit 5).

Exhibit 4: Patient catering service costs are increasing at the Health Board and reducing across Wales

Year	Cost of patient catering services (£ million)	
	Aneurin Bevan	Wales
2011-12	5.43	38.95
2012-13	5.99	37.26
2013-14	6.27	36.97

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

Exhibit 5: The cost per patient meal shows small fluctuations

Year	Aneurin Bevan	Wales
2011-12	£3.23	£3.34
2012-13	£3.22	£3.26
2013-14	£3.34	£3.29

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

Food waste is regularly audited with wastage below the national target but monitoring at ward level is inconsistent

61. In 2010, levels of un-served food waste were not consistently monitored across hospitals with un-served food waste high on some wards. At that time, we recommended that the Health Board strengthen existing arrangements for monitoring food waste to identify practices increasing waste and to identify the demand for patient meals more accurately based on the bed occupancy.

62. Currently, the Health Board uses the EFPMS definition to calculate un-served meal waste.[7] Un-served meal waste is monitored across all hospitals as part of the nutrition, catering and food quality audits while plate waste (that is food left on the plate by patients) is not monitored. If plate waste appears high at the time of the nutrition,

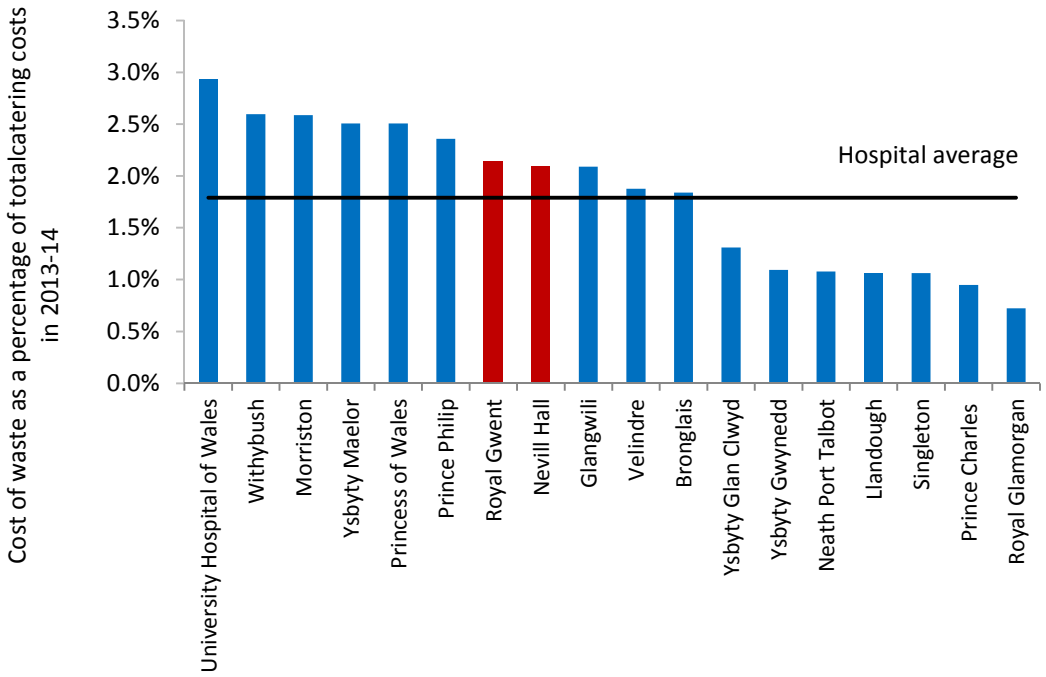
[7] This is the number of untouched/unserved patient meals remaining at the end of the meal service period expressed as a percentage of the total number of meals provided.

catering and food quality audits, staff will try to find out why. The Health Board's audit data for 2014-15 show that un-served meal waste was seven per cent, which is well below the 10 per cent target set by the Welsh Government.

63. The Health Board is clear that facilities and nursing staff have collective responsibility for monitoring food waste and identifying the reasons for it. However, we were told that un-served food waste is not recorded routinely after each meal and we observed different practices within and between the hospitals that we visited. Ward-based catering staff at Nevill Hall told us that they do not routinely record un-served waste and at the time of our visit, only one meal out of the 53 requested at Nevill Hall was un-served. At the Royal Gwent, ward-based catering staff on one ward told us that they did not routinely record un-served waste while on the second, the facilities supervisor recorded the un-served food waste.

64. Although un-served food wastage is below the national target, the cost of food waste as a proportion of total catering costs at the Royal Gwent and Nevill Hall hospitals was higher than the Welsh hospital average (Exhibit 6). In 2013-14, the EFPMS data show that the cost of un-served meals was £211,000 at the Health Board, or two per cent of total catering costs.

