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Hospital Catering and Patient Nutrition Follow-up Review

Abertawe Bro Morgannwg University Health Board

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Status of report

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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 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. In 2014, we undertook a follow-up audit at Abertawe Bro Morgannwg University Health Board, and reported on the progress made in relation to the local recommendations we made in 2010.

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.

5. To support the implementation of the standards, caterers and dieticians across Wales worked together to produce the All Wales Hospital Menu Framework, which was launched at the end of January 2013. The Framework consists of a database of an agreed set of menu items, a standardised set of recipes and cooking methods, nutritional analysis of each menu item and a range of snacks that are compliant with the standards and procured through all-Wales contracts.

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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 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. Our 2015 follow-up work at Abertawe Bro Morgannwg University Health Board (the Health Board) assessed the extent to which the Health Board 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 2014.

8. The 2015 Trusted to Care report[6] noted excellent progress against the recommendation on improving hydration, mobility and feeding practice for older patients, and publishing audit results on a quarterly basis. The review team welcomed the way in which publication of the results had helped to drive improvement.

9. We concluded that the Health Board has made good progress in addressing our previous recommendations. More work is needed to further strengthen documentation processes and patient information, extend meal choices, ensure regular training, and reduce the gap between cost and income of non-patient catering. We reached this conclusion because:

- Arrangements for meeting patients' dietary and nutritional needs have improved but training, documentation processes and patient information need to be strengthened:
  - patients are routinely screened on admission but some inconsistency of care planning, rescreening and documentation remains;
  - the nutritional care pathway is routinely monitored but a systematic approach to nutrition, hydration and food safety training is needed;
  - current arrangements support patient access to food and beverages 24 hours a day with mechanisms to monitor compliance;
  - menu items are nutritionally assessed through the All Wales Menu Framework with which the Health Board is largely compliant, and resources for local nutritional analysis have been allocated; and
  - written information for patients on what to expect in relation to food and nutrition catering services remains variable.

[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.
[6] **Trusted to Care –- 2015 Review**.

- An appropriate range of menu choices is available for most patients and mealtime experiences are generally good:
  - the level of nursing support and supervision at mealtimes is generally good;
  - protected mealtimes are well embedded and flexible visiting enables relatives and friends to help support patients during mealtimes; and
  - the mealtime experience is generally good and an appropriate range of menu options is available for most patients, but there is some scope to extend meal choices.
- Patient catering costs are relatively unchanged, cost per patient meal compares well to other NHS bodies and food waste is below the national target. However, non-patient catering services are running at a loss:
  - although there have been small fluctuations in the cost of patient catering services, cost per patient meal compares favourably with other NHS bodies;
  - levels of food waste have reduced and are now below the national target;
  - non-patient catering services still run at a loss and the gap between income and cost is increasing;
- Arrangements for planning, monitoring and reporting on hospital catering and nutrition services are largely robust:
  - the Nutrition and Catering Steering Committee ensures national policies and standards are implemented but organisational changes may affect current arrangements and executive responsibility for catering is less clear than five years ago;
  - mechanisms are in place to capture and act upon patient feedback about catering and nutrition; and
  - corporate arrangements for monitoring the nutritional care pathway are well established but information on waste, cost and food quality is less visible.

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

Recommendations

11. The Health Board has fully achieved 25 of the 44 recommendations previously set out in our national and local reports and is on track against 18 others. The Health Board needs to maintain focus on implementing the remaining recommendations where progress is reported to be on track but is not yet completed, or where we consider insufficient or no progress has been made. The key issues identified in 2015 are summarised in Exhibit 1 together with the references to the relevant recommendations. A full list of the national and local recommendations, along with the status of each is set out in Appendix 2.

Exhibit 1: Key issues identified in 2015

Recommendation	Key issues in 2015
Ensuring patients' nutritional needs are met	
2010 R10/2011 R1b/d	Consistency of rescreening and quality of documentation
2010 R9 / 2011 R1d / 2014 R3	Improving training: e-learning compliance, regular training and food safety training provision
2010 R14 / 2014 R4	Improving patient information, drawing on the work at the Princess of Wales
Improving patients' mealtime experience	
2011 3a	Extending meal choices where arrangements may not offer sufficient choice
2010 R2 / 2011 8B	Completing roll out of cook-freeze model as single food production approach
Controlling the costs of the catering service	
2011 R7a/b	Addressing the cost – income gap in providing non-patient catering services
2014 R2	Assessing the impact of the new private food outlets at Morriston on the profitability of the non-patient catering service and future subsidy policy
Effective service planning and monitoring	
2011 R8b	Assessing the potential impact of organisational changes on membership and operation of the Nutrition and Catering Steering Committee and sub-groups
2011 8b	In the context of meeting standards of care for older people, review how the Nutrition and Catering Steering Committee inter-relates with other groups focussed on issues relevant to the care of older people, in providing assurance on these standards.
2011 R8c	Clarifying the location and reporting lines for support services within the new organisational structures and executive responsibility for these services
2010 R1 / 2011 R10a	Considering the benefits of a consolidated report to provide a collective picture of performance, drawn from the various monitoring reports
2011 R10a	Improving the visibility of information on food waste, costs of catering services and food quality at a corporate level
2011 R10b	Collating screening information to assess the numbers of patients admitted requiring nutritional support

Detailed report

Arrangements for meeting patients' dietary and nutritional needs have improved but training, documentation processes and patient information need to be strengthened

12. In 2010, many hospitals in Wales had improved their arrangements to ensure patients' nutritional needs were met but information was fragmented and did not allow for a quick overview of patients' nutritional problems or for reviewing nutritional status easily. The lack of standardised nursing documentation to record key assessment information may have contributed to the variation in quality of the nursing records. Not all NHS bodies regularly monitored compliance with the nutritional care pathway.

13. At the Health Board in 2010, we found that patients were generally screened on admission for nutritional risk but the information recorded as part of the screening process was often incomplete. Too many patients identified as being at risk of malnutrition did not have care plans in place, and a small number of patients identified as at high risk of malnutrition were not referred for a dietetic assessment.

14. By 2014, compliance with nutritional screening within 24 hours of admission had improved and generally exceeded 90 per cent, but the proportion of patients rescreened at the appropriate interval was significantly lower. There were also notable gaps in information on patients' oral health and normal dietary intake, while nutritional care plans were not always in place for those patients who needed one. Our findings from 2015 are set out below.

Patients are routinely screened on admission but some inconsistency of care planning, rescreening and documentation remains

15. As part of our 2015 work, we reviewed five sets of case notes on each of the four wards that we visited as part of the audit, 20 case notes in total. We assessed whether nursing staff screened patients on admission using a validated nutritional assessment tool and repeated the process at least weekly, as well as assessing 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 weight, 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.

16. Our case note review found that all 20 patients were screened on admission using the Nutritional Risk Adult Screening Tool (NRAST), and while it had not been possible to weigh five of the patients, their weight had been estimated. A nutritional risk score was calculated for all 20 patients.

17. Completion of functional assessments as part of the nutritional screening process was carried out consistently, although documentation does not readily lend itself to distinguishing between a patient's cognitive and physical ability to eat and drink, and

the extent of their mobility to sit up unaided to do so. None of the patient case notes that we reviewed contained information about patients' dietary preferences and requirements or usual dietary intake, although in one clinical area supported by a ward hostess, this information was available outside of the formal case note.

18. The All Wales Nutrition and Catering Standards make it clear that oral health and communication are part of nutritional care. In 2010 and again in 2014, we found that very few patients had received a documented oral health assessment. Our latest case note review found notable improvement in the assessment of oral health with all 20 case notes including an assessment. Although our case note sample is small, it shows further improvement against the Health Board's 2014 Fundamentals of Care audit[7], which found three-quarters of patients received an oral health assessment.

