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Hospital Catering and Patient Nutrition Follow-up Review

Betsi Cadwaladr University Health Board

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Status of report

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The team who delivered the work comprised Philip Jones and Charlotte Owen.

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The Health Board has made further progress in addressing recommendations to improve catering and nutrition services. More work is needed to strengthen aspects of the nutritional screening process, to improve mealtime experiences for some patients, to further reduce the gap in income and costs for non-patient catering services, and to review planning and reporting arrangements following recent reorganisation.

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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 coordination of a range of processes involving menu planning, procurement, food production, and distribution of meals to wards and patients. Good communication is also required across the range of staff groups involved, including managers, catering staff, dieticians, nurses, support staff and porters.

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

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

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

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

[2] 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.

5. To support the implementation of the standards, caterers and dieticians across Wales worked together to produce the All Wales Hospital Menu Framework, (AWMF) 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.
6. The Public Accounts Committee has maintained a keen interest in the issues highlighted by the Auditor General's work, taking evidence from witnesses and publishing its own report in February 2012[4]. In 2014, the Auditor General gave a commitment to the Public Accounts Committee that he would undertake appropriate follow-up work to monitor how NHS bodies have taken forward his national and local recommendations. This commitment included taking account of the findings of any subsequent follow-ups undertaken in NHS bodies since 2010.

Our main findings

7. Between March and June 2015, we undertook follow-up work at Betsi Cadwaladr University Health Board (the Health Board) to assess the extent to which it had implemented the Auditor General's national recommendations[5]. We also assessed the extent to which the Health Board had addressed the recommendations made as part of the local audit in 2010 and again in 2013.
8. We concluded that the Health Board has made further progress in addressing recommendations to improve catering and nutrition services. More work is needed to strengthen aspects of the nutritional screening process, to improve mealtime experiences for some patients, to further reduce the gap in income and costs for non-patient catering services, and to review planning and reporting arrangements following recent reorganisation. We reached this conclusion because:
   - Arrangements for meeting patients' dietary and nutritional needs continue to improve but the screening process and provision of beverages and patient information are inconsistent:
     - patients are screened for nutritional problems but gaps in the process risk diminishing its robustness;
     - compliance with the nutritional care pathway is routinely assessed and reported both locally and corporately;
     - arrangements to ensure patients have access to snacks have significantly improved although compliance with standards for the provision of beverages and water jug changes remains a challenge
     - menu items are nutritionally assessed through the All Wales Hospital Menu Framework with which the Health Board is largely compliant; and

[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.

- written information for patients on how their nutrition and hydration needs will be met is limited.

- Patient mealtime experiences continue to improve:
  - an appropriate range of menu choices is available to patients;
  - nursing support and supervision at mealtimes is generally good; and
  - protected mealtimes are largely in place.
- The cost of patient catering services has risen and, although non-patient catering services still run at a loss, the gap between income and cost is reducing:
  - the cost of patient catering services has risen but the cost per patient meal varies between hospitals;
  - the cost of unserved patient meals is significantly higher at Wrexham Maelor; and
  - non-patient catering services still run at a loss but the gap between income and cost is reducing.
- Reporting on catering and nutrition issues and capturing patient feedback has improved, but some oversight arrangements remain complex:
  - aspects of oversight and scrutiny of catering and nutrition issues remain complex;
  - operational and corporate reporting are clearer following reorganisation although routine reporting to the Board on patient experience is limited; and
  - the Health Board has strengthened mechanisms for capturing patient feedback.

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

Recommendations

10. The Health Board has fully achieved 25 out of 56 recommendations and suggestions previously set out in our national and local reports. The Health Board needs to maintain focus on implementing the remaining recommendations and suggestions where progress is reported to be on track but is not yet completed, or where we consider insufficient or no progress has been made. These recommendations and suggestions are set out in Exhibit 1. A full list of the national and local recommendations and suggestions, along with the status of each one, is set out in Appendix 2.

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

Ensuring patients' nutritional needs are met	
National 2011	
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*).
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.
R15	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.
R16	Reinforce the need to measure a patient's weight and height in order to calculate the associated patient Body Mass Index (BMI).
Improving patients' mealtime experience	
National 2011	
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.
Controlling the costs of the catering service	
National 2011	
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.
R5b	We recommend that NHS bodies review their current cost control mechanisms to ensure that they are making full use daily food and beverage allowances for patients.
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.
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.
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.

Local 2010

R6 Introduce a clear subsidy policy to set the framework for delivering non-patient catering services.

R7 Develop consistent ledger arrangements across the Health Board to ensure that sufficient and robust catering business information is available.

Follow Up 2011

R7 The Health Board should aim to create consistent and comparable catering financial information reflecting true cost of food provisions and services. Alongside this, the Health Board should aim to reduce variation in catering funding approaches and actively pursue consistency in catering provision to ensure best possible patient mealtime experience.

Effective service planning and monitoring

National 2011

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.

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.

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.

R11b We recommend that NHS bodies demonstrate how they have taken patients’ views into account when developing catering and nutrition services.

Local 2010

R1 Strengthen strategic planning arrangements for catering to ensure a clear and consistent agenda for the catering service across the Health Board.

R2 Establish planning structures for catering and nutrition services which are consistent across the Health Board.

R5 Improve the Board scrutiny arrangements for monitoring catering and nutrition risks and performance.

Follow Up 2013

R1	While strategic planning arrangements have been strengthened, they need to develop further to ensure there is a clear and consistent agenda and consistent processes across the Health Board where required.
R2	While there is evident improvement in nutritional service planning, catering service planning needs to be further strengthened.
R5	Include nutrition and catering in quality reports and take quality reports to the Board.
R5	The INCHS group structure may be overly complex, which may result in lack of clear lines of accountability.

Detailed report

Arrangements for meeting patients' dietary and nutritional needs continue to improve but the screening process and provision of beverages and patient information are inconsistent

11. In 2010, many hospitals in Wales had improved their arrangements to meet patients' nutritional needs 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.

12. At the Health Board at that time, not all wards carried out nutritional screening, and the screening process was inconsistent between hospitals with information recorded across separate documents. Assessments of patients' oral health was largely absent and there was a lack of consistent monitoring and recording of food and fluid intake. Our follow-up audit work in 2013 found that the Health Board had introduced standardised nursing assessment documentation and nutritional care plans, which was helping to improve the quality of nutritional screening.