Exhibit 6: The cost of food waste at the Royal Gwent and Nevill Hall hospitals is higher than the Wales hospital average



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

Non-patient catering services operate at a small loss with the gap between income and costs reducing and one of the lowest in Wales

65. In 2010, the Health Board was committed to not subsidising non-patient catering services but it did not have a clear policy framework in place. The catering department had invested in electronic point of sales technology for controlling its restaurant activities. There was a clear pricing policy and prices were standardised across all hospitals. The restaurant at the Royal Gwent Hospital was the only hospital at that time to generate a profit. At that time, we recommended that the Health Board introduce a clear subsidy policy to set the framework for delivering non-patient catering services.

66. The Health Board's 'Nutrition and Catering Standards' make it clear that where the volume of business is insufficient to cover operating costs of non-patient catering services, the Health Board will assess and agree the projected subsidy required. All catering sales outlets are connected to the IT network via Electronic Point of Sales cash registers, which are programmed with the recipe/ingredient costs and linked to the Menumark system. Meal waste is captured and included in the overall cost. Monthly trading figures are provided to monitor income and expenditure for all non-patient catering services.

67. The income generated by the Health Board's non-patient catering services has been insufficient to recover operating costs but the gap has been reducing year on year since 2011-12 (Exhibit 7). In 2013-14, the total income generated was enough to recover 90 per cent of the £2.75 million costs, a subsidy of around £280,000. Non-patient catering services at the Health Board's community hospitals are not profitable compared with the service at the Royal Gwent, which made a small profit of £1,200. The service at Nevill Hall recovered 99 per cent of its costs, making a loss of £7,500. Across Wales, no NHS organisation recovered the cost of non-patient catering services in 2013-14 but the Health Board's performance is comparatively better than others (Exhibit 8).

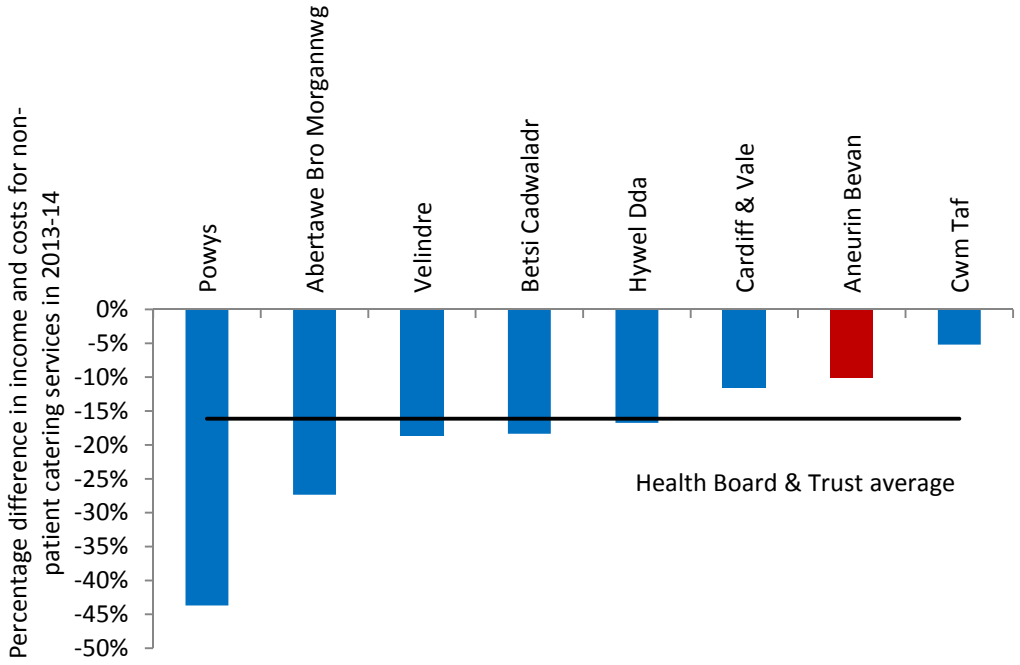
Exhibit 7: The gap between the income and costs of the Health Board's non-patient catering service is reducing

Year	Cost of non-patient catering services	Income achieved	Percentage gap in costs and income
	(£ millions)		%
2011-12	2.81	2.25	-20
2012-13	2.92	2.37	-19
2013-14	2.75[1]	2.47	-10

[1] Includes rental costs for vending machines

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

Exhibit 8: In 2013-14, non-patient catering services ran at a loss across Wales with the Health Board's performance comparatively better than most other NHS bodies



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

Arrangements for operational monitoring and oversight are robust but board assurance reporting needs strengthening

68. 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 the 2009 NHS re-organisation. 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. We recommended that NHS bodies develop a more comprehensive approach to reporting performance to the Board, by bringing together information on the nutritional care pathway, performance data on service costs, food wastage and patient feedback.

