Archwilydd Cyffredinol Cymru
Auditor General for Wales

WALES AUDIT OFFICE
SWYDDFA ARCHWILIO CYMRU

Hospital Catering and Patient Nutrition Follow-up Review

Cardiff and Vale University Health Board

Audit year: 2015

Issued: October 2015

Document reference: 436A2015

Status of report

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

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

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

Contents

Cardiff and Vale University Health Board has made good progress in addressing recommendations to improve catering and nutrition services. More work is needed to strengthen some aspects of the nutritional screening process, to engage all nursing staff in patient mealtimes and to reduce the gap between the cost of non-patient catering services and the income generated.

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.

---

[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, which was launched at the end of January 2013. The framework consists of a database of an agreed set of menu items, a standardised set of recipes and cooking methods, nutritional analysis of each menu item to ensure these meet the nutrition and catering standards, and a range of snacks that are compliant with 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 Cardiff and Vale 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 good progress in addressing recommendations to improve catering and nutrition services. More work is needed to strengthen some aspects of the nutritional screening process, to engage all nursing staff in patient mealtimes, and to reduce the gap between the cost of non-patient catering services and the income generated. We reached this conclusion because:

- Arrangements for meeting patients' dietary and nutritional needs continue to improve but screening and documentation processes need to be strengthened:
  - although patients are nutritionally screened, not all patients are weighed, care plans are not always in place or followed, and gaps in screening information risks diminishing the quality of the process;
  - compliance with the nutritional care pathway is routinely assessed and reported, both locally and corporately, with action taken to address deficits in the screening process;
  - current arrangements ensure patients have access to food and beverages 24 hours a day with compliance regularly monitored;

[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.

  - menu items are nutritionally assessed through the all Wales menu framework with which the Health Board is compliant; and
  - written information for patients on what to expect in hospital is limited.
- Scope remains to improve mealtime experiences for some patients:
  - patients are generally positive about food services but there is not enough choice for some patients;
  - nursing support and supervision at mealtimes is limited on some wards; and
  - protected mealtime principles are more widely embedded than previously.
- The cost of patient catering services are better controlled but the income from non-patient catering services is still insufficient:
  - the cost of patient catering services is reducing and cost per patient meal compares favourably with other NHS bodies;
  - there are clear guidelines about what constitutes un-served meals and plate waste, with un-served wastage below the national target; and
  - non-patient catering services still run at a loss but the gap between income and cost is reducing.
- Arrangements for planning, monitoring and reporting on hospital catering and nutrition services are largely robust:
  - there are well-established arrangements through the Nutrition and Catering Steering Group to ensure national policies and standards are implemented;
  - corporate arrangements for monitoring the nutritional care pathway and food quality are well established but information on waste and costs is less visible; and
  - there are effective mechanisms in place to capture and act upon patient feedback about catering and nutrition.

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

Recommendations

10. The Health Board has fully achieved 38 of the 47 recommendations previously set out in our national and local reports. The Health Board needs to maintain focus on implementing the remaining recommendations where progress is reported to be on track but is not yet complete, or where we consider insufficient or no progress has been made. These recommendations are set out in Exhibit 1. A full list of the national and local recommendations, along with the status of each recommendation, is set out in Appendix 2.

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

Ensuring patients' nutritional needs are met	
R1b	We recommend that NHS bodies use the results presented in our local audit reports as a basis for ensuring that they are effectively implementing the all-Wales Nutritional Care Pathway. In particular, ensure that nutritional screening effectively identifies all patients who have nutritional problems, or are at risk of developing them, and that appropriate care plans and monitoring activities are instigated (national).
R9	Through the fundamentals of care forum monitor the effectiveness of the red tray system approach, its development and the emerging traffic light systems (local 2010).
R11	Improve the nutritional assessment tool to include an assessment of oral health and the ability to communicate (local 2010).
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 (national).
R3b	We recommend that NHS bodies continue to roll out the protected mealtime policy to as wide a range of wards as possible, communicating its importance to all the relevant staff groups working in the hospital, and regularly reviewing compliance with the policy (national).
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 (national).
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 (national).
R2	The Restaurant Non-Patient Subsidy Group should reinforce its strong focus on key performance indicators to achieve the target of zero subsidy for non-patient catering services (local 2013).
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 (national).

Detailed report

Arrangements for meeting patients' dietary and nutritional needs continue to improve but screening and documentation processes need to be strengthened

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

12. At that time, nutritional screening was embedded at the Health Board and nutritional care plans were in place for patients who needed them, with food and fluid intake monitored appropriately. However, there was scope to improve the nutritional assessment process by including an assessment of oral health and the ability to communicate. These factors were not part of nutritional screening at the Health Board and were subject to separate risk assessments. Follow-up audit work in 2013 found neither factors had been incorporated within the nutritional screening process.

Although patients are nutritionally screened, not all patients are weighed, care plans are not always in place or followed, and gaps in screening information risks diminishing the quality of the process

13. As part of our 2015 work, we reviewed a set of case notes on each of the four wards that we visited as part of the audit; 19 case notes in total. We assessed whether nursing staff nutritionally screened patients on admission, repeated it at least weekly, and the quality of the nutritional screening process. We found that nursing staff routinely screened and rescreened patients using the WAASP nutritional screening tool[6] but not all patients were weighed within 24 hours of admission and the reason for not doing so was not recorded. Nor were self-reported weights recorded.

14. The All Wales Nutrition and Catering Standards make it clear that oral health and communication are part of nutritional care but ward staff told us that it was not usual practice to assess oral health, unless problems were evident. Our review found information on oral health recorded in five out of 19 case notes, while 14 out of 19 case notes recorded communication difficulties. Findings from the 2014 Fundamentals of Care audit, which was completed at the Health Board between October and November 2014, also found poor compliance with the assessment of oral health with one in three patients having a record of an assessment.