Patients are screened for nutritional problems but gaps in the process risk diminishing its robustness

13. The Health Board's 2013 'Improving Food, Fluids and Nutritional Strategy for Patients' seeks to ensure that all adults are screened on admission and that appropriate action is taken in accordance with national guidelines. As part of our 2015 work, we reviewed a set of case notes on each of the three wards that we visited as part of the audit; 15 case notes in total. We assessed whether nursing staff nutritionally screened patients on admission and repeated the process at least weekly, as well as the quality of the nutritional screening process. We looked specifically for information that we would expect to see as part of the admission and screening process, such as measures of 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.

14. Our case note review found that nursing staff generally screened and rescreened patients using the MUST nutritional screening tool but measures of height and BMI were frequently estimated. For example, on Glyder Ward, Ysbyty Gwynedd (YG), three out of the five patient records reviewed had estimated heights and BMIs; one had no weight, height or BMI recorded; and one had no weight or height, but had an estimated BMI. Recent Healthcare Inspectorate Wales (HIW) Dignity and Essential Care Inspections on wards across the Health Board also found a number of issues relating to the quality and completeness of patient documentation and care planning.

15. The All Wales Nutrition and Catering Standards make it clear that oral health and communication are part of nutritional care. We found that 15 out of 15 patient case notes contained an assessment of oral health. This is a notable improvement over our findings in 2010 when we found virtually no evidence of this type of assessment. The Health Board's 2014 Fundamentals of Care audit also showed improvement in compliance with 83 per cent of patients having a record of an oral health assessment compared with less than half the previous year.

16. The Health Board's 'Improving Food, Fluids and Nutritional Strategy for Patients' indicates that all patients should have a plan of care for nutrition that identifies risk, likes, dislikes, cultural or religious needs relating to food, any food allergies, or any physical difficulties with eating or drinking. We found that information on patients' functional abilities in relation to eating and drinking, such as the ability to feed themselves, the extent of mobility, and swallowing difficulties were captured as part of the screening process. However, we found little information had been documented on likes, dislikes, appetite and usual dietary intake.

17. In February 2015, the Health Board implemented standard adult nursing documentation across most acute wards, to support frontline staff in documenting and evidencing the care they deliver in a more patient-centred way. It incorporates a 'what matters to me' conversation between the healthcare professional and the patient. However, this documentation is not yet included in all patient notes, and it does not include prompts for information, such as food likes and dislikes.

18. Of the 15 case notes that we reviewed, only three patients required a nutritional care plan. Of these three patients, we could not locate a documented care plan for one patient although the patient had been referred to, and assessed by, a dietician. Where patients had higher nutritional risk scores, food and fluid charts were used appropriately. Nursing staff also regularly monitored food and fluid intake for patients for whom they were concerned despite a 'normal' MUST score.

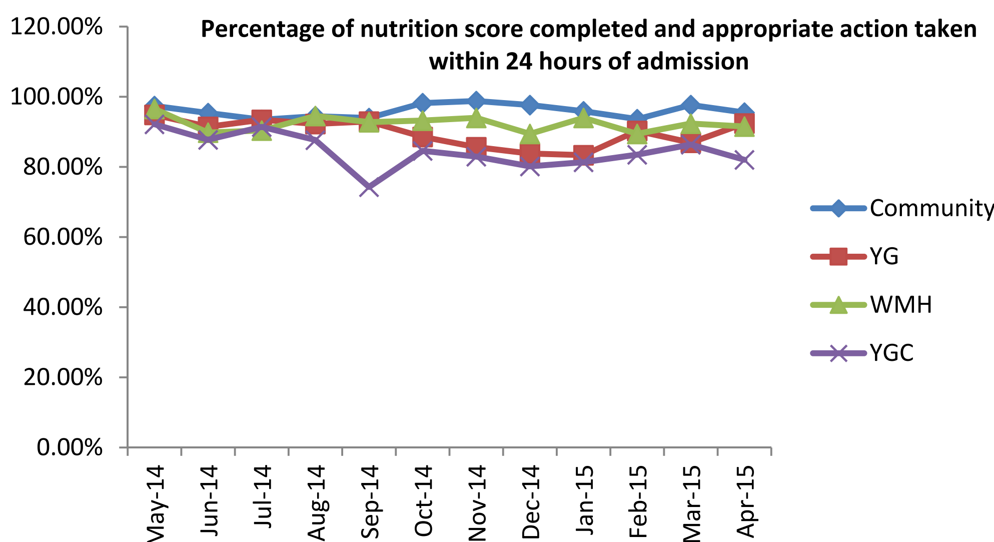
19. The Health Board promotes both patients' independence in eating and drinking and support for patients who need assistance, which is underpinned by the nutritional assessment and standardised nutritional care plan. The Health Board has also introduced 'intentional rounding' on wards and implemented its 'Putting Nutrition at the Heart of Human Rights' toolkit, which also promote independence and the support of those who need help with eating and drinking.

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

20. 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. The Health Board's 2013 'Improving Food, Fluids and Nutritional Strategy for Patients' indicates that evaluation and audit are key to the cycle of continuous improvement, and refers to a regular audit cycle to be maintained and reviewed by the Improving Nutrition, Catering and Hydration Standards (INCHS) group on an annual basis. Our follow-up review in 2013 found that the Health Board was developing an audit tool to assess compliance and by 2015, the Health Board was using this audit tool to conduct MUST screening audits and to monitor compliance through the Health Board's Nursing Dashboard.

21. In addition, compliance with nutritional screening is assessed through the Quality and Safety Audit, and reported monthly using the all Wales Fundamentals of Care nursing metric system. The relevant measure is whether a nutritional assessment is made and appropriate action taken within 24 hours of admission. Data extracted by the Health Board from the Fundamentals of Care system on 11 May 2015 show that compliance varied significantly between acute and community hospitals (Exhibit 2). Ysbyty Glan Clwyd (YGC) scored consistently lower than Wrexham Maelor Hospital (WMH) and YG. Overall compliance was 91 per cent across the Health Board.