69. At this time, the Health Board had comprehensive catering and nutrition strategies with appropriate oversight by the Clinical Nutrition Steering Group. Although lines of accountability were clear, arrangements for Board reporting were less clear. We recommended that the Health Board develop a range of performance indicators to improve scrutiny and to introduce effective arrangements for sharing patient feedback.

Structures for oversight and scrutiny of catering and nutrition services remain robust at operational and subcommittee levels

70. The Health Board continues to support a multidisciplinary approach to meeting patients' nutrition and hydration needs. Executive director responsibilities remain well defined with responsibility shared between by the Director of Nursing (for patient feeding and nutritional care and standards) and the Chief Operating Officer (for the operational management of all staff).

71. In November 2010, the Audit Committee delegated responsibility for ongoing monitoring of progress against the recommendations in our local report, and the subsequent national report, to the Quality and Patient Safety Committee. Minutes from the meetings of the Quality and Patient Safety Committee show that the Committee regularly monitored progress and sought updates from responsible officers, particularly around actions taken to support patients at mealtimes.

72. The Clinical Nutrition Steering Group, chaired by the Assistant Director of Nursing, is comprised of a wide membership of senior staff from relevant disciplines and includes a member from the local CHC. The Clinical Nutrition Steering Group has a broad programme of work and continues to provide assurance and oversight of compliance with the all-Wales Nutrition and Catering Standards, the health and care standard related to nutrition[8], the all-Wales menu framework and the nutritional care pathway. It also reviews multidisciplinary mealtime audits and patient feedback ensuring patients and their representatives are involved in the development and evaluation of the nutrition and catering service. It also monitored progress against the Auditor General's recommendations. The Group reports to the Quality and Patient Safety Committee via the Quality and Patient Safety Operational Group and to the Standards for Health Services Co-ordinating Group in relation to compliance with the standard related to nutrition.

73. The Clinical Nutrition Steering Group also influences the work programme of the FIGs, which were established several years ago. These multidisciplinary groups comprise relevant operational staff drawn from catering services (both chefs and catering supervisors), dieticians, speech and language therapists, and nursing staff. One local FIG includes a member from the local CHC. The Health Board's catering liaison

[8] Welsh Government, **Health and Care Standards**, April 2015 (Standard 2.5 'Nutrition and Hydration) and previously Welsh Government, **Doing Well, Doing Better, Standards for Health Services in Wales**, (Standard 14 'Nutrition'), April 2010.

dietician is a member of every FIG and provides a common link between each group. The FIGs discuss common themes, such as compliance with the nutritional care pathway, mealtime audits, patient feedback and waste. Any issues or concerns are addressed locally.

74. Board members that we met as part of the audit are confident that its committees receive appropriate information about patient care. It was evident that members are triangulating information about patient nutrition and hydration and more broadly around the Fundamentals of Care standards. Independent members also took part in the 1000 Lives walkarounds to observe the patient experience with some members taking part in the Health Board's spot checks of patient care similar to the national 'Trusted to Care' spot checks.

Performance is regularly monitored but board reporting is not comprehensive and relies on the annual Fundamentals of Care Audit

75. Performance information on catering and nutrition services, including patient feedback, is not routinely reported to the Board. Instead, the Board receives the annual self-assessment against the health and care standards and the Fundamentals of Care audit. This means that the Board is not sighted of the work undertaken to ensure patients receive good quality catering and nutrition services or organisational compliance with the all-Wales Nutrition and Catering Standards and nutritional care pathway.

76. Reporting to the Board on patient experience in relation to catering and nutrition is also limited to the annual Fundamentals of Care audit report although mechanisms are in place to capture patient feedback locally, with concerns addressed by the FIGs. At two neighbouring health boards, Cardiff and Vale University Health Board and Cwm Taf University Health Board, compliance with nutritional screening is reported at each Board meeting. Patient feedback on food and mealtime experiences is also presented to every board meeting at Cardiff and Vale University Health Board as part of its patient experience report.

77. Performance is monitored and reported regularly at an operational level. Compliance with nutritional screening is monitored at divisional nurse meetings and by the Clinical Nutrition Steering Group (see paragraph 20). Key performance indicators for catering services, such as waste, compliance with food hygiene, food quality, patient day meal costs, provisions costs and meal numbers, are collated on a monthly basis. These indicators are reported both quarterly and annually to the facilities division management team. Comparative data on catering costs across Welsh hospitals, which are derived from the EFPMS, are also presented in the facilities division annual reports. Findings from the multidisciplinary nutrition, catering and food quality audits are reported bi-monthly to the catering and facilities management teams, quarterly to the Clinical Nutrition Steering Group and annually to the Quality and Patient Safety Committee.