19. Healthcare Inspectorate Wales reported in their annual report for 2014-15 that observations during Dignity and Essential Care Inspections had indicated regular care interventions by staff. However, written care documentation had not always supported this, with an inconsistent approach to the completion of care and risk assessment documentation used on hospital wards.

20. The Health Board has developed an integrated nursing assessment approach and supporting documentation, to promote holistic nursing assessment, identification of patients who need more detailed risk assessment and care bundles, and to address variation in standards of documentation. The approach, which includes relevant nutritional screening, has been piloted, and revised nursing documentation recently introduced. Arrangements to monitor the standard of completion have been put in place and should support the Health Board in making continuing improvements to the consistency and quality of nursing assessments and the standards of documentation.

21. Our case note review found that while 15 of the 20 patients had been in hospital long enough to be nutritionally rescreened, only eight had documented reassessments. We also found some continuing issues in the use of care plans, food and fluid charts. Twelve of the 20 patients required a nutrition care plan with care plans in place for 10 of these patients and 11 referred to a dietician. Nutrition and hydration charts were used consistently for those patients identified as at high risk of nutritional problems but there were gaps in entries and signatures. The 2014 Fundamentals of Care audit also found gaps in signatures on food and fluid charts.

22. As part of our latest audit, we reviewed a sample of monthly Fundamentals of Care summary reports for five wards across the Health Board. These reports contained the following indicators:

- percentage of 'Nutrition Score Completed and Appropriate Action Taken' within 24 hours of admission;
- percentage of repeat nutritional risk assessments being undertaken within identified timescale (out of the number of patients looked at in the sample); and
- percentage of patients assessed as being a moderate or high risk with a food chart in place and care plan

[7] The Fundamentals of Care Audit was completed at the Health Board between October and November 2014.

23. The reports show that compliance against each indicator was generally high and frequently at 100 per cent on these five wards. However, there were monthly variations in compliance from otherwise high scores on some of the five wards as well as gaps in data, suggesting that monitoring is not consistently completed.

The nutritional care pathway is routinely monitored but a systematic approach to nutrition, hydration and food safety training is needed

24. In 2010, not all NHS bodies monitored compliance with the all-Wales Nutritional Pathway and in 2011 we recommended that every health board establish regular arrangements to assess compliance with all aspects of the pathway.

25. In 2013, the Health Board undertook a full nutrition audit to assess compliance against all elements of the all-Wales Nutrition Pathway. The results were reported to Heads of Nursing, responsible for developing action plans. Although the Health Board has not repeated the whole pathway audit, the pathway elements are regularly monitored through a number of methods, including monthly care metrics reported to the Nursing and Midwifery Board and Quality and Safety Committee, spot-check audits by senior nurses and integrated nursing assessment documentation audits.

26. In addition, the Health Board has developed standards for the care of older people and a dashboard to measure associated performance indicators. Standard four relates to patient nutrition and hydration, with monitoring in three key areas:

- improvement in the number of patients needing help with eating and drinking who responded positively that they received help;
- reduction in the number of complaints related to avoidable episodes of nil by mouth; and
- improvement in the number of patients aged 80 and over, with an identified swallowing problem with evidence of up-to-date plan of care, evaluated and reviewed within agreed timescales.

27. In September 2011, the Welsh Government introduced an e-learning package in the use of the all-Wales nutrition care pathway and all-Wales food and fluid charts. All ward-based nursing staff were required to complete the e-learning within 12 months of this date while new staff should complete it within 12 months of appointment. In April 2015, the Nursing Midwifery Board's 'Annual Progress Report and Update on Patient Nutrition and Catering' to the Quality and Safety Committee reported that while the numbers of staff completing the e-learning model have increased, compliance was only 25 per cent compared with 23 per cent in 2014.

28. The Health Board has promoted awareness of nutrition and hydration, for example, through its intranet site and the Nutrition and Hydration week, which took place during 16 to 20 March 2015. A package of training to support the new 'nil-by-mouth' protocol and to increase knowledge and confidence around swallowing assessment has also been provided for staff caring for frail elderly people.

29. However, broader nutrition and hydration training is currently only provided as part of the Health Board's induction process or when requested by specific departments or wards. The Health Board recognises the need for more in-depth and regular training and this has been escalated as an area of risk, due to the lack of capacity of the Nutritional Nurse and Dietetics Team. In addition, food safety training for nurses has not been progressed while a decision on wider roll out of a ward-based catering model (hostesses) remains pending. In order to meet food safety legislation, this position needs to be addressed.

Current arrangements support patient access to food and beverages 24 hours a day with mechanisms to monitor compliance

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

31. In 2014, the Health Board's Fundamentals of Care operational survey found that 99 per cent of areas confirmed that nutritious snacks were available for all patients compared with 91 per cent in 2013. A large proportion (87 per cent) of patients responding to the Fundamentals of Care patient survey felt that they were provided with nutritious snacks. Health Inspectorate Wales' Dignity and Essential Care Inspections found that snacks were available on the wards they visited during 2014-15, and similarly, the 2015 Trusted to Care report also noted snacking as one of the initiatives supporting proper feeding of older patients on wards.

32. Senior catering staff told us that the Health Board is currently working to extend the hours that main meal services operate to reduce overall intervals between meals. Currently the last meal is between 5 pm and 6 pm.with bedtime snacks offered at 8 pm. Wards are able to order snacks daily and most wards keep a good supply. Wards can requisition food as needed to account for situations such as new admissions, patients returning from theatre, and special dietary requests.

33. The All-Wales Nutrition Standards for patient food and fluid require seven to eight hot and cold beverage rounds take place each day, with water jugs placed in easy reach of patients and changed three times a day. The Health Board's 2014 Fundamentals of Care audit found that 91 per cent of clinical areas confirmed that drinking water was available for patients and within reach. However, only 60 per cent of the areas confirmed that water jugs were changed three times a day, although this was up from 40 per cent in 2013. Only 57 per cent of the clinical areas confirmed that there were seven or more daily beverage rounds compared with 72 per cent in 2013.

34. During our ward visits in 2015, staff were focussed on meeting these standards but told us it was challenging to provide seven to eight drinks rounds and three water jug changes day. We noted a positive difference in wards supported by a ward hostess, with the hostess being well placed for helping to ensure patients can access food, snacks and beverages throughout the day. Ward hostesses have been introduced in a

number of areas and patient feedback has been positive[8]. The Health Board has set out proposals in its Integrated Medium Term Plan for wider introduction of hostesses as part of a ward-based catering model. The pace with which this can be achieved, however, is dependent on wider issues concerning resourcing.

35. The Health Board has a number of mechanisms for checking compliance with the all-Wales Nutrition and Catering Standards. These include multi-disciplinary meal monitoring audits, patient surveys to monitor patient experience of catering provision and spot checks carried out by senior nurses.

Menu items are nutritionally assessed through the All Wales Menu Framework with which the Health Board is largely compliant and resources for local nutritional analysis have been allocated

36. In 2010, we found that dieticians were involved in menu planning at all hospitals but not all hospital menus were nutritionally assessed. At the Health Board, not all local recipes were nutritionally assessed and validated by dieticians largely due to a lack of dietetic resources. In 2014, we found that efforts to resolve the situation had not been successful. In 2011, the Welsh Government published the All Wales Nutrition and Catering Standards which specify the 12 minimum nutrients for analysis.

37. In 2015, the Health Board has been able to make resources available to recruit a part-time dietician for 12 months, from July 2015. The appointment will support the nutritional assessment of local menus and recipes. The post holder will also be responsible for completing an analysis of therapeutic menus, which is a key priority in the Health Board's 2015 catering and nutrition action plan.