[6] The Weight Appetite Ability to Eat – Stress Fractures and Pressure Sores (WAASP) – nutritional screening tool developed and validated by the former Cardiff and Vale NHS Trust. The WAASP tool does not capture information on height and hence the body mass index (BMI) is not recorded but the BMI is one element of the Waterlow risk assessment framework.

15. The Health Board's 'Inpatient Nutrition and Catering Policy' indicates that as well as nutritional screening, an assessment of patient's dietary needs should form part of the nutrition care plan, such as a patient's ability to communicate their food and fluid preferences, help needed to eat, or special therapeutic or cultural dietary need. There were gaps in this information, as well as information on appetite and usual dietary intake, factors that we would expect to see as part of the admission and screening process. This may be due in part to a lack of prompts for a more detailed description of the problem and the help needed.

16. 'Ability to eat' is one of the categories within the WAASP screening tool and this category is subdivided further. One of these subdivisions is the 'ability to eat and drink independently' or 'requires prompting, encouragement or assistance'. There is no clear indication, however, whether assistance means help with eating, sitting up in bed, getting out of bed, etc.

17. The 'ability to eat' category also covers difficulties with swallowing. Ten out of 19 case notes indicated that patients had, or might have, swallowing difficulties but no indication of whether referrals for swallowing assessments had been made and carried out. We looked for, and found evidence in, the medical notes that referrals for, and assessments of, swallowing had been made for these 10 patients.

18. Fifteen out of 19 case notes did not record patients' current therapeutic, lifestyle or cultural requirements in relation to food and fluids while 16 out of 19 case notes did not record a patient's usual dietary intake. Instead, there seems to be a reliance on the nutrition and hydration bed plans to capture this information, along with dietary preferences and the need for modified textured meals.

19. Nursing staff used generic care plans that varied in style and format across the hospital wards that we visited. Nutritional care plans were missing for two of the 19 patients. The care plans used tick boxes to indicate what care should be carried out. In some instances, planned actions, indicated by a tick mark, were not carried out. For example, care plans for three patients indicated that fluid intake should be monitored using the fluid balance chart. However, only fluid consumed at mealtimes was recorded on the all Wales food chart. For two of the 19 patients, food intake was not recorded even though these patients were identified as at moderate or high risk and identified as losing weight. Where patients' intake was recorded, information on the size of the portion eaten was missing.

20. The Health Board has a range of mechanisms in place to identify those patients who need help with eating and drinking. These include the nutrition and hydration bed plan, the 'intentional rounding' sheet, which identifies the level of assistance needed, the butterfly scheme for those patients with a cognitive problem and the 'at a glance' patient boards. We observed these different mechanisms in practice during our ward visits but there is a risk that these mechanisms are unconnected to the screening process giving rise to the gaps in screening information.

21. At the time our fieldwork, ward staff told us that all Wales standardised nursing documentation, including prompts for specific information about activities of daily living, such as eating and drinking, would be introduced in late summer. This standardised documentation should support improvements in the quality of information captured.

Compliance with the nutritional care pathway is routinely assessed and reported both locally and corporately with action taken to address deficits in the screening process

22. In 2010, not all NHS bodies monitored compliance with the nutritional care pathway and we recommended that the Health Board establish arrangements for routine assessment of compliance. By 2013, the Health Board was piloting systems to monitor and report on compliance with the nutritional care pathway.

23. The Health Board's current 'Inpatient Nutrition and Catering Policy' states that compliance with nutritional screening should be recorded monthly using the all Wales nursing metrics system and this was evident from our ward visits at University Hospital Wales (UHW) and Llandough Hospital (Llandough). Dietetic staff also audit the use of the WAASP screening tool by nursing staff, for both quality and concordance, and audit findings are shared immediately with ward staff. The audit tool assesses whether:

- screening is undertaken within 24 hours of admission;
- a weight is recorded and, if not, could the patient have been weighed;
- the risk score is accurate and patients are rescreened as per risk score; and
- patients with a risk score greater than seven are referred to dietetic staff.

24. A schedule of audits ensures adequate coverage across hospital sites. For example, one audit is undertaken each week at UHW. A recent dietetic audit found that compliance with nutritional screening and weighing within 24 hours was less positive than the findings from our case note review. In particular, dietetic staff found:

- just over half the patients had been screened within 24 hours;
- less than a fifth of patients were weighed within 24 hours while most of those patients not weighed were deemed by dietetic staff to be medically fit enough to have been weighed;
- the risk score was judged accurate for just under half the patients which means that those deemed to be at high risk were missing out on a dietetic referral; and
- two patients identified by nursing staff as at high risk on admission had not been referred to dieticians.

25. Compliance with nutritional screening is reported as a key performance indicator (percentage of nutrition scores completed and appropriate action taken within 24 hours of admission) in performance reports to the Board. At the most recent Board meeting in July 2015, compliance was 94 per cent, just below the Health Board's threshold target of 95 per cent.

26. 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. Forty-five per cent of the Health Board's nursing staff are compliant, with compliance monitored by the Nutrition and Catering Steering Group. During our ward visits, we found evidence that some ward managers actively monitor compliance with the e-learning package, with compliance figures displayed. While on other wards, staff were less sure that this training had been completed.

27. The Health Board has established a nursing nutrition and hydration working group, which is accountable to the deputy director of nursing. The group was established to drive the nutrition and hydration agenda and one of its tasks is to develop and pilot nutrition champion roles. Meanwhile, there is ongoing collaboration between dietetic and nursing staff to embed nutrition training in existing training packages.

28. At the Health Board in 2010, training for ward-based catering staff needed to be reviewed to ensure they had a good understanding of nutrition and patients' nutritional needs. By 2013, the Health Board had introduced basic nutrition training for these staff but had yet to roll it out fully. Our latest audit found that catering staff had received mandated training on nutrition, therapeutic diets, customer care and food safety. Furthermore, the 'Come dine with us…' video supports a multidisciplinary training programme on the patient mealtime experience and is seen as a key resource for staff induction.