Exhibit 2: Between May 2014 and April 2015, compliance with nutritional screening varied significantly between acute and community hospitals



Source: Betsi Cadwaladr University Health Board Fundamentals of Care findings

22. Dieticians conducted their own review of nutritional screening in 2011 and again in 2014. The assessments included a number of criteria, two of which were the:

- percentage of patient records containing a completed nutritional assessment; and
- percentage of nutritional assessments which were correct.

23. While the national measure of compliance with nutritional screening (see above) is different, local dietician review of nutritional screening suggests that more needs to be done than the former suggests. In 2011, dieticians found that 41 per cent of patient case notes reviewed contained a completed nutritional assessment. Of these, 49 per cent were evaluated as being correct. By 2014, dieticians found that 62 per cent of patient case notes reviewed contained a completed nutritional assessment. Of these, 65 per cent were evaluated as being correct.

24. The Health Board has a system of monthly peer-reviewed Quality and Safety Audits, which include indicators related to the nutritional care pathway. The findings are reported to the Quality, Safety and Experience Sub Committee, which shares them with the regional quality, safety and experience subgroups. The Board receives scores from spot checks, using the Quality and Safety Audit Process, on a range of aspects related to the nutritional care pathway as part of its 'Ward to Board' metrics, for example, compliance with aspects of protected mealtimes, assistance for patients with food and drinks, and completion of nutritional information in case notes. We reviewed the scores for the period August 2014 to April 2015. These were for the Health Board as a whole and did not include scores for individual hospitals.

25. 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.

26. By 2013, 2,050 Health Board staff and students had registered for the e-learning programme, with 947 of these staff having attempted or completed, the training. The Health Board has been well ahead of other health boards despite the recognised technical challenges that have made undertaking the training difficult. Recent figures indicate that 1540 nursing staff at the Health Board have attempted or completed the training. It was not feasible for the Health Board to identify the total number of nurses who will need to undertake the e.learning. During our visits, ward managers told us that they provide opportunities for staff to complete the training but technical problems accessing the web portal still exist.

27. By 2013, clinical nurse specialists for nutrition were providing a rolling programme of training across all acute wards, community settings and nursing home sector. The training covered all high-risk areas such as MUST screening, care planning, and ethical decision making. During our latest review, we were told that the clinical nurse specialists for nutrition have been developing and rolling out the 'Putting Nutrition at the Heart of Human Rights' toolkit, as well as other aspects of training. Dieticians also accept bespoke training requests based on need, although their capacity to respond is influenced by other commitments. The Health Board recognises the importance of training and the Workforce Organisational Development and Workforce Educational Development teams are implementing a health-board-wide education framework on nutrition for nurses.

Arrangements to ensure patients have access to snacks have significantly improved although compliance with standards for the provision of beverages and water jug changes remains a challenge

28. 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 to patients two to three times a day with evening snacks offered to all patients because of the long gap between the evening meal and breakfast. At the Health Board, arrangements for ordering snacks and criteria around eligibility for snacks varied between hospitals and there was no budget for snacks.

29. The Health Board funded the provision of snacks from 1st April 2013. 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'.

30. Snack Menus are in place across the Health Board. The snacks are shown on the hospital in-patient menus. The lunch menu advertises the mid afternoon snack which is based on biscuits, and the supper menu advertises the evening snack which is based on cake. In addition, all wards have small supplies of bread and cereal products so patients can eat out of the normal meal times. These items are kept at ward level and are replenished as required.

31. A significant amount of work has been undertaken to develop and introduce a MUST support snack menu to supplement the diet of patients identified at nutritional risk (with a nutritional risk score of two or above) across the Health Board. The menu includes items such as sandwiches, crackers, rice pudding, custard and muffins. Healthcare support workers assist patients in placing an order from the menu, before sending it to the kitchen.

32. The Health Board's Fundamentals of Care annual report highlighted that the delivery of standards relating to water jug changes and beverage rounds remains a challenge. Only 41 per cent of wards were able to ensure that water jugs were refilled three times daily, and only 69 per cent of wards managed to provide a minimum of seven beverage rounds during the day.

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

33. In 2010, we found that dieticians were involved in menu planning at all hospitals but there had not been nutritional assessment of all menus and arrangements to oversee any changes to menus varied across the Health Board. Since then, the Welsh Government published the All Wales Nutrition and Catering Standards, which specify the 12 minimum nutrients for analysis.

34. In January 2013, the All Wales Hospital Menu Framework (AWMF) was launched to support implementation of these standards. At that time, the Health Board's Food Service Transformational Group, which included dietetic and catering representatives, worked closely with the All Wales Lead Dietician to implement the AWMF. The Health Board is now largely compliant with the AWMF and menus are subject to collective review by catering managers and dieticians. The Food Service Transformational Group was disolved once the menu framework was implemented and changes to the menu cycle or menu content are shared with INCHS.

35. The Health Board continues to contribute to the All Wales Hospital Menu Framework Group where compliance with the menu framework and catering and nutrition standards are discussed, as well as how it can be integrated within current reporting mechanisms across the NHS.

Written information for patients on how their nutrition and hydration needs will be met is limited

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

37. During our recent review, ward staff told us that patients do not receive information routinely about how the hospital will meet their nutritional needs and preferences. Some wards provide information but this is not consistent. We saw catering information and nutrition picture charts on boards in some wards but again, this varied between wards.

Patient mealtime experiences continue to improve

38. 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 some wards did not implement protected mealtime principles properly. At the Health Board, we found that most wards had adopted protected mealtimes although no formal policy was in place. Our follow-up work in 2013 found that the Health Board was still assessing protected mealtime requirements.

39. There were several themes relating to nutrition and catering in the Healthcare Inspectorate Wales Dignity and Essential Care Inspection reports following unannounced inspections at the Health Board during 2014 and 2015. While the inspections found that patients were generally positive about food services, they also found a lack of coordination and adherence to protected mealtime principles, instances where food and fluid charts were not completed correctly, and a lack of trained support during mealtimes for patients with cognitive impairments.

An appropriate range of menu choices is available to patients

40. The Health Board operates a two-week menu cycle. Menu choices conform to the All Wales Nutrition and Catering Standards. All patients at YG and YGC have the opportunity to choose from a daily selective menu and request preferred portion sizes. WMH has a bulk serve system and patients can choose from the options available from the trolley at each mealtime.