78. The Health Board, as in other NHS bodies, has yet to regularly collate information from nutritional screening to understand the number of patients identified with nutritional problems on admission. The Health Board indicated that the national system to collect metrics for the all-Wales nursing and midwifery dashboard does not yet allow a high-level overview of the different levels of risk and that the NHS Wales Informatics Service are working to develop a solution.

Appendix 1

Audit approach

The audit sought to answer the question: 'Has the [Health Board/Trust] 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, an Independent Member, 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 four wards, selected by the Assistant Director of Nursing, Patient Experience and Safety, 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 4/1 and 1/2 at Nevill Hall and wards C5E and B3 at the Royal Gwent.

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 16 local recommendations set out in our report summarising the findings on hospital catering and patient nutrition services at the Health Board in 2010. The status of each recommendation[9] is also set out in Tables 1 and 2.

Table 1 – 2010 local recommendations

Recommendation		Status at July 2015
Strategic planning and management arrangements		
R1	Improve the Health Board scrutiny arrangements for monitoring catering service risks and performance.	A
R2	Develop a range of performance indicators that monitor the main service risks such as food wastage, protected mealtime compliance, food safety issues and financial performance.	A
R3	All menu items should be nutritionally assessed along with any changes before they are implemented.	A
Procurement production and cost control		
R4	Improve Nevill Hall's meal ordering processes to ensure the patient is clearly identified and ward orders reflect the true patient demand.	A
R5	In Nevill Hall, introduce portion size choice onto the existing menu selection form and change existing catering practice to meet this choice.	A
R6	Strengthen existing wastage monitoring arrangements to identify practices which increase wastage.	A
R7	Introduce a clear subsidy policy to set the framework for delivering non-patient catering services.	A
Delivery of food to the ward		
R8	In Nevill Hall, establish whether the bed state data can identify demand more accurately and minimise unnecessary wastage.	A
R9	Introduce basic nutrition into the training programme for ward-based catering staff to improve their awareness of its importance and the need to follow ward procedures.	A

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

Recommendation		Status at July 2015
Meeting patients' nutritional needs and supporting recovery		
R10	Introduce protected mealtimes on all appropriate wards and establish arrangements that monitor compliance.	O
R11	Establish whether the current domestic service shift arrangements are impacting on protected mealtimes by requiring waste bins to be emptied between 12.00 and 13.00.	A
R12	Establish monitoring arrangements that measure compliance with the nutritional care pathway and the effectiveness of the chart review process.	A
R13	In Nevill Hall, improve the communication process between the ward and the catering departments to ensure patients always receive the right meal for their dietary needs.	A
Gathering views from patients and sharing information		
R14	Introduce effective arrangements for sharing information between nursing, dietetic and catering staff on nutrition management.	A
R15	Involve patients fully in developing the catering service.	A
R16	Building on the model established in RGH, and as part of the process of empowering ward managers under Free to Lead, Free to Care arrangements, introduce effective ward manager and senior nurse forums across the Health Board and all its hospitals.	A

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

Table 2 – 2011 national recommendations

Recommendation		Status at July 2015
Ensuring patients' nutritional needs are met		
R1b	We recommend that NHS bodies use the results presented in our local audit reports as a basis for ensuring that they are effectively implementing the all-Wales Nutritional Care Pathway, in particular, ensure that nutritional screening effectively identifies all patients who have nutritional problems, or are at risk of developing them, and that appropriate care plans and monitoring activities are instigated.	O

Recommendation		Status at July 2015
Ensuring patients' nutritional needs are met		
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 dieticians.	A
Improving patients' mealtime experience		
R3a	We recommend that NHS bodies ensure that their menus provide an appropriate choice of food and that the arrangements for ordering and serving food support adequate patient choice.	A
R3b	We recommend that NHS bodies review their practices at ward level to make sure that patients are helped to get comfortable in readiness for their meals, and are given the opportunity to wash their hands before the meal is served.	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.	O
Controlling the costs of the catering service		
R4b	We recommend that NHS bodies introduce computerised catering information systems, supported by clear cost benefit analysis in comparison to existing manual based information systems.	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

Recommendation		Status at July 2015
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.	A
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 that NHS bodies should 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
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

Recommendation		Status at July 2015
Effective service planning and monitoring		
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 EFPMS 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.	N
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

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