38. The Health Board is largely compliant with the All Wales Menu Framework (AWMF), with only one non-compliant recipe from the local menu plan in use at the time of our fieldwork. All AWMF recipes are nutritionally assessed and the one non-compliant local recipe had been taken to the all-Wales menu group for inclusion in the AWMF. Health Board catering staff are actively involved with the all-Wales menu group in adapting and developing menus and recipes for the AWMF.

Written information for patients on what to expect in relation to food and catering services remains variable

39. The 2011 all-Wales Nutrition and Catering Standards make it clear that information should be provided to patients and their carers on what to expect in relation to meals and snacks while in hospital. In 2012, the Chief Medical Officer and Chief Nursing Officer for Wales issued a joint letter in relation to hospital catering and food 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**.

[8] Monthly catering patient experience surveys identify positive feedback on hotel service staff in those wards supported by a ward hostess.

40. In 2010, we found that the provision of information for patients about food options and mealtimes was inconsistent across the Health Board. Our follow-up work in 2014 found that the provision of menus to patients was variable and appeared to have declined since our work in 2010, with nursing and ward-based catering staff reading out menu options to patients in most areas. In 2014, the catering service was developing bedside information covering a range of information of about food availability, including menus. In April 2015, patient bedside menus were being consulted upon prior to their introduction. A patient bedside menu provides patients with a clear guide to the meals available and affords patients the opportunity to make their individual choices from the daily options.

41. Information and advice for patients coming into hospital, available on the Health Board's website, include a section about food, general catering provision and help with eating and drinking if needed. It is useful and informative, although not all patients will access this information before coming into hospital and it was not available in leaflet form on the wards where we carried out our observations. Ward staff, senior staff, and non-office members were not always familiar with the **Eating Well in Hospital** leaflet. Some catering information was on notice boards in some wards, but this varied from ward to ward.

42. A new patient manual for the Princess of Wales Hospital was being issued at the time of our fieldwork in 2015. It includes information on food, snacks, eating well and assistance with eating and drinking. However, the provision of patient information in relation to food and catering services remains inconsistent across the rest of hospital sites with no single format or version of patient information. There is an opportunity to develop patient information packs for other hospitals, as done for the Princess of Wales, as part of establishing the new hospital-based operational units.

An appropriate range of menu choices is available for most patients and mealtime experiences are generally good

43. In 2010, most hospitals provided an appropriate choice of meals and patients were generally satisfied with the food they received. However, not all patients got the help they needed at mealtimes and more could be done to embed protected mealtime principles on some wards. At the Health Board, protected mealtimes were in place although there were variations between wards in how protected mealtime principles were applied. In general, staff provided patients with appropriate support to eat and drink at mealtimes.

44. In 2014, our ward mealtime observations showed that compliance with various elements of protected mealtimes was not always consistent. However, we found that the use of white boards in many ward areas was helping to identify patient dietary needs while the Health Board was introducing ward-based nutritional care champions to support this aspect of patient care. Our findings from our 2015 audit are set out below.

The level of nursing support and supervision at meal times is generally good

45. The 2015 Trusted to Care report found significant improvements in hydration and feeding practice for older people. As part of our work, we observed the lunchtime meal service on four wards – one ward at each of the four district general hospitals (Princess of Wales, Neath Port Talbot, Singleton and Morriston). We found that the provision of support with eating for patients was generally good.

46. The Health Board has a range of mechanisms in place to identify those patients who need help with eating and drinking or for whom food and fluid intake should be recorded. These include symbols at the bedside, such as a knife and fork and the butterfly scheme for those patients with cognitive problems, and the red tray system and water jugs with red lids that act as a visual prompt for staff. We observed these different mechanisms in practice during our ward visits although at Morriston Hospital, red trays were not limited to those patients who needed help.

47. As discussed in paragraph 34, the Health Board has introduced ward hostesses in a number of wards and proposals to extend this cohort of staff are included in the integrated medium-term plan. Our ward visits in general found that these ward-based catering staff were knowledgeable about patients' nutritional needs and dietary preferences, and would help to cut up food and open packaging. They also encouraged patients to eat, tempting them with different meal options if they refused to eat a hot meal.

48. At the time of our visit, the Morriston AMAU ward hostess had recently received a Health Board award for support services, for her work supporting patients' nutritional needs and dietary preferences. Food courses were served separately which helped maintain temperature and made food more appetising and we noted good organisation of the mealtime service, with patients fully prepared to receive their meal, nurses available in patient areas to support those who needed help and a calm atmosphere conducive to eating.

49. Exhibit 2 sets out the differences we observed between mealtime practices across the four 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 2: Key actions observed as part of the lunchtime service

Observations of the lunchtime service	Morriston	Singleton	Neath Port Talbot	Princess of Wales
Ward	AMU	7	E	18
Patients helped to prepare for mealtimes, including using the toilet, washing hands and sitting up or getting out of bed	All	All	Some	Some
Bedside areas/tables tidied before meals served	All	All	All	Most
Bedside areas/tables cleared of clinical waste before the meal service	All	All	All	All
Staff providing food service wear protective clothing	All	All	All	Most
Temperatures of meals are recorded before service begins	All	All	All	All
Nursing staff accompany ward-based catering/hotel staff during the service	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[9]	All	All	NA[9]	NA[9]
Patients needing help receive it promptly	All	All	All	All
Nursing staff supervise and encourage patients with eating throughout mealtimes	All	All	Some	All

Source: Wales Audit Office observations of lunchtime services

50. The Health Board's 2014 Fundamentals of Care Audit operational survey found that in 93 per cent of clinical areas, patients were offered the chance to cleanse their hands before meals, up from 81 per cent in 2013. However, the Healthcare Inspectorate Wales inspection had identified that patients were not consistently offered the opportunity to wash their hands. A number of wards have purchased wet wipes to help facilitate this and during our visit to Morriston AMAU, these were available at every bedside.

[9] NA indicates that packaging was removed from all items before being served to patients.

51. The audit also found that nearly all (98 per cent) wards had systems in place to allow family or friends to assist with meal times. The Health Board promotes this and has introduced a flexible visiting policy this year, with visiting times now between 11 am and 8 pm. Nursing staff told us that they welcome and encourage family and friends to help patients at mealtimes. We observed patients receiving help with eating from relatives and friends on the wards that we visited.

Protected mealtimes are well embedded and flexible visiting enables relatives and friends to help support patients during mealtimes

52. There is a protected mealtime policy in place to assist clinical staff in the implementation of, and adherence to protected mealtimes. In 2014, we found that most staff worked to maintain protected mealtimes for patients, although there was some variation in practice. In 2015, we again observed the implementation of protected mealtimes on the four wards that we visited across the Health Board. Compliance with the key elements of the policy was good. Although, we note that there is no signage at ward entrances to explain the times and purpose of protected mealtimes.

53. At the time of our fieldwork, the Director of Nursing and Patient Experience was meeting senior nurses and ward sisters to clarify the interpretation of protected mealtimes in the context of the new flexible visiting policy. Senior nurses are required to provide leadership in this matter.

54. Some judgements are required regarding protecting privacy and dignity of patients needing assistance to eat or use bedpans/commodes, and for patients to have sufficient periods of rest within extended hours visiting. The flexible visiting information leaflet for patients and visitors clearly explains why it is necessary to limit patient visitor numbers to two at a time, so that the number of visitors does not affect other patients. Although the policy was relatively new at the time of our fieldwork, some ward staff were finding it challenging to manage visitor numbers.

55. The Community Health Council (CHC) reviewed patient and public perceptions on flexible visiting in October 2015. It found that 80 per cent of the 172 people interviewed rated the new arrangement as very good or excellent overall. Less than two per cent rated the arrangements negatively overall. The negative aspects that most people identified with included the impact on privacy and dignity for some patients. Many respondents reported more than two visitors per bed.