41. 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.

42. The INCHS group reviews patients' menus. At the time of our fieldwork, the All Wales Hospital Menu Framework Group had conducted a questionnaire survey of inpatients across all NHS bodies about the choice and quality of food. Analysis of the findings was expected at the end of the summer.

Nursing support and supervision at mealtimes is generally good

43. As part of our latest audit, we visited three wards, one each at YG, YGC and YM, to meet with ward staff and to observe the lunchtime meal services. Overall, we found that:

- ward-based catering staff were knowledgeable about, and responsive to, patients' nutritional needs and dietary preferences and would adjust portion sizes if required;
- at WMH, meal choices are not ordered in advance, with staff asking patients what they would like after the trolley has arrived on the ward;
- nutritionally at-risk patients were identified during handover and safety meetings while nutrition signs above patients' beds alerted staff to specific dietary needs;

- patients were encouraged to eat their meals in the ward dining room if they were able to as part of their programme of rehabilitation; and
- staff generally provided timely support to patients who needed help with eating and drinking but there were a small number of instances where patients with poor appetites could have been given more encouragement to eat the meal provided.

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

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

Observations of the lunchtime service Ward	YG Glyder	YGC 14	WMH MAU
Patients helped to prepare for mealtimes, including using the toilet, washing hands and sitting up or getting out of bed	All	All	Most
Bedside areas/tables tidied before meals served	All	All	Some
Bedside areas/tables cleared of clinical waste	All	All	All
Ward-based catering staff wear protective clothing	All	All	All
Temperatures of meals are recorded before service begins[1]	None[1]	None[1]	None[1]
Nursing staff accompany ward-based catering/hotel staff during the service	All	All	All
Patients needing help with eating are easily identified	All	All	All
Meals are left within reach of patients	All	All	All
Help is given to cut up food or to remove packaging	All	All	All
Patients needing help receive it promptly	All	All	Most
Nursing staff supervise and encourage patients with eating throughout mealtimes	All	All	Most

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

Source: Wales Audit Office observations of lunchtime services

45. The 2014 Fundamentals of Care audit found that nearly all (98 per cent) wards had systems in place to allow family or friends to assist with mealtimes. On the three wards that we visited, nursing staff told us that they actively welcome and encourage family and friends to help patients at mealtimes in line with the Health Board policy. During our ward visits, we observed families helping their relatives with eating.

46. The 2014 Fundamentals of Care audit also found that a registered nurse coordinated every mealtime on 89 per cent of wards while all nursing staff were engaged in the mealtime service on 98 per cent of wards.

Protected mealtimes are largely in place

47. An updated protected mealtime policy has been drafted by the nursing nutritional support team and is due to be presented to INCHS at its next meeting before the Board is asked to approve it.

48. The monthly peer review Quality and Safety Audits include a number of indicators relating to protected mealtimes, including whether patients are adequately prepared for the meal, if help is provided with eating and drinking, and whether drinks are left within patients' reach. We saw the Health Board summary figures for August 2014 to April 2015, showing that compliance in these areas was high.

49. Ward managers we spoke to were generally confident that protected mealtimes work well with professional colleagues supportive of the principles. However, we found that compliance with the protected mealtimes approach varied to some extent between the wards that we visited. We found:

- Variation in the signage used at ward entrances to explain the times and purpose of protected mealtimes.
- No signage was visible at the entrance to the Medical Admissions Unit (MAU) at WMH, where staff told us that complying with protected mealtimes was more difficult because patient flow and clinical needs took priority. Blood samples were taken from several patients and nothing was done to screen this activity from other patients eating nearby.
- Routine medical and medicine rounds stopped at the start of the meal service and healthcare professional staff for the most part left patient areas and staff remained, interactions with patients and nursing staff were minimised.
- Cleaning activities were generally completed prior to the meal service and where they continued, it was in areas away from patients' bedsides and cleaning activities were not observed to impede the food trolley.
- Replacement meals were provided for patients who were absent from the ward during the meal service.
- Food trays were collected from some patients who had finished eating while other patients were still eating their meal, which might discourage these patients from finishing their meals.

The cost of patient catering services has risen and, although non-patient catering services still run at a loss, the gap between income and cost is reducing

51. 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) and supported by revised data definitions.

52. Little progress had been made in computerising hospital catering systems and most of the current catering information management systems relied on manual paper processes. In his national report, the Auditor General recommended that NHS bodies should introduce computerised catering information systems and NHS Wales Informatics Service and NHS Shared Services Partnership have developed an outline business case to procure a national catering IT solution. Our latest audit found that NHS bodies, including the Health Board, have commented on the outline business case.

53. In 2010, NHS bodies were adopting measures to control the costs of catering services. There was scope, however, to make more use of standard costed recipes, agreeing food and beverage allowances for patients, standardising local catering contracts and reducing levels of food waste, which was unacceptably high. The Auditor General recommended that NHS organisations should aim to ensure that wastage did not exceed 10 per cent. The Welsh Government subsequently set a 10 per cent food waste target for unserved meals for achievement by the end of 2012-13.

The cost of patient catering services has risen but the cost per patient meal varies between hospitals

54. Across Wales, the cost of patient catering services have been reducing year on year (Exhibit 4). The Health Board's EFPMS data submissions show that patient catering costs reduced by 10 per cent from £8.49 million in 2011-12 to £7.62 million in 2012-13 but increased by two per cent the following year to £7.82 million. Our analysis of the EFPMS data suggests that patient catering costs increased because provision costs increase by 22 per cent from £2.43 million in 2012-13 to £2.97 million in 2013-14. However, the rise in food provision costs was not matched by a similar increase in patient meal requests. Between 2012-13 and 2013-14, the number of patient meals requested increased by only 6,600, or 0.3 per cent.