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

29. 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.

30. At the Health Board, snacks are available between meals and for patients who miss a meal. A range of snacks, such as biscuits, fresh fruit, yoghurts, cheese and crackers and sandwiches, as well as staples like bread, cereal and milk, is stored in ward kitchens. Dietetic staff produced simple guidance for patients about suitable snacks for poor appetites and the times when snacks are typically available. Snacks are offered during the mid-morning and mid-afternoon beverage rounds but patients can request snacks from nursing staff and ward-based catering staff anytime of the day. During our ward visits, we observed ward-based catering staff or dietetic support staff preparing the mid-afternoon 'snack round'.

31. The Health Board's 'mealtime experience audit tool' also assesses whether snacks are available in ward kitchens and offered during beverage rounds, and recent audits found good compliance. 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 90 per cent of patients always or usually provided with nutritious food and snacks.

32. The standards for patient food and fluid identify that seven to eight beverage rounds should take place each day, offering hot and cold beverages and that water in jugs should be changed three times a day. The 2014 Fundamentals of Care audit found that drinking water was available and within patients' reach, while 70 per cent of wards achieved seven or more beverage rounds a day and water jugs replenished three times a day. The multidisciplinary mealtime experience audits found two water jug changes throughout a 24-hour period with patients and nursing staff reporting that there were four to five hot beverage rounds per day. During our ward visits, ward managers and ward-based catering staff told us it was challenging to provide seven to eight drinks per day and that typically water jugs were changed twice a day. Patient feedback captured as part of the 'Two minutes of your time' found that 95 per cent of patients always get a drink when they want one.

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

33. In 2010, we found that dieticians were involved in menu planning at all hospitals but not all hospital menus had been nutritionally assessed. At the Health Board, dieticians were fully involved in menu planning and assessed the nutritional content of the standard costed recipes used by catering staff. Since then, the Welsh Government published the All Wales Nutrition and Catering Standards, which specify the 12 minimum nutrients for analysis. The Health Board indicated that it is fully compliant with the all Wales menu framework using the recipes in the database to design the patient menu. The multidisciplinary operational menu group works to design menus to meet energy and minimum nutrient requirements. The Health Board contributes to the all Wales menu framework group where compliance with the menu framework and catering and nutrition standards is discussed, as well as how it is integrated into current reporting mechanisms with NHS organisations.

34. Staff also indicated that the all Wales commodity advisory group, working with the procurement dietician, based with the NHS Shared Services Partnership, means that food suppliers are required to provide nutritional information about their products to assess compliance with nutritional standards.

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

35. 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'. Ward staff told us that patients do not receive information routinely about how their nutritional or dietary needs or preferences will be met while in hospital. With the exception of the snack guidance sheet, we did not find written information provided to adult inpatients. A brief description about catering services and protected mealtimes within the children's hospital is set out in the Health Board's booklet for children and families. The Health Board recognises the gap in information for other inpatient areas. It has worked to produce a patient handbook that will include information on food services. The handbook will be available shortly and several copies will be available on each ward and the Health Board's website.

Scope remains to improve mealtime experiences for some patients

36. 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, more could be done to prepare the ward environment for mealtimes so it was more conducive to the enjoyment of food and many wards had yet to adopt protected mealtimes. For the most part, catering arrangements were flexible enough to support patient choice but some patients did not always get the correct meal.

37. At the Health Board, dietetic support staff were deployed on some wards, which worked well in identifying patients needing help with eating and drinking and ensuring help was given. In 2010, and again in 2013, we recommended that the Health Board should establish the benefits of extending access to dietetic support at mealtimes. The use of the red tray system at mealtimes to identify patients needing help with eating had been widely adopted but its use varied between wards. When we followed up progress in 2013, we found that the Health Board was monitoring the use of the red tray system but there was still inconsistency in its use while work continued to embed protected mealtime principles.

Patients are generally positive about food services but there is not enough choice for some patients

38. Currently, the Health Board operates a one-week menu cycle. At the beginning of 2015, the catering department reduced the choice available for the weekend supper menu to improve cost efficiencies. The decision resulted in adverse publicity for the Health Board. The decision was reversed and at the time of the audit, staff indicated that the menu choice had been increased in line with the rest of the week. Meanwhile, feedback from patients in long-stay units indicates that there is not enough choice across the one-week menu cycle. The Health Board's operational menu planning group is currently considering whether to move to a two-week menu cycle across all inpatient areas with more tailored menus for long-stay units. The group is currently awaiting the findings from the all Wales menu framework survey before making changes to menu cycles and printing new menu cards. Additional menus are available for those patients with special dietary requirements for therapeutic, cultural or religious reasons.

39. The Health Board's 'Two minutes of your time' survey captures patients' views on important aspects of inpatient care, such as tasty and appetising food and whether patients miss meals because no one helped or they wanted a drink and could not get one. Feedback from patients is generally positive but work continues to ensure that meals are appetising and served at the correct temperature, patients get beverages when requested and the help needed at mealtimes is given.

Nursing support and supervision at mealtimes is limited on some wards

40. The Health Board undertook an assessment of the benefits of extending the dietetic support role but the number of ward-based dietetic support staff has not increased. Extending this cohort of staff is being discussed with clinical board nurses for consideration as part of the integrated medium-term planning. In the meantime, the Health Board continues to explore opportunities for developing roles for generic rather than uni-professional support workers.

41. The Health Board's 'Inpatient Nutrition and Catering Policy' indicates that nutrition and hydration bed plans should be used to identify patient's dietary, therapeutic, cultural and religious dietary requirements and that catering and nursing staff should work jointly to ensure patients' needs and choices are met with all nursing staff available to help patients requiring assistance to eat and drink. We observed lunchtime meal services on two wards at UHW and two wards at Llandough. From our observations, we found that:

- Ward-based catering staff were knowledgeable about patients' nutritional needs and dietary preferences, and would help to cut up food and open packaging. They also encouraged patients to eat, tempting them with different meal options when they refused to eat a hot meal.