56. The principle of flexible visiting is an opportunity for relatives and friends to engage in the support of patients during mealtimes and this should not conflict with the principles of protected meal times, namely no routine clinical activity. The Health Board will need to consider the CHC findings and determine how any negative consequences might be mitigated.

The mealtime experience is generally good and an appropriate range of menu options is available for most patients, but there is some scope to extend meal choices

57. The Health Board's multi-disciplinary Menu Planning Group, which includes patient representation, has made improvements to inpatient menus in 2015. The work has seen the introduction of the single weekly inpatient menu with individual patient bedside ordering in operation in main hospital wards. Although individual patient meal ordering cards were not in use, patients were able to select their choices for the next meal following the previous service ie, after breakfast for lunch. On one ward visited, the weekly menu list was provided to help a patient with specific cultural dietary needs select suitable options in advance with her family.

58. The general patient menu includes 42 main courses and 12 desserts, as well as soups and sandwiches, taken from the all-Wales menu framework. A single health board protocol for the ordering of therapeutic diets and out-of-hours requests has also been developed to improve the patient service. The Health Board is also developing an in-house IT option for meal ordering whilst an NHS Wales catering IT system is awaited. Piloting the electronic meal ordering system on AMAU at Morriston Hospital was being planned at the time of our fieldwork.

59. A multidisciplinary review, led by speech and language therapists, has also been carried out in 2015 to assess the quality of textured modified meals, which some vulnerable patients require. Working with patients and procurement, the Health Board has chosen a new supplier and reports improved quality and selection of dishes.

60. There appears to be an appropriate range of menus to provide most patients with choice, although menus are currently based on historical types of food served and there remains scope to further improve patient choice. This is especially so for older patients who may prefer more finger foods, long-stay patients where a weekly menu may not offer sufficient choice and in the few service areas where bulk orders may still be made by nurses. The Health Board recognises this and is considering, for example, more seasonal menus.

Patient catering costs are relatively static, cost per patient meal compares well to other NHS bodies and food waste is below the national target. However, non-patient catering services are running at a loss

61. In 2010, financial information on catering services was typically poor and where it existed, it showed significant variations in costs within and between NHS organisations. Few hospitals generated enough income to recover all the costs of providing non-patient catering services and few NHS bodies had an agreed policy on subsidy. The Auditor General recommended that a clear model for costing patient and non-patient catering services should be developed. NHS bodies in Wales jointly agreed in 2012 to implement a new costed model for catering services as part of the Estates and Facilities Performance Management System (EFPMS) supported by revised data definitions. Little progress had been made in computerising hospital catering systems and most of the current catering information management systems relied on manual paper processes.

62. At the same time, NHS bodies were adopting measures to control the costs of catering services. There was scope, however, to make more use of standard costed recipes, agreeing food and beverage allowances for patients, standardising local catering contracts and reducing levels of food waste, which 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.

Although there have been small fluctuations in the cost of patient catering services, the cost per patient meal compares favourably with other NHS bodies

63. In 2010, the Health Board's food production processes varied, and cost control mechanisms differed which meant that cost comparisons were difficult to make. In 2014, we found that the Health Board had made progress towards a single approach to food production and ward catering. Although arrangements were not fully standardised across all sites, a consultation was underway to consider the introduction of the cook-freeze model to the Princess of Wales Hospital. At the time of our follow-up work in 2015, the Heath Board had yet to take any decision on the roll out of the cook-freeze model. There was a clearer understanding of the cost of food production and delivery, and the Health Board was making full use of the EFPMS data to monitor and benchmark services. In addition, prices for non-patient catering services were harmonised and a profit and loss account generated for non-patient meal services at each hospital.

64. The Health Board's EFPMS data submissions show fluctuations in the cost of patient catering services, with costs reducing by six per cent from £6.59 million in 2011-12 to

£6.13 million in 2103-14, but increasing by four per cent the following year (Exhibit 3). Across Wales, the cost of patient catering services reduced by five per cent over the three years. Meanwhile at the Health Board, the number of patient meals requested reduced by seven per cent (or 168,000 meals) over the same period compared with a four per cent reduction across Wales.

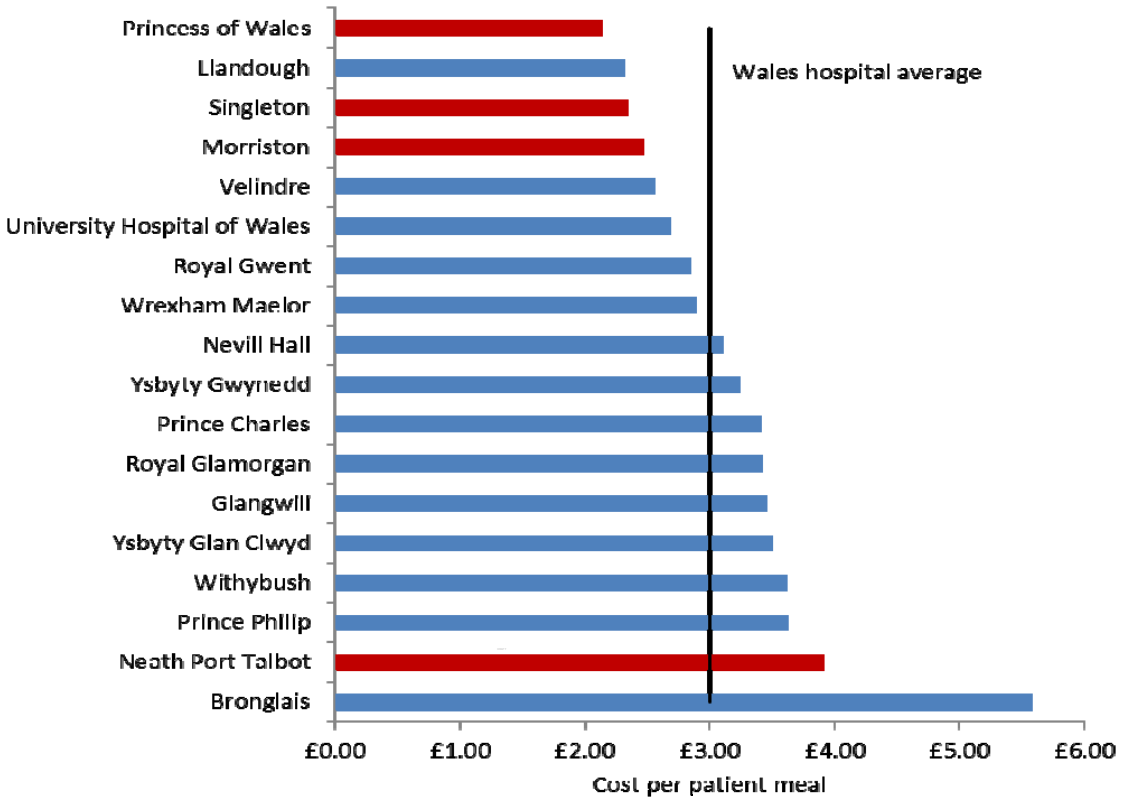
Exhibit 3: Patient catering service costs are reducing

Year	Cost of catering services (£ million)	
	Abertawe Bro Morgannwg	Wales
2011-12	6.59	38.95
2012-13	6.13	37.26
2013-14	6.44	36.97

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

65. The Health Board's 2013-14 EFPMS data show that the cost per patient meal across all its hospitals was £2.76, having increased from £2.64 in 2011-12. Across all Welsh hospitals, including community hospitals, the cost per patient meal was £3.29 in 2013-14 with costs ranging from £2.56 at Velindre to £6.93 at Powys. Exhibit 4 shows that costs per patient meal at three of the Health Board's four district general hospitals were amongst the lowest in Wales. At Neath Port Talbot Hospital, the cost per patient meal was above the hospital average (£3.00) and the second highest in Wales.