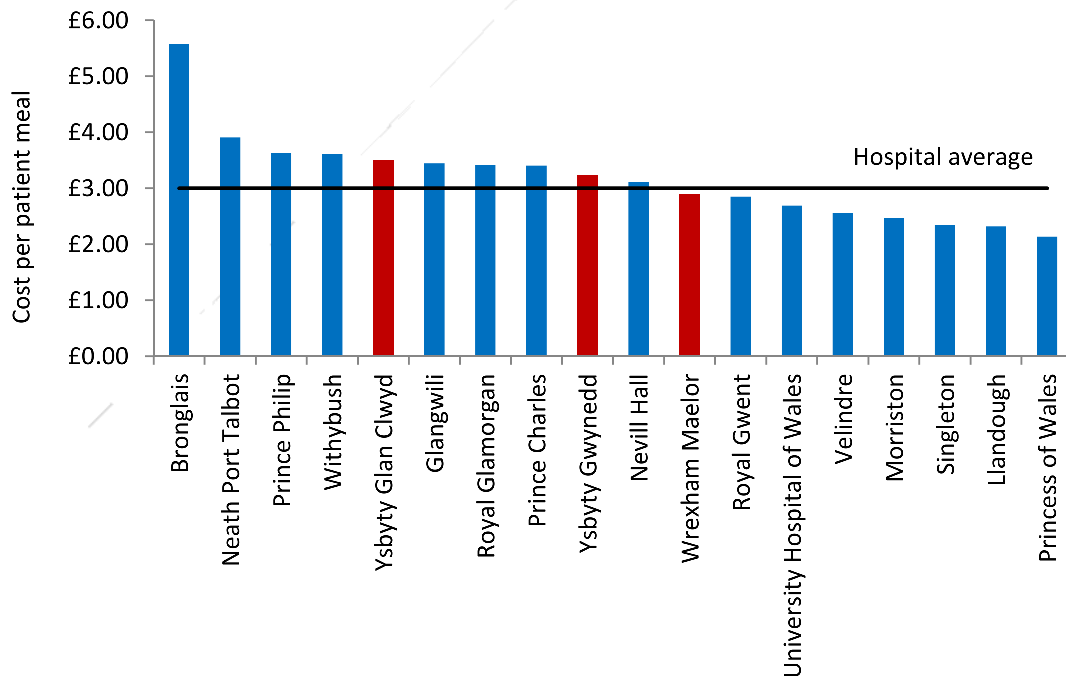
Exhibit 4: Patient catering service costs are reducing

Year	Cost of catering services (£ million)	
	Betsi Cadwaladr	Wales
2011-12	8.49	38.95
2012-13	7.62	37.26
2013-14	7.82	36.97

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

55. The EFPMS data for 2013-14 show that the cost per patient meal was £3.43 across all the Health Board's hospitals. The cost per patient meal at YGC (£3.51) and YG (£3.24) are above both the Health Board average and Wales average (Exhibit 5). At WMH, the cost per patient meal (£2.89) was just below the Wales average.

Exhibit 5: The Health Board's costs per patient meal vary above and below the average cost for acute hospitals



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

56. In 2010, the Health Board's food production arrangements relied heavily on manual paper systems rather than an IT solution. By 2013, the Health Board had introduced the MenuMark catering information system at YGC but intended rolling it out more widely. Our latest audit found that the basic system had been rolled out. The Health Board indicated that it was disappointed with the slow progress in procuring an all Wales system and has developed a business case to upgrade the MenuMark system following a review by Internal Audit.

57. To support the implementation of the 2011 nutrition and catering standards, the AWMF was launched in January 2013. Recipes within the menu framework are costed. All health boards jointly funded the appointment of a procurement dietician working in the NHS Shared Services Partnership – Procurement Service to support the development of all Wales procurement contracts to source food provisions commodities for the dishes on the menu framework. The Health Board contributes to the All Wales Hospital Menu Framework Group and the All Wales Commodity Group to progress procurement issues, including developing contracts to source local produce from local suppliers.

The cost of unserved patient meals is significantly higher at Wrexham Maelor

58. In 2010, unserved meal wastage was below 10 per cent suggesting arrangements were well managed at that time. By the time of our follow-up work in 2013, ward-based food wastage monitoring had improved to the point that all wards monitored waste at breakfast, lunch and dinner. Monitoring considered only unserved meals rather than plate waste. Patterns of waste were fairly consistent between sites although there was variation related to the type of ward (eg MAUs had more wastage than other wards). In 2013, we recommended further improvement of the food waste monitoring approach to include plate waste. Our latest audit found no progress in monitoring plate waste.

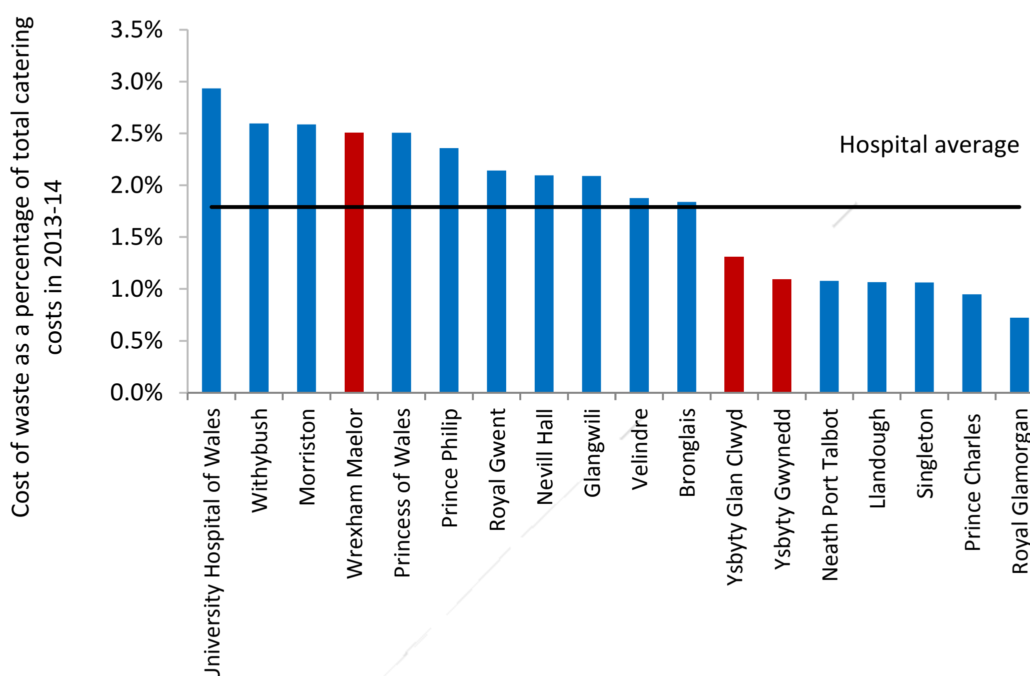
59. The Health Board indicated that it uses the EFPMS definition to calculate unserved meal waste.[6] We reviewed a sample of the monthly waste reports which were presented by region (east, central and west) and contained details for individual wards/units. The reports varied in format between regions, and sometimes changed within the same region over time. The data presented related to the number of meals served and unserved. However, we were told that overall analysis of the amount of waste is currently by specialty, rather than by district general hospital sites, and that a waste figure for the Health Board as a whole is not available. The approach to this analysis will need to change if there is to be a clear understanding of waste at each district general hospital in future.