- On both wards at UHW, there was a reliance on the dietetic support staff to move quickly between patients to help with eating. Where nursing staff were available to support patients, they did not always follow the order of the meal trolley. These practices contrast with our observations at Llandough where all nursing staff were fully engaged in the lunchtime service and worked alongside the ward-based catering staff to serve patients and to provide prompt support with eating. This was particularly helpful at Llandough where patients took lunch in the day room and were not easily matched to a bed number on the nutrition and hydration bed plan.
- Nursing staff on one ward at UHW did not accompany the ward-based catering staff during the meal service with ward-based catering staff relying on the nutrition and hydration bed plan for identifying patients with special dietary or nutritional needs. Bed plans were up to date at the point meals were regenerated for the lunchtime service but by the time the meal service began, one patient was 'nil by mouth'. On the second ward at UHW, we observed nursing staff engaged in activities other than the mealtime service, like note writing or taking their own lunch break. Where ward-based catering staff had any doubts about a patient's requirements, they would check with the nursing staff.
- The red tray system to identify patients needing help at mealtimes was not used on all wards visited. Where the red tray system was used, patients were sometimes served their meals before nursing staff or dietetic staff were available to help, which risks meals cooling down and becoming unappetising.

42. The 2014 Fundamentals of Care audit found that nearly all (95 per cent) of wards had systems in place to allow family or friends to assist with mealtimes. On the four wards that we visited, nursing staff told us that they actively welcome and encourage family and friends to help patients at mealtimes. During our ward visits, we observed families helping their relatives with eating. Meanwhile, 74 per cent of wards complied with having a registered nurse supervising mealtimes.

43. Exhibit 2 sets out the differences we observed between UHW and Llandough. Our observations are based on the activities that we expected to see and whether these activities applied to all, most, some or no patients. On the day that we visited the wards at UHW, the wards were short staffed, which may account for some of the differences observed in practice.

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

Observations of the lunchtime service	UHW	Llandough
Patients helped to prepare for mealtimes, including using the toilet, washing hands and sitting up or getting out of bed	Most	All
Bedside areas/tables tidied before meals served	Most	All
Bedside areas/tables cleared of clinical waste	Some	All
Ward-based catering staff wear protective clothing	All	All
Temperatures of meals are recorded before service begins	All	All
Nursing staff accompanied the ward-based catering staff during the service	Some (times)	All
Patients needing help with eating are easily identified	Most	All
Meals are left within reach of patients	Most	All
Help is given to cut up food or to remove packaging	All	Most
Patients needing help receive it promptly	Some (times)	All
Nursing staff supervise and encourage patients with eating throughout mealtimes	Most	All

Source: Wales Audit Office observations of lunchtime services

44. The Health Board regularly assesses compliance with food hygiene and expected meal service practice and the patient experience. A multidisciplinary team composed of senior nurses, and dietetic and catering staff assess compliance against a checklist of factors, such as recording food waste, supporting patients to cut up food and eating, and recording food temperatures. Ward staff receive immediate feedback from the audit team. Our lunchtime observations set out above resonate with the findings from recent multidisciplinary audits at Llandough, in particular:

- there was good knowledge on part of ward-based catering staff about patients' dietary needs and preferences;
- ward-based catering staff provided support for eating by opening packages and cutting up food;
- visitors on the ward supported patients to eat;
- ward areas were sometimes cluttered, making it difficult for ward-based catering staff to serve meals;
- nutrition and hydration bed plans were not always up to date or were poorly completed; and
- there was limited nursing support during meal services.

Protected mealtime principles are more widely embedded than previously

45. The standard for protected mealtimes is set out in the Health Board's 'Inpatient Nutrition and Catering Policy'. On the four wards where we observed the lunchtime meal service, we found signage at ward entrances explaining the purpose of protected mealtimes and the times it operated. On one ward, a poster and leaflet sets out the purpose of protected mealtimes for patients, visitors and staff. For the most part, protected mealtimes were observed with non-essential clinical activity 'winding down' just before the meal service commenced. The four ward managers that we met were confident protected mealtimes worked well with professional colleagues supportive of the principles. Breakfast was the one meal that ward managers reported finding more challenging to apply protected mealtimes. During our wards visits, we found:

- Healthcare professional staff for the most part left the ward areas at the start of the meal service, and, if they remained, interactions with patients and nursing staff were minimised. On one ward at UHW, a pharmacist was reviewing patients' medicine charts and talking with patients about their medication. On the second UHW ward, nursing staff carried out a discreet medicine round, including providing prescribed nutritional supplements, ahead of the food trolley.
- Cleaning activities continued in ward corridors during the meal service on one UHW ward but cleaning activities were not carried out near patients' bedsides. For the most part, cleaning activities did not impede the food trolley.
- On one ward at Llandough, an engineer arrived at the start of the meal service to check repairs but these repairs were not in patient areas and his presence did not affect the mealtime service.

46. The corporate team undertaking ward observations as part of the 2014 Fundamentals of Care audit found that protected meals were 'well observed' in some areas with particular challenges at breakfast time. The Health Board plans to include information on protected mealtimes on ward information boards and in the patient handbook.

The cost of patient catering services is better controlled but the income from non-patient catering services is still insufficient

47. 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.

48. 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.

The cost of patient catering services is reducing and cost per patient meal compares favourably with other NHS bodies

49. The Health Board's EFPMS data submissions show year-on-year reductions between 2011-12 and 2013-14 with costs reducing by 42 per cent, from £7.85 million to £4.54 million (Exhibit 3). Across all NHS bodies, the cost of patient catering services reduced by five per cent. Our analysis of the EFPMS data suggests patient catering costs have reduced at the Health Board because provision and other non-consumable costs reduced. Meanwhile, the number of patient meals requested reduced by 18 per cent from 1.96 million meals in 2011-12 to 1.61 million meals in 2013-14 compared with a four per cent reduction across Wales.