Exhibit 4: Costs per patient meal are amongst the lowest in Wales with the exception of Neath Port Talbot which is the second highest



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

66. In 2010, the Health Board's food production arrangements relied heavily on manual paper systems and simple spreadsheet software rather than on an IT solution, and the Health Board still relies on these paper-based systems. In his national report in 2011, the Auditor General recommended that NHS bodies should introduce computerised catering information systems. The NHS Wales Informatics Service and NHS Shared Services Partnership have developed an outline business case to procure a national catering IT solution but progress has been slow to date. This audit found that NHS bodies, including the Health Board, had commented on the outline business case and it is still awaiting a decision. As an interim measure, the Health Board was developing an in-house bespoke IT option for patient meal ordering. It planned to pilot the system on the Acute Medical Admissions Unit at Morriston Hospital at the time of our fieldwork.

67. 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 provisions commodities for the dishes on the menu framework. Catering managers have been actively involved (see paragraph 38) with the AWMF group and with the all-Wales Nutrition Co-ordinators Group, helping to ensure that nutrition work in the Health Board informs, and is informed by, national developments.

Levels of food waste have reduced and are now below the national target

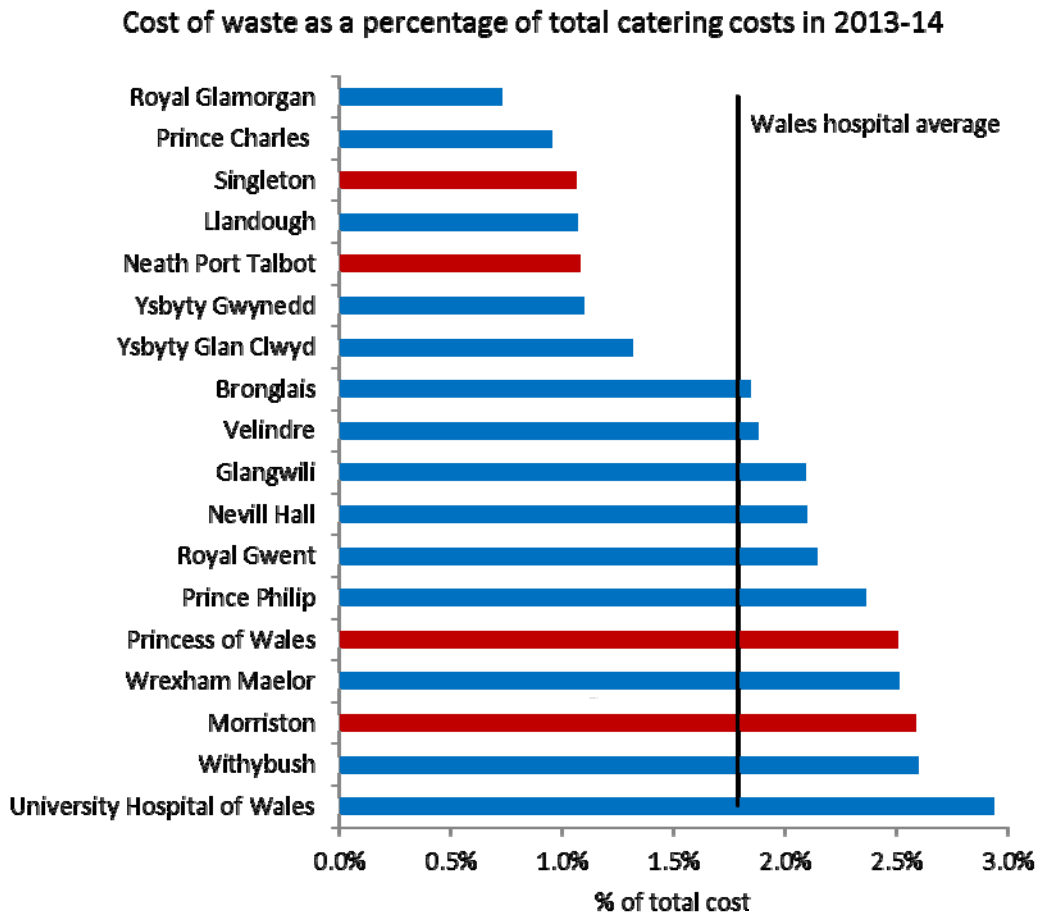
68. In 2010, the Health Board had did not have consistent systems in place to monitor un-served food waste and plate waste was not recorded. We evaluated un-served food waste at an average of 13 per cent across the Health Board, which was higher than the figures recorded by the Health Board at the time. In 2014, we reported that the catering service was building on its existing activities to measure untouched food waste and understand the reasons for it.

69. Current EFPMS data suggests that food wastage is below five per cent across all Health Board sites, which is well below the national target of 10 per cent. Our latest audit work found that un-served food and other food waste is returned to the main kitchens on trolleys, where it is recorded. Un-served food waste is reported through the catering operational structure, and catering managers liaise with wards where waste levels appear to be high.

70. The Health Board currently macerates all food waste although this will be illegal from 2017. It is considering what options will be available, and generally estimates that the cost of managing food waste will be approximately £20,000 per site. The Health Board is working with the Waste Resources Action Programme (WRAP) to help address this issue. The latter has an objective to send 30 per cent of food waste to anaerobic digesters. There is a lot of liquid waste, eg, soup and custards. This has a high volume with a high potential cost for disposal. The Health Board is working with menu planners to consider how to reduce waste, for example, using cream instead of custard.

71. Analysis of the 2013-14 EFPMS data shows that the cost of un-served meals was £151,000 for the Health Board's four district general hospitals. This equates to three per cent of total catering costs, which is above the hospital average in Wales (1.8 per cent) (Exhibit 5).

Exhibit 5: The cost of waste as a percentage of total catering costs is amongst the lowest and highest in Wales across the Health Board's four district general hospitals



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

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

72. In 2010, the Health Board did not have a subsidy policy for non-patient catering services but there was an expectation that services should break even. Its restaurant services were running at a loss of £711,000. 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. By the time of our follow-up audit in 2014, and based on the Health Board's own methodology for deriving the figures, the gap between income and expenditure for non-patient catering services had reduced by 20 per cent from £745,000 in 2010-11 to £595,000 in 2012-13. The catering service intended to carry out a more detailed analysis of the apportionment of cost for non-patient catering services. At that time, it reported that vending income varied significantly across sites,

ranging from around £9,000 at Neath Port Talbot Hospital to £137,000 at Morriston Hospital. The catering service identified that there was more to do with regard to vending in order to maximise income potential, and planned to review the vending policy and the number of vendors on main sites. This work was ongoing at the time of our fieldwork in 2015.

73. In its action plan following our work in 2014, the Health Board set the objective to establish pricing policies and income generation targets to ensure that non-patient catering services at least break even; or, if they do not, it should be as the result of a deliberate subsidy policy. A subsidy policy has been approved and will be reviewed annually, although we did not see the policy during our review in 2015.

74. The income generated by the Health Board's non-patient catering services is insufficient to recover operating costs and the gap is increasing, as income reduces (Exhibit 6). In 2013-14, the total income generated was enough to recover 73 per cent of the £3.07 million costs, which equates to a subsidy of £840,000. Across Wales, no NHS organisation recovered the cost of non-patient catering services in 2013-14 but the Health Board's performance is comparatively worse than other health boards (Exhibit 7).