60. During two of our mealtime observations, we were told that unserved meals are recorded after the meal is finished and the information is reported back to ward staff straight away.

[6] 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.

61. Analysis of the 2013-14 EFPMS data shows that the cost of unserved meals was £126,500 at the Health Board, or 1.3 per cent of total catering costs. There were variations between all the Health Board's hospitals. The cost of food waste as a proportion of total costs at WMH was higher than the acute hospital average while at YG and YGC costs were well below the average (Exhibit 6).

Exhibit 6: The cost of food waste at Wrexham Maelor compares less favourably with YGC and YG and the average for other hospitals in Wales



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

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

62. In 2010, we said that non-patient catering financial information was not as robust as it could be for the catering services across different hospital sites. The Health Board did not have an agreed policy for the levels of subsidy for non-patient catering services. Instead, these services operated on a breakeven basis but ran at a loss in excess of £370,000 (non-patient catering costs for YG were not available). At that time, we recommended that the Health Board introduce a clear policy on subsidy to set the framework for delivering non-patient catering services.

63. By the time of our follow-up audit in 2013, the Health Board had taken steps to improve the quality of financial information for planning and monitoring, and to ensure consistent reporting. In particular, menu prices for non-patient catering services had been standardised across all sites along with separate cost centres. At that time, the Health Board had forecast a £180,000 shortfall in income to cover the cost of non-patient catering services based on a one-week audit of activity. However, at the end of March 2013, the shortfall in income was nearly three times greater and totalled £535,000. The EFPMS data for 2013-14 show that the gap between the cost and income generated is reducing (Exhibit 7).

Exhibit 7: The gap between income and costs of non-patient catering service is reducing

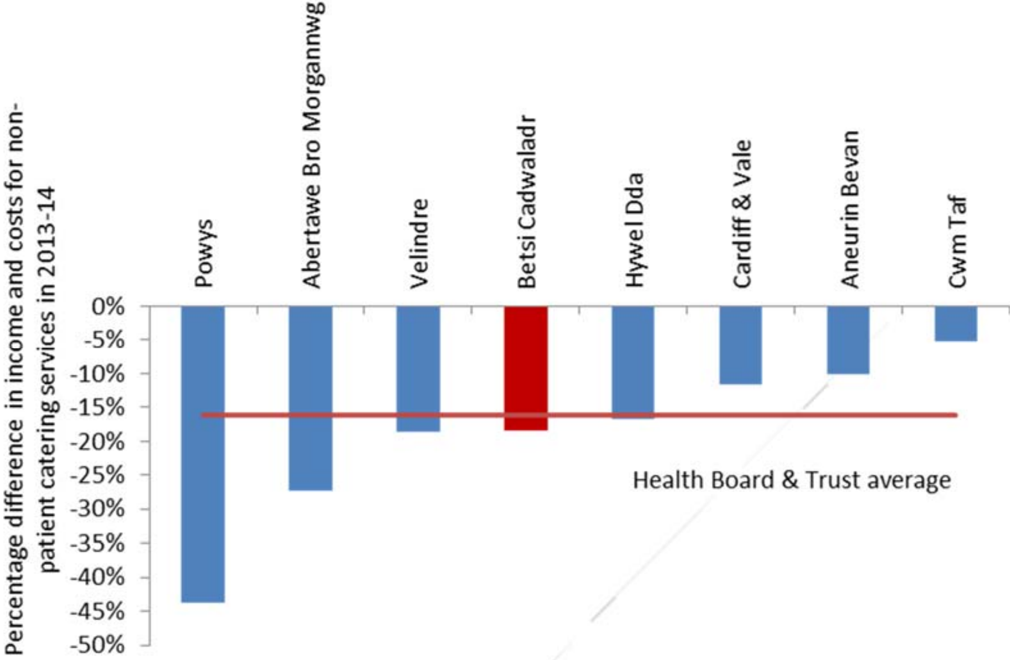
Year	Betsi Cadwaladr			Wales		
	Cost of non-patient catering services (£ millions)	Income achieved	Percentage gap in costs and income (%)	Cost of non-patient catering services (£ millions)	Income achieved	Percentage gap in costs and income (%)
2011-12	2.74	1.69	-38%	15.05	11.20	-26%
2012-13	2.331	1.80	-23%	14.50[1]	11.53	-20%
2013-14	2.201	1.79	-19%	13.43[1]	11.26	-16%

[1] Includes rental costs for vending machines.

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

64. Across Wales, the income generated from non-patient catering services was insufficient to recover operating costs at any NHS body in 2013-14 (Exhibit 8). At the Health Board, the cost of non-patient catering services was £2.2 million. The total income generated was enough to recover 81 per cent of these costs, which equates to a subsidy of around £400,000. 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 further improvements. The Health Board has indicated that it is considering different models of provision and associated profitability.

Exhibit 8: NHS organisations do not generate enough income to recover the cost of non-patient catering services; there is a 19 per cent shortfall in income at the Health Board



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

Reporting on catering and nutrition issues and capturing patient feedback has improved, but some oversight arrangements remain complex

65. 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 reorganisation in 2009. A more comprehensive and coordinated 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 could be clearer.

66. In the Health Board at that time, executive accountability for catering and nutrition was clear although the Health Board lacked a clear strategy and consistent supporting policies. The Board received limited information on catering and nutrition services, including the outcome of food hygiene inspections, and different mechanisms for seeking patient feedback meant that patients' views were not collated and shared effectively. Our follow-up work in 2013 found that the Health Board had yet to finalise its catering and nutrition strategy.