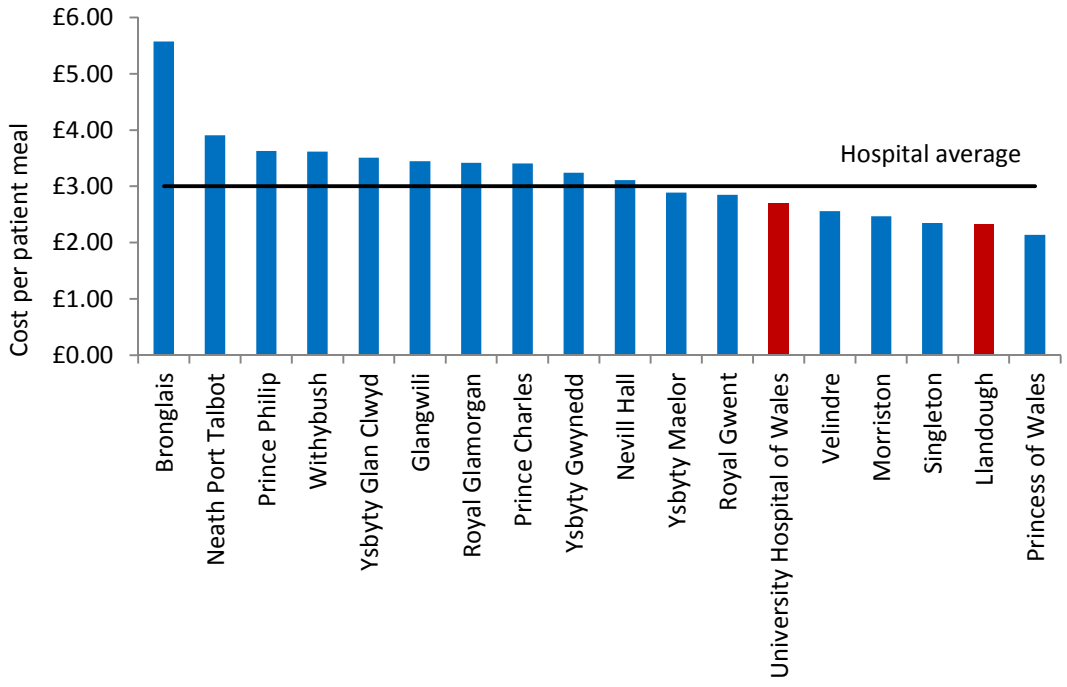
Exhibit 3: Patient catering service costs are reducing

Year	Cost of catering services (£ million)	
	Cardiff and Vale	Wales
2011-12	7.85	38.95
2012-13	5.31	37.26
2013-14	4.54	36.97

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

50. Our follow-up work in 2013 found that the Health Board had set a target meal cost of no more than £2.93 per patient. Analysis of the EFPMS data for 2013-14 shows that cost per patient meal was £2.82, within three per cent of the Health Board's target cost, having reduced from £4.00 in 2011-12. The cost per patient meal at UHW and Llandough are both below the hospital average (Exhibit 4).

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



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

51. In 2010, the Health Board's food production arrangements relied heavily on manual paper systems rather than an IT solution. 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 and the Health Board is awaiting the outcome before making any decisions to invest in a local IT solution.

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

There are clear guidelines about what constitutes un-served meals and plate waste, with un-served wastage below the national target

53. In 2010, levels of un-served food waste were high on some wards across the Health Board with improvements needed to measure accurately un-served food waste. By the time of our follow-up work in 2013, the Health Board had developed arrangements to monitor food waste and waste was reducing. Regular patient feedback on the quality of meals suggests that quality and choice were not adversely affected by the actions taken to reduce waste.

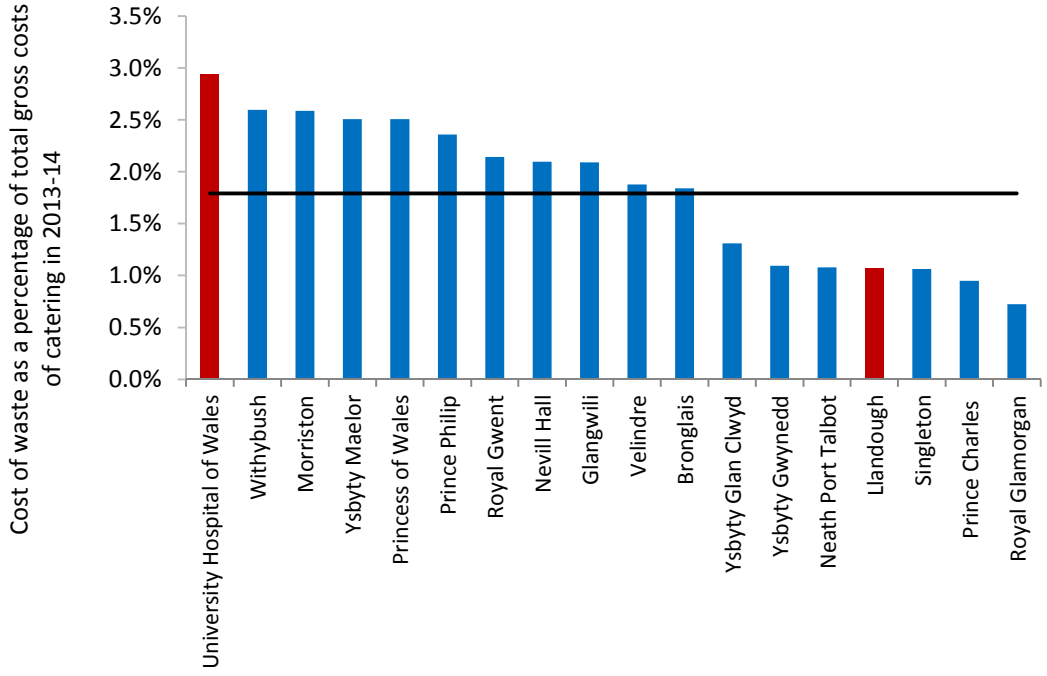
54. The Health Board has clear guidelines about what constitutes un-served meal waste and plate waste. Un-served waste (known as trolley waste) is the protein portion of food not served from the food trolleys while plate waste (known as meal waste) is the protein portion of the meal served to the patient but not eaten. The protein portion of meals is recorded after each mealtime service with these indicators monitored locally.