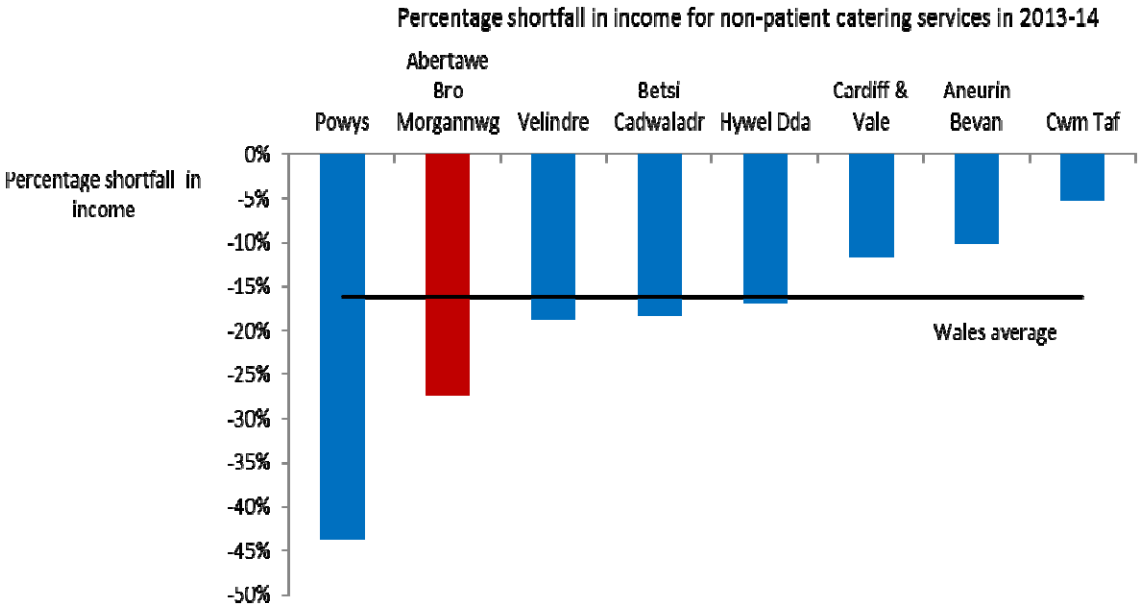
Exhibit 6: The gap between income and costs of the Health Board's non-patient catering service is increasing

Year	Cost of non-patient catering services	Income achieved	Percentage gap in costs and income
	(£)		%
2011-12	2,907,187	2,350,588	-19
2012-13	3,090,912	2,344,195	-24
2013-14	3,071,493	2,231,360	-27

[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 7: NHS organisations do not generate enough income to recover the cost of non-patient catering services; there is a 27 per cent shortfall in Health Board income



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

75. A number of new commercial vendors accompanied the opening of the new outpatients department at Morriston hospital in July 2015. These outlets provide choice and convenience for patients, visitors and staff, and generate rental income for the Health Board. However, the full impact on the profitability and level of subsidy required for the Health Board's non-patient catering service had not yet been assessed at the time of our fieldwork. Review of the financial impact of the 'competition' from private outlets is recognised as a priority action for 2015-16. This needs to be accounted for in the review of subsidy policy and income generation targets in 2016.

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

76. 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, and in several NHS bodies arrangements needed to be harmonised following NHS re-organisation in 2009. A more comprehensive and co-ordinated approach was needed to seek the views of patients and families to inform plans and developments. NHS boards received limited information on the delivery and performance of catering services and issues relating to patient nutrition. There was no collation of information from nutritional screening to help 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.

77. In the Health Board in 2010, there was clear professional leadership and executive accountability in relation to patient nutrition and catering. We identified that while there was no single operational planning and business framework for the catering service, several options were under consideration. In 2014, we found that the Health Board had made progress towards a single approach to food production and had improved the ward-catering model in some areas, although arrangements were not fully standardised across all sites.

78. In 2010, we found that the Board gave limited consideration to the performance of nutrition and catering services. In 2014, we found that the Quality and Safety Committee was considering catering and nutrition issues, although catering and nutrition issues still did not have a high profile at Board meetings. There was a lack of detail and robustness in the information received, as well as a lack of agreement about the extent of the Board's role in relation to the monitoring of performance. Findings from our 2015 work are set out below.

The Nutrition and Catering Steering Committee ensures national policies and standards are implemented but organisational changes may affect current arrangements and executive responsibility for catering is less clear than five years ago

79. The Director of Nursing and Patient Experience is the nominated Board-level director with lead responsibility for nutrition. The Head of Support Services, which includes catering services, reports to, and receives support from, the Director of Strategy. Support services are not, however, specifically identified in the latter's job description as had been the case for the predecessor Director of Planning post. Six unit structures will fully replace the directorate/locality structure in March 2016. Decisions about the location and reporting lines for support services within the structures and more clarity of executive responsibility for these services will be needed.

80. The Nutrition and Catering Steering Committee is a well-established senior, multidisciplinary, Health Board-wide 'team', with responsibility for co-ordinating

nutritional care and catering services, developing strategy and monitoring performance against key standards and priorities for catering and nutrition. The Director of Nursing and Patient Experience chairs the group, which includes inter-directorate, locality and patient representation. Although, membership of this Committee and its sub-groups will need to be reviewed in the light of revised organisational structures. There is also opportunity to review how this Committee and other groups focussing on issues relevant to the care of older people, such as falls, tissue viability and dementia, inter-relate, and collectively provide assurance on standards of care for older people.

81. There are four sub-groups of the Nutrition and Catering Steering Committee, ie, the Nutrition and Food Service Group, the Clinical Nutrition Group, the Paediatric Nutrition Group and the Community Nutrition Group . In 2014, we recommended that arrangements for these groups be reviewed and clarified to avoid any confusion around responsibilities. The groups' terms of reference were subsequently reviewed and ratified by the Nutrition and Catering Steering Committee.

82. There is an agreed annual work plan for the four sub-groups to support the actions in the annual nutrition and catering action plan. The 2015 action plan priorities included:

- development of further standard recipes and a nutritional analysis of inpatient menus;
- introduction of a single approach to food production;
- reviewing and managing the cost implications of all-Wales food contracts and the financial impact of competition;
- developing food service standards further to promote the best possible eating experience for patients;
- developing therapeutic menus further;
- addressing the need for nutritional value of menus and food standards for children;
- work to ensure that the maximum period between the last meal at night and breakfast the following morning does not exceed 14 hours; and
- meeting food safety legislation.

Mechanisms are in place to capture and act upon patient feedback about catering and nutrition

83. The Health Board has a good range of methods to gather patient feedback. There is routine thematic analysis and reporting of patient feedback gathered through the 'friends and family test[10]' and the all-Wales Patient Experience Framework. The Health Board has invested in SNAP 11 survey software, which together with internet access across the Health Board, provides a good platform for gathering and analysing large numbers of patient responses. For example, 4,861 patients completed the friends and family test in September/October 2015, with 35 per cent doing so electronically. In

[10] The 'friends and family test' asks patients and carers whether they would recommend the service to friends and family, and captures comments on aspects of care or service.

addition, email alerts have been set up in SNAP 11 online to trigger an immediate local response in the clinical area if particular words or phrases are used. ‘Nutrition’ is a trigger word.

84. The Fundamentals of Care Audit, carried out annually, asks patients for their views on three indicators relating to meal provision and support. For the 2014 audit, 1,475 patients were surveyed. There was an overall compliance of 89 per cent with Standard 9, which covers eating, and drinking, which was a slight improvement from the 2013 audit. Each ward/unit has access to their specific findings, to address any identified issues.