Aspects of oversight and scrutiny of catering and nutrition issues remain complex

67. There is clear and separate executive accountability for nutrition and catering. The Director of Nursing and Midwifery is accountable for nutrition and the Chief Operating Officer is accountable for catering. Catering services have a line of management accountability through the Head of Facilities, up to the Director of Estates and Facilities, who reports in turn to the Chief Operating Officer.

68. Nursing and patient services leads across clinical programme groups were delegated responsibility to self-assess compliance against recommendations made in 2010 local Wales Audit Office report on catering and nutrition, to take improvement actions and to provide evidence of change on a quarterly basis to INCHS.

69. By 2013, planning structures for patients' nutrition and hydration needs were predominantly through the INCHS, which reported to the Improving Service User Experience Group (ISUE). It had a broad programme of work, including assurance and oversight of compliance with the All Wales Nutrition and Catering Standards, the health and care standard related to nutrition, the AWMF and the nutritional care pathway. Membership included senior staff from relevant disciplines, including a member of the Community Health Council (CHC).

70. In 2013, we found that catering staff were under-represented on INCHS. In 2015, we found that catering managers have been attending INCHS meetings regularly and staff told us that this has been very beneficial in terms of their contribution to a range of issues.

However, unlike similar groups in some other health boards, the current chair is not an executive director. There is recognition that the functions and membership of INCHS have not kept pace with the changed organisational structure and arrangements. These issues were due for consideration at the September 2015 meeting of the group.

71. Several groups fed into INCHS in 2013, including the Nutritional Screening Group; the Artificial Nutrition Group; the Human Rights Group, and the Mealtimes/Menus Patient Experience Group. In addition, the Catering Group and the Catering Commodities Group fed into the latter. We said there was a potential risk of over-complexity in these arrangements, which could result in a lack of clear lines of accountability. In 2015, we found that these arrangements remained largely the same.

72. In the interim period, the INCHS set up three task-and-finish transformational groups to drive strategic change. On completion of their tasks, the groups were either dissolved or developed into other arrangements. However, the current status of the groups staff was not always clear to staff.

73. INCHS is responsible for ensuring that the Health Board complies with the legislation for the safe handling and storage of food. Recent food hygiene inspections by environmental health officers resulted in poor ratings at two hospitals and led to significant adverse publicity for the Health Board. Staff told us that the inspection reports were not communicated effectively internally, which slowed the Health Board's response to the inspection. INCHS should have directly received copies of these reports and ensured that there was urgent action in response to them.

74. In 2013, we reported that the Quality, Safety and Experience Sub Committee received reports from the ISUE and that the former had stronger oversight of aspects of the nutritional services and associated arrangements, than it did with regard to Catering Services risks. In 2015, we found a similar situation.

75. 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 triangulated information about patient nutrition and hydration and more broadly around the Fundamentals of Care standards. An independent member of the Board has recently been appointed as Patient Experience Champion and expects to be involved regularly in ward visits.

Operational and corporate reporting are clearer following reorganisation although routine reporting to the Board on patient experience is limited

76. In 2010, reporting to the Board on catering and nutrition issues was inconsistent. During our current review, we found that the Board receives periodic reports on compliance with the nutritional care pathway through its 'Ward to Board' metrics and the Health Board's Nursing and Midwifery Dashboard. Catering issues are reported to the Food Safety Group, which reports in turn to the Strategic Infection Prevention Group. The latter produces an annual report for the Board which includes catering and food safety issues. The Board also receives the annual Fundamentals of Care report.

77. However, routine reporting to the Board on patient experience in relation to food and nutrition is limited. At Cardiff and Vale University Health Board, patient feedback on

food and mealtime experiences is presented to every Board meeting as part of its patient experience report, along with compliance with nutritional screening.

78. Performance is monitored and reported regularly at an operational level. Compliance with nutritional screening is monitored at senior nurse meetings and by INCHS. Key performance indicators for catering services, such as waste, food provisions costs and meal numbers are collated on a monthly basis. This information is reported periodically through the year to the Estates and Facilities management team.

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

80. Clinical programme groups were previously required to provide updates to INCHS on their position in relation to the Health Care Standards. Assessment mechanisms include Fundamentals of Care reviews, Quality and Safety Audits and completion of the All Wales Nursing and Midwifery Dashboard. We understand that plans to update the INCHS terms of reference will provide an opportunity to update these arrangements.

The Health Board has strengthened mechanisms for capturing patient feedback

81. In 2013, we suggested that the Health Board should repeat its participation in the NHS Inpatient Survey, conducted by the Picker Institute. The survey includes a number of questions relating to food and mealtimes. The Health Board did subsequently repeat this process and, at the time of our work in 2015, it was waiting for the findings of the most recent survey.

82. The 2014 Fundamentals of Care annual user experience survey recorded a 96 per cent user satisfaction score in relation to Standard 9, Eating and Drinking. The survey recorded a 94 per cent user satisfaction score for oral health and hygiene. The report shows a small improvement over the scores from 2013 (93 per cent and 90 per cent respectively). However, it notes that comparison between the two years would not be entirely reliable because of a change in methodology in 2014. The Quality, Safety and Experience Sub Committee receives the Fundamentals of Care annual audit report, and subsequently presents it to the Board.

83. The local CHC has developed a 'Food Watch' audit to assess the cleanliness of ward kitchens and arrangements to ensure that patients are well nourished and hydrated. The assessment was developed in conjunction with infection prevention, nursing and catering professionals. It includes gathering informal feedback from patients, in addition to ward observations. The CHC reports these findings to the strategic Food Safety Group. It has been working through 2014 and 2015 to extend its programme of 'Food Watch' visits across the Health Board, to provide an additional source of feedback.

84. Between October 2014 and April 2015, WMH piloted the real-time patient feedback system 'I Want Great Care'. We were told that staff at Wrexham Maelor believed

the real-time feedback helped to address issues quickly and raised staff morale. The Health Board has allocated funding to roll out the scheme across its hospitals.

85. 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. Dietetic staff distributed surveys to 490 patients across its hospitals and there were 234 returns, which equates to a response rate of 48 per cent. The survey findings were expected mid-summer and the Health Board intends using the findings to inform future revisions of 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, an independent member, a patient representative and ward managers.
We also reviewed a number of documents, including reports from other relevant external organisations and the Health Board's response to these reports.