55. The Health Board continues to monitor food waste from both un-served meals and plate waste. In 2014-15, the volume of food waste from both un-served meals and plate waste was less than 10 per cent across all hospital sites compared with 39 per cent at the time of our 2010 audit. However, this is greater than the Health Board's local target of five per cent. The multidisciplinary approach to mealtime audits ensures waste issues are tackled collectively.

56. The ‘Come dine with us …’ training DVD indicates that offering ‘seconds’ helps reduce waste and ensures patients are satisfied nutritionally. Although we did not observe ‘seconds’ being offered during our ward visits, the Health Board’s meal service audit tool looks for evidence that un-served meals leftover at the end of the service are offered to patients. The ‘meal service audit tool’ also captures information on the number of portions of food cooked and wasted, including the protein element, potatoes and vegetable and desserts. If nutrition and hydration bed plans are up to date, the right amount of food should be ordered and cooked, helping to minimise waste. The Health Board’s waste data for May 2015 show that 13 per cent of food portions were wasted.

57. Analysis of the 2013-14 EFPMS data shows that cost of un-served meals was £169,659 at the Health Board, which equates to two per cent of total catering costs. There were small variations between hospitals but the proportion of costs for un-served meals was highest at UHW (2.9 per cent), nearly three times that at Llandough (1.1 per cent) and well above the hospital average (Exhibit 5).

Exhibit 5: The cost of food waste at UHW is nearly three times that at Llandough and well above the hospital average



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

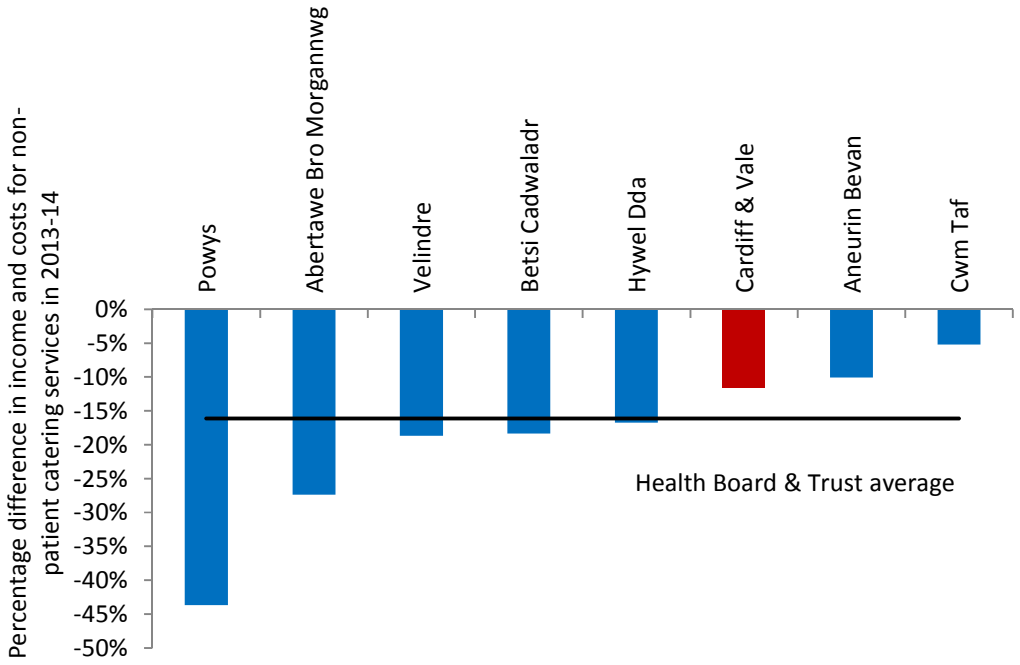
58. In 2010, the Health Board did not have a subsidy policy in place but catering services operated on a breakeven basis and its restaurant services were running at a loss of £342,000. At that time, we recommended that the Health Board introduce a clear policy on subsidy to set the framework for delivering non-patient catering services. By the time of our follow-up audit in 2013, the Health Board was taking action to reduce the non-patient subsidy with the work led by the restaurant non-patient subsidy group. Actions included introducing profit and loss accounts for monitoring individual food outlets, and reducing restaurant opening hours and numbers of catering staff. Meanwhile, restaurant performance was monitored monthly through finance meetings with respective service managers.

59. The planned actions were expected to narrow the gap between costs of non-patient catering services and the income generated, with the ultimate aim for all restaurants to breakeven by the end of 2012-13. At the time of our follow-up work in early 2013, the Health Board had forecast a £158,000 shortfall in income to cover costs of non-patient catering services. At the end of March 2013, the shortfall totalled £279,000 but EFPMS data for 2013-14 show that the gap between cost and income continues to reduce. New tills in the Health Board's restaurants are reported to be improving management information and to help with stock control.

60. Across Wales, the income generated from non-patient catering services was insufficient to recover operating costs at any NHS body in 2013-14 (Exhibit 6). At the Health Board, the cost of non-patient catering services and the income generated have been reducing (Exhibit 7). In 2013-14, the cost of these services totalled £1.9 million while the income generated was enough to recover 88 per cent of these costs. This equates to a subsidy of around £221,000. Analysis of the EFPMS data show that staff costs for non-patient catering services have reduced while numbers of staff are increasing.