85. In addition, the Health Board also undertakes other patient experience work including:

- monthly catering patient questionaries at each of the four main hospital sites to monitor patient experience of catering and hotel services and to develop food service expectations;
- multi-disciplinary meal monitoring audits of the whole food service process, including food temperature, quality of food on tasting and presentation;
- spot-checks by senior nurses to check compliance with nutrition and hydration standards; and
- dashboard monitoring against the standards of care for older people in respect of whether patients feel they have a choice in what they eat and drink, and receive support if needed.

86. There is evidence of the Health Board seeking to continually improve the capture of patient feedback. For example, consideration is being given to extending the meal monitoring audits to include monitoring of support provided to patients, and working with the patient experience team to increase the number of patient responses captured through the older people’s dashboard.

87. The results of fundamentals of care audit, senior nurse spot checks and patient experience survey findings are all reported at ward level to enable clinical areas to take corrective actions and learn lessons, whilst enabling comparison across areas and identification of any hotspots. While there are comparatively few specific complaints or negative feedback about catering and patient nutrition, there is evidence that these are identified and acted upon. For example, the patient feedback report presented to the Quality and Safety Committee in December 2015 included a food related issue together with a summary of the action taken to address it.

Corporate arrangements for monitoring the nutritional care pathway are well established but information on waste, cost and food quality is less visible

88. The four Nutrition and Catering Groups (Nutrition and Food Service Group, Clinical Nutrition Group, Paediatric Nutrition Group and the Community Nutrition Group) report directly to the management-led Nutrition and Catering Steering Committee. This committee monitors performance against key standards and priorities, and the progress made in delivering the Health Board's nutrition and catering action plan.

89. The Nutrition and Catering Steering Committee reports to the Board's Quality and Safety Committee, which provides scrutiny on behalf of the Board and in turn provides assurance to the Board, with a key issues paper prepared for the Board following every Quality and Safety Committee meeting. In April 2015, the Nutrition and Catering Steering Committee presented its annual progress report and update on patient nutrition and catering to the Quality and Safety Committee. The paper set out the key improvements achieved during 2014, continuing risks such as staff training, and the key priorities for action during 2015. Updates from the Steering Committee are included in the Quality and Safety Committee work plan, to maintain oversight of improvements and risks.

90. In addition to the reports from the Nutrition and Catering Steering Committee, the Quality and Safety Committee regularly receives a variety of relevant reports to assist it in its scrutiny role with regard to nutrition and catering. These include:

- patient feedback reporting on the all-Wales Patient Experience Framework surveys and 'friends and family' tests, thematically analysed;
- the older people's dashboard;
- Community Health Council (CHC) reporting on their monitoring programme including hospital food visits and patient experience ward monitoring;
- Healthcare Inspectorate Wales Inspection reports;
- the Fundamentals of Care Audit; and
- assurance reports on key arrangements, such as revision to integrated nursing assessments and revised nursing documentation.

91. Independent members and executives carry out regular 'walkabouts' following Quality and Safety Committee meetings using the 15 step challenge[11]. The approach supports the Committee in its scrutiny role. It enables members to triangulate information received by the Committee with their own observations. We were told about a recent 'walkabout' visit to the Morriston Hospital Emergency Department which gave members confidence that staff are aware of the importance of providing appropriate nutrition and hydration, and take action to make it happen..

[11] Developed by the NHS Institute for Innovation and Improvement, the 15 step challenge helps assess a ward from a patient perspective, gain an understanding of how patients feel about the care provided and how to improve confidence in the service.

92. Monitoring and reporting on patient nutrition and catering are collectively comprehensive, particularly in the level of detail available to the Nutrition and Catering Steering Committee. However, the various reports are not routinely combined although this could give the Quality & Safety Committee a more consolidated view of compliance with the whole nutritional pathway. Information on food waste, costs of catering services and food quality is also less visible at a corporate level.
This information is instead monitored and reported at an operational level, as are the results of the meal monitoring audits and patient feedback on food services.
However, the Health Board, as in other NHS bodies, has yet to collate regularly information from nutritional screening to understand the number of patients identified with nutritional problems on admission.

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 in July 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 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, Professional Standards and Practice, 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 the Acute Medical Admissions Unit, Morriston Hospital; Ward 7, Singleton Hospital; Ward E, Neath Port Talbot Hospital; and Ward 18, Princess of Wales Hospital.

Case note review

We undertook a case note review on each ward of the lunchtime service to assess whether:

- nutritional screening for patients admitted is undertaken using a validated tool;
- information on weight, recent unintentional weight loss, current appetite, 'normal' dietary intake, special dietary requirements, ability to eat independently, difficulties eating or drinking and problems with oral health and hygiene, including dentition, had been recorded;
- care plans were in place for those patients identified with, or at risk of nutritional problems and whether 'at risk' patients were referred for a dietetic assessment; and
- ward managers selected the five sets of case notes reviewed on each ward.

Appendix 2

National and local recommendations

Table 1 sets out 14 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[12] is also set out in Tables 1, 2 and 3.

Table 1 – 2010 local recommendations

Recommendation		Status at November 2015
Strategic planning and management arrangements		
R1	Develop a range of indicators for monitoring and benchmarking the performance of the catering services and potential service risks, which are reported to the Board at least annually, such as patient satisfaction, environmental health inspection issues, food waste, financial performance and the time taken to implement new initiatives. **Note on progress: 2015 findings indicate that performance of the catering services are monitored at an operational level but the indicators are not reported at the Quality and Safety Committee or the Board.**	O
R2	Progress plans for standardising catering practices across hospitals, including: • agreeing the production and delivery models; • reviewing the recipes used across each hospital; • nutritionally assessing all recipes and menus; • standardising ward practices at the Princess of Wales and Morriston hospitals in relation to recording food temperatures prior to mealtimes and if necessary recording end of service food temperatures if there are complaints of cold meals; • undertaking periodic supervision of meal services at the Princess of Wales and Morriston hospitals to assess the quality of the meal service and to improve efficiency if necessary; • establishing a schedule of taste testing sessions at Princess of Wales, Neath Port Talbot and Morriston hospitals which mirror that at Singleton Hospital; • involving nursing staff and patients in taste testing sessions; and • engaging nursing staff more fully in meal services at Neath Port Talbot Hospital like those at Singleton Hospital.	O

[12] (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 insufficient or no progress has been made.

Recommendation		Status at November 2015
Strategic planning and management arrangements		
R2	**Note on progress: In 2015 roll out of the cook-freeze model at the Princess of Wales to provide a single approach to food production was not completed but was being progressed as a priority action for 2015. All other actions relating to this recommendation had been completed.**	O
R3	Expand the remit of the Nutrition Steering Group, or its subgroups, to include oversight of the emerging themes and issues from patient satisfaction surveys, the Fundamentals of Care audit and Point Prevalence Reviews.	A
R4	Find a mechanism to enable ward staff to contribute to the Food and Nutrition Development Group.	A
Procurement production and cost control		
R5	Seek to standardise local catering contracts for the same or similar products ie, one contract for all hospital sites.	A
R6	Review pricing structures in the staff/visitor restaurants and in doing so make a clear decision about the level of costs to be recovered from non-patient catering services.	A
R7	Work with catering and nursing staff to improve the meal ordering process for patients at the Princess of Wales and Morriston hospitals.	A
R8	Improve arrangements for monitoring un-served food waste, particularly at the Princess of Wales and Morriston hospitals and monitor reasons for waste.	A
Delivery of food to the ward		
R9	Ensure all nursing staff responsible for serving patients receive training and guidance on the following: • portion control; • basic food safety and hygiene; • appropriate protective clothing, including standardising the apron colour used during meal services; and • the need to comply with procedures for recording food temperatures and what to do if temperatures do not meet the required standards. **Note on progress: 2015 audit findings indicate that continuing action is needed to improve compliance with e learning and provide regular training on patient nutrition and food safety.**	O