Data analysis

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

Ward observations

We undertook observations of the lunchtime mealtime service on three wards, selected by the Executive Director of Nursing and Midwifery, 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
- there was compliance with protected mealtimes.

We visited the MAU – Wrexham Maelor; Ward 14 – YGC; and Glyder Ward – YG.

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, 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 20 local recommendations set out in our report, which summarised the findings from our 2010 audit work on hospital catering and patient nutrition services at the Health Board. The status of each recommendation[7] is also set out in Tables 1, 2 and 3.

Table 1: 2010 local recommendations

Recommendation		Status at July 2015
Strategic planning and management arrangements		
R1	Strengthen strategic planning arrangements for catering to ensure a clear and consistent agenda for the catering service across the Health Board.	O
R2	Establish planning structures for catering and nutrition services which are consistent across the Health Board.	O
R3	Address kitchen management and staffing issues at Wrexham Maelor Hospital as a matter of urgency.	A
R4	Reduce the time it takes to develop and establish new catering and nutrition processes.	A
R5	Improve the Board scrutiny arrangements for monitoring catering and nutrition risks and performance.	O
Procurement production and cost control		
R6	Introduce a clear subsidy policy to set the framework for delivering non-patient catering services.	O
R7	Develop consistent ledger arrangements across the Health Board to ensure that sufficient and robust catering business information is available.	O
R8	Improve the current food wastage monitoring arrangements to accurately reflect production efficiency and help identify the potential to improve existing systems.	A

[7] (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
Delivery of food to the ward		
R9	Address the food quality and delivery deficiencies identified in this report which are affecting the quality of food patients receive at Wrexham Maelor Hospital.	A
R10	Address shortcomings identified in the catering environment at Wrexham Maelor Hospital as a matter of urgency.	A
R11	Implement improvements to ward food delivery arrangements to ensure that food temperature is maintained at appropriate levels.	A
R12	Decommission the damaged and unclean grey plastic trolleys in use by catering for minor catering deliveries at Wrexham Maelor Hospital.	A
R13	Introduce protected meal times in all appropriate wards which meet the approach adopted in the best wards.	A
R14	Reinforce the need for patient hand cleansing.	A
R15	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.	O
Meeting patients' nutritional needs and supporting recovery		
R16	Reinforce the need to measure a patient's weight and height in order to calculate the associated patient Body Mass Index (BMI).	O
R17	Improve the format and types of nutrition-related information recorded in the nursing notes for patients.	A
R18	Develop practical methods to assist in the regular completion of food record charts and fluid intake/output charts.	A
Gathering views from patients and sharing information		
R19	Introduce effective arrangements for sharing information on patients' views of the service between ward managers and the catering service.	A
R20	Involve patients fully in developing the catering service, building on the recent positive experiences of patient engagement.	A

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

Table 2: 2011 national recommendations

Recommendation		Status at July 2015
Ensuring patients' nutritional needs are met		
R1b	We recommend that NHS bodies use the results presented in our local audit reports as a basis for ensuring that they are effectively implementing the all-Wales Nutritional Care Pathway, in particular, ensure that nutritional screening effectively identifies all patients who have nutritional problems, or are at risk of developing them, and that appropriate care plans and monitoring activities are instigated.	O
R1c	We recommend that NHS bodies regularly audit compliance with all aspects of the nutritional care pathway across all their hospital sites and share the results of these monitoring exercises with all the relevant staff groups involved in catering and patient nutrition services.	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.	O
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 hospitals sites have been nutritionally assessed by dieticians.	A
Improving patients' mealtime experience		
R3a	We recommend that NHS bodies ensure that their menus provide an appropriate choice of food and that the arrangements for ordering and serving food support adequate patient choice.	O
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.	O
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 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.	O
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.	O
R6d	We recommend that NHS bodies emphasise to their staff that controlling food waste is a collective responsibility and that catering and ward-based staff should work together to tackle the problem.	A
R7a	We recommend that set pricing policies and income generation targets that aim to ensure that non-patient catering services at least break even, or, if they do not, it is the result of a deliberate subsidy policy that is based on a detailed analysis of costs.	A
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.	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.	O
R11b	We recommend that NHS bodies demonstrate how they have taken patients' views into account when developing catering and nutrition services.	O
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 nine suggestions for further action arising from follow-up audit work on the Health Board's hospital catering and patient nutrition services in 2013. The recommendation numbers relate to the 2010 local recommendations set out in Table 1 above.

Table 3: 2013 suggestions for further work and review

Recommendation[1]		Status at July 2015
Effective service planning and monitoring arrangements		
R1	Catering group representation needs to continue to strengthen at the INCHS group. This should ensure improved alignment between catering and nutritional plans.	A
R1	While strategic planning arrangements have been strengthened, they need to develop further to ensure there is a clear and consistent agenda and consistent processes across the Health Board where required.	O
R2	While there is evident improvement in nutritional service planning, catering service planning needs to be further strengthened.	O
R5	The INCHS should seek a more direct link with the Quality and Safety Committee to ensure oversight in relation to how well the Catering Services are meeting patient's needs.	A
R5	Include nutrition and catering in quality reports and take quality reports to the Board.	O
R5	The INCHS group structure may be overly complex, which may result in lack of clear lines of accountability.	O
Procurement production and cost control		
R7	The Health Board should aim to create consistent and comparable catering financial information reflecting true cost of food provisions and services. Alongside this, the Health Board should aim to reduce variation in catering funding approaches and actively pursue consistency in catering provision to ensure best possible patient mealtime experience.	O
R8	The food waste monitoring approach will need to improve further to include plate waste and trolley waste when the Health Board moves to a bulk delivery service in Wrexham Maelor. This approach will then enable the catering service to reduce unnecessary production waste and to help ensure patients receive the nutrition they require.	A

Recommendation[1]		Status at July 2015
Meeting patients' nutritional needs and supporting recovery		
R19	The Health Board should undertake the Picker Survey or a comparable during 2013, to identify if progress has been made, particularly in regard of patient quality and safety.	A
R20	Ensure patient representative on the INCHS group is recruited by April 2013.	A

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