61. 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, particularly for the UHW restaurant, and where new builds are changing the infrastructure, for example at Llandough.

Exhibit 6: NHS organisations do not generate enough income to recover the costs of providing non-patient catering services; there is a 12 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

Exhibit 7: Both the cost of the Health Board's non-patient catering services and the income generated are reducing

Year	Cardiff and Vale		Wales	
	Cost of non-patient catering services	Income achieved	Cost of non-patient catering services	Income achieved
	(£ millions)			
2011-12	2.23	1.76	15.05	11.20
2012-13	2.00[1]	1.72	14.50[1]	11.53
2013-14	1.91[1]	1.69	13.43[1]	11.26

[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

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

63. In 2010, the existence of up-to-date strategies and plans to give effect to national policies in relation to hospital catering and patient nutrition was patchy while in several NHS bodies arrangements needed to be harmonised following NHS re-organisation in 2009. A more comprehensive and 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.

64. In the Health Board at that time, executive accountability for catering and nutrition was clearly identified and sound strategies and policies, developed by appropriate multidisciplinary staff, were in place. However, the Board received limited information on catering and nutrition services, and different mechanisms for seeking patient feedback meant that patients' views were not collated effectively to inform plans. Our follow-up work at the Health Board in 2013 found that key performance indicators had been developed and implemented but reporting lines from task and finish groups related to catering were not through its Nutrition and Catering Steering Group.

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

65. The Health Board's 'Inpatient Nutrition and Catering Policy' makes it clear that the organisation has collective responsibility for meeting patients' nutrition and hydration needs from those departments involved in the food chain, from food production to helping patients eat, to the Executive Board. The Health Board supports a multidisciplinary approach to meeting patients' nutrition and hydration needs with assurance and oversight provided by the Nutrition and Catering Steering Group. This group, chaired by the Executive Director of Therapies and Health Science, is composed of a wide membership of senior staff from relevant disciplines and a member of the community health council. The group has a broad programme of work, including monitoring compliance with inpatient nutrition and catering standards, the all Wales menu framework, leading on implementing the health and care standard on nutrition and hydration, reviewing findings from multidisciplinary mealtime audits and patient feedback on food and beverage services to ensure service improvements are put in place where needed.

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

66. The catering strategy group and its subgroups (nutrition and catering working group and patients' menu group) now report directly to the Nutrition and Catering Steering Group. The Nutrition and Catering Steering Group continues to report to the Quality Safety and Patient Experience Committee with the most recent paper to the committee highlighting key areas for improving nutritional care related to the Health and Care standards.

67. The Board continues to receive regular reports on compliance with the nutritional care pathway and patient feedback on food services. Information on food waste and costs of catering services is less visible at a corporate level and is instead monitored and reported at departmental level. 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. Patients' nutrition and hydration needs are included on the Health Board's corporate risk and assurance framework to ensure adequate controls and assurance mechanisms are available and to identify actions for mitigating risks.

68. The Quality Safety and Patient Experience Committee, through the Nutrition and Catering Steering Group, monitored progress in implementing the recommendations from both the local and national reports on hospital catering and patient nutrition. When the committee was assured that adequate progress was being made, the Nutrition and Catering Steering Group was no longer required to provide regular updates.

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

69. The Health Board continues to strengthen its arrangements for sharing patients' views between nursing, dietetic and catering staff. Since 2012, ward patients are regularly invited to take part in the 'Two minutes of your time' survey, which includes questions about food services. Patients' views are shared through the multidisciplinary Nutrition and Catering Steering Group and subgroups, and reported at each Board meeting. The multidisciplinary mealtime experience audits also provide opportunities to capture patients' experiences in 'real time' and to manage any problems immediately.

70. At the time of our fieldwork, the all Wales menu framework group was conducting a questionnaire survey of inpatients across all NHS bodies about the choice and quality of food. The Health Board included additional questions on menu choice of relevance to its local services. Dietetic staff distributed surveys to 800 patients across its hospitals, which seems to have ensured an excellent response rate (96 per cent). The Health Board is waiting for the survey findings expected in mid-summer, at which time it can begin revising the menu cycle and menu options. Meanwhile, the overall number of formal complaints is very low. The Health Board received six formal complaints in 2014-15 compared with the 1.6 million meals prepared.

Appendix 1

Audit approach

The audit sought to answer the question: 'Has the [Health Board/Trust] implemented fully the Auditor General's recommendations for securing improvements in meeting patients' nutritional needs and their mealtime experience, in controlling catering costs and planning and monitoring?' We carried out a number of audit activities between March and June 2015 to answer this question. Details of these are set out below.

Interviews and document review

We undertook a number of interviews with key individuals at the Health Board, including officers, 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/Trust'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 Head of Dietetics, 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
- compliance with protected mealtimes.

We visited wards C6 and B6 at UHW and wards E7 and E8 at Llandough.

Case note review

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

- nutritional screening is undertaken using a validated screening tool when patients are admitted to hospital;
- information on weight, height, body mass index (BMI), recent unintentional weight loss, current appetite, 'normal' dietary intake, special dietary requirements, the ability to eat independently, difficulties eating or drinking and problems with oral health and hygiene, including dentition, had been recorded; and
- care plans were in place for those patients identified with, or at risk of, nutritional problems and whether patients identified as at risk were referred for a dietetic assessment.

We reviewed up to five sets of case notes selected by the senior nurse on duty on the wards that we visited.