Recommendation		Status at November 2015
Meeting patients' nutritional needs and supporting recovery		
R10	Improve compliance with nutritional screening and care planning by: • recording comprehensive information about patients' nutritional health on the Unified Assessment/Nursing Assessment form, including information on oral health; • exploring the reasons for non-compliance with nursing staff; • changing the format of the WAASP monitoring tool to clearly show the score of each element when re-screening patients; • re-enforcing the threshold at which patients should be referred for dietetic assessment; and • reminding nursing staff about the importance of the all-Wales food and fluid charts and how these should be completed.	A
R11	Ensure all nursing staff have easy access to information about good nutritional care, including the different types of therapeutic diets.	O
R12	Compare the extent to which nurses and dieticians agree (inter-rater reliability) when scoring nutritional risk using the WAASP tool; if testing shows poor concordance then provide refresher training on the use of the WAASP tool.	O[13]
Gathering views from patients and sharing information		
R13	Improve the patient experience by: • continuing to promote the protected mealtime policy amongst wider groups of staff; • ensuring patients are treated with dignity by serving meals on plates where appropriate; • working with the patient liaison representatives and patients to assess the quality of catering services; and • taking account of, and addressing, the less favourable views expressed by patients responding to our survey.	A

[13] The Health Board uses an alternative tool to WAASP. We did not identify any concerns about the accuracy of scoring between dieticians and nurses at the time of our fieldwork.

Recommendation		Status at November 2015
Gathering views from patients and sharing information		
R14	Provide explicit information about catering and nutrition services for patients that sets out the following: • the arrangements for ordering meals at the different hospitals, including the use of menus; • the availability of snacks and how these can be ordered; • why patients are discouraged from bringing their own food into hospitals; and • why some food items are not routinely available, like skimmed milk or toast. **Note on progress: there is patient information on the Health Board's website for patients coming into hospitals and a new patient information pack has been developed for the Princess of Wales Hospital in 2015. Patient information at other hospitals remains variable.**	O

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. **Note on progress: 2015 work found that all patients were screened on admission and an integrated nursing assessment approach with supporting documentation has been introduced. But the consistency of care planning, rescreening and documentation requires improvement.**	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. **Note on progress: 2015 work found that the pathway compliance was audited but the opportunity to provide more consolidated reporting to the Quality and Safety Committee to better support scrutiny and assurance should be considered.**	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. **Note on progress: 2015 findings indicate that compliance audit is in place and results are shared with wards, but training is not in place.**	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 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.	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 of daily food and beverage allowances for patients.	O
R5c	We recommend that NHS bodies review their current cost control mechanisms to ensure that they are making full use of standardised local catering contracts for the same or similar products across all their hospital sites.	A
R6a	We recommend that local and national targets are set for food wastage; as a guide NHS organisations should aim to ensure that wastage from un-served meals does not exceed 10 per cent.	A
R6b	We recommend that NHS bodies routinely monitor food wastage according to clear guidelines of what constitutes an un-served meal, and that this information is used to generate meaningful comparisons locally and nationally.	A
R6c	We recommend that monitoring of food waste should include identification of the reasons for the wastage that is observed, and this information should be used to identify priorities for improvements in systems and processes that are causing the waste.	A
R6d	We recommend that NHS bodies emphasise to their staff that controlling food waste is a collective responsibility and that catering and ward-based staff should work together to tackle the problem.	A
R7a	We recommend that set pricing policies and income generation targets aim to ensure that non-patient catering services at least break even, or, if they do not, it is the result of a deliberate subsidy policy that is based on a detailed analysis of costs.	O
R7b	We recommend that NHS bodies regularly monitor income and expenditure of non-patient catering services to ensure that the financial performance of these services is as expected and that unacceptable deficits are not being incurred.	O

Recommendation		Status at July 2015
Effective service planning and monitoring		
R8b	We recommend that NHS bodies ensure that they have up-to-date plans and procedures that set out the local arrangements for implementing national policy requirements and to ensure that as far as possible, catering and nutritional services are standardised, particularly where NHS re-organisation has brought together a number of different service models under one organisation. **Note on progress: In 2015 the roll out of the cook-freeze model at the Princess of Wales to provide a single approach to food production was not complete.** **While we found well-defined and established arrangements for the co-ordinated planning and monitoring of services via the Nutrition and Catering Steering Committee chaired by the Director of Nursing and Patient Experience, the potential impact of organisational restructure on steering committee membership will need to be assessed.**	O
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. **Note on progress: greater clarity on executive accountability for support services (including catering) and the potential impact of the current organisational restructure on support services is needed.**	O
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. **Note on progress: the 2015 audit found a more comprehensive approach to reporting with most information on nutrition reported to the Quality and Safety Committee with the exception of finance and waste which is reviewed by the facilities management team and not integrated with nutrition. There is also opportunity to consider more consolidated reporting to provide a collective picture of performance.**	O

Recommendation		Status at July 2015
Effective service planning and monitoring		
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 considered patients' views when developing catering and nutrition services.	A
R11c	We recommend that NHS bodies establish mechanisms to involve patients' in activities that assess the quality of catering and nutrition services.	A

Table 3 sets out the four local recommendations set out in our report summarising the findings from follow-up audit work on the Health Board's hospital catering and patient nutrition services in 2014.

Table 3 – 2014 local recommendations

	Recommendation	Status at July 2015
R1	**There is still scope to improve the framework to develop, monitor, and report catering and nutrition issues. The Health Board should:** • develop appropriate indicators to monitor the hydration, mobility and feeding of all older people; • review, clarify and streamline the arrangements for groups and committees associated with catering and nutrition in the Health Board to minimise duplication and ensure effective communication; • ensure that catering and nutrition are key elements in the Health Board's new arrangements for patient, carer and service user engagement. • further develop the format of the Annual Nutrition Report, particularly in light of the recommendations in Trusted to Care; • review the information received by the Board[14] in relation to catering and nutrition, and it's performance management role for those areas; • revise the reporting of ward care metrics to always include actual patient numbers.	A A[15] A A A O
R2	**Some aspects of food provision need standardisation and evaluation. The Health Board should:** • ensure, as a matter of urgency, that the nutritional assessment of local recipes and menus is carried out, and that the funding used is not diverted from any important aspects of patient nutrition; • ensure that there is full compliance with standards for measuring food temperatures on wards; • review the impact of snacks and cooked breakfasts on individual patient nutrition, and on food wastage; and • review the financial impact of competition from private food outlets to ensure that the Health Board is obtaining the best value in relation to the income from its own services.	A A A O

[14] In 2015, we note that information is provided to the Quality and safety Committee for scrutiny and the Committee in turn provides assurance to Board
[15] Changes to organisational structures will require reassessment in 2016

Recommendation		Status at July 2015
R3	**Compliance with the e-learning package introduced in 2011 to support the nutritional evaluation of patients remains poor, and the rollout of food safety training is proving challenging. The Health Board should:** • progress the uptake of e-learning on patient nutrition as a matter of priority; and • reinforce the need for ward staff, and other staff, to attend food safety training.	O O
R4	**Compliance with nutritional assessment and protected mealtimes needs continual reinforcement and patient information across the Health Board regarding food needs to be improved. The Health Board should:** • review patient nutritional assessment procedures in light of the findings in this report; • reinforce protected mealtime requirements on all wards in light of the findings in this report; • improve the provision of information to patients across the Health Board regarding food and nutrition; and • work together with the Abertawe Bro Morgannwg Community Health Council and its Food and Nutrition Sub-Committee, to address the range of concerns raised through its work, and highlighted in this report.	A A O A

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