Appendix 2

National and local recommendations

Table 1 sets out the 14 local recommendations set out in our report summarising 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	Ensure that the Board receives more meaningful information on catering services to support effective scrutiny, management of risks and monitoring of performance.	A
R2	As part of the process of empowering ward managers under Free to Lead Free to Care arrangements, establish an effective fundamentals of care forum that ensure nutrition management issues are effectively managed and the many examples of good practice and innovation are shared.	A
Procurement production and cost control		
R3	Introduce a clear policy on subsidy to set the framework for delivering non-patient catering services.	A
R4	Improve the current food wastage monitoring arrangements so that they accurately reflect the level of un-served meals, identify the potential to improve existing systems and then enable food wastage targets to be set.	A
Delivery of food to the ward		
R5	Introduce basic nutrition into the training programme for ward based catering staff to improve their awareness of its importance and the need to follow ward procedures.	A
Meeting patients' nutritional needs and supporting recovery		
R6	Introduce protected mealtimes on all appropriate wards and establish arrangements that monitor compliance.	A
R7	As part of the new nutrition and catering strategy establish the benefits of extending access to the dietetic assistant role.	A
R8	As part of the new catering strategy look at strengthening and improving the speed of the service at mealtimes through improving staff availability or increasing nursing staff involvement.	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
R9	Through the fundamentals of care forum monitor the effectiveness of the red tray system, approach, its development and the emerging traffic light systems.	O
R10	Establish monitoring arrangements that routinely measure compliance with the nutritional care pathway and the effectiveness of the chart review process.	A
R11	Improve the nutritional assessment tool to include an assessment of oral health and the ability to communicate.	N
R12	In Llandough, improve communication processes and the catering service quality monitoring arrangements to ensure patients always receive the right meal for their dietary needs.	A
Gathering views from patients and sharing information		
R13	Improve information sharing between the catering service and ward managers by integrating the current arrangements used to obtain patients' views of the service.	A
R14	Involve patients fully in developing the catering service building on the recent positive experiences of their involvement in the puréed and soft food evaluation.	A

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

Table 2: 2011 national recommendations

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

Recommendation		Status at July 2015
R1d	Where poor compliance with nutritional care pathway requirements is identified, we recommend that NHS bodies should establish the reasons for this, and implement clear plans of action to address the problem and include provision of necessary training to staff.	A
R1e	We recommend that NHS bodies have arrangements in place to ensure that patients have access to food 24 hours a day; provision of snacks should be part of these arrangements and patients should be made aware of what snacks are available to them, and when.	A
R2a	We recommend that NHS bodies take steps to ensure that all menus in use across 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.	O
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
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.	N
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.	A
R5c	We recommend that NHS bodies review their current cost control mechanisms to ensure that they are making full use of standardised local catering contracts for the same or similar products across all their hospital sites.	A
R6a	We recommend that local and national targets are set for food wastage; as a guide NHS organisations should aim to ensure that wastage from un-served meals does not exceed 10 per cent.	A
R6b	We recommend that NHS bodies routinely monitor food wastage according	A

Recommendation		Status at July 2015
	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.	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 that aim to ensure that non-patient catering services at least break even, or, if they do not, it is the result of a deliberate subsidy policy that is based on a detailed analysis of costs.	O
R7b	We recommend that NHS bodies regularly monitor income and expenditure of non-patient catering services to ensure that the financial performance of these services is as expected and that unacceptable deficits are not being incurred.	A
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.	A

Recommendation		Status at July 2015
R10b	We recommend that NHS bodies systematically collate the information from nutritional screening on the number of patients identified with, or at risk of, nutritional problems to understand the scale of the problem and the likely impact on catering and nutrition services to meet these patients' needs.	N
R11a	We recommend that NHS bodies ensure that there are effective arrangements in place for sharing information on patients' views about catering services between ward sisters/charge nurses and the catering service.	A
R11b	We recommend that NHS bodies demonstrate how they have taken patients' views into account when developing catering and nutrition services.	A
R11c	We recommend that NHS bodies establish mechanisms to involve patients' in activities that assess the quality of catering and nutrition services.	A

Table 3 sets out the seven local recommendations set out in our report summarising the findings from follow-up audit work on the Health Board's hospital catering and patient nutrition services in 2013.

Table 3: 2013 local recommendations

Recommendation		Status at July 2015
Strategic planning and management arrangements		
R1	Following on from the recent committee review, the UHB should make sure the reporting lines for the key nutrition and catering groups, including the Restaurant Non-Patient Subsidy Group and Food Waste Reduction Task and Finish Group, bring all issues relating to nutrition and catering together and create a single reporting line to the Board.	A
Procurement production and cost control		
R2	The Restaurant Non-Patient Subsidy Group should reinforce its strong focus on key performance indicators to achieve the target of zero subsidy for non-patient catering services.	O
R3	As part of reducing food waste, the Food Waste Reduction Task and Finish Group should ensure its focus on quality is maintained so that reductions in waste do not have a detrimental impact on food quality.	A

Recommendation		Status at July 2015
Delivery of food to the ward		
R4	To support the rollout of training for ward based catering staff, the UHB should develop a deputising arrangement to ensure the training schedule is maintained in the event of staff sickness.	A
R5	The UHB needs to reinforce its focus on the Fundamentals of Care action plan arising from the mealtime audits, to ensure that protected meal times are fully embedded across all wards.	A
Meeting patients' nutritional needs and supporting recovery		
R6	The Executive Director of Therapies should establish a continual assessment of the benefits of supporting patient feeding at meal times through a role such as dietetic assistant or healthcare assistant.	A
R7	The Nutrition and Catering Steering group should consider the findings of the pilot audit tool as a matter of priority so that monitoring arrangements can be rolled out across wards in a timely manner.	A

Wales Audit Office
24 Cathedral Road
Cardiff CF11 9LJ

Tel: 029 2032 0500
Fax: 029 2032 0600
Textphone: 029 2032 0660

E-mail: info@audit.wales
Website: www.audit.wales

Swyddfa Archwilio Cymru
24 Heol y Gadeirlan
Caerdydd CF11 9LJ

Ffôn: 029 2032 0500
Ffacs: 029 2032 0600
Ffôn Testun: 029 2032 0660

E-bost: post@archwilio.cymru
Gwefan: www.archwilio.cymru