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Hospital Catering

Cwm Taf Health Board

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Summary

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 required across the range of staff groups involved, including managers, catering staff, dieticians, nurses, support staff and porters.
2. 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. 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.
3. The importance of hospital food in supporting patients' recovery has been recognised in a number of Assembly Government initiatives. The most recent of these takes the form of a *Hospital Nutritional Care Pathway* and the development of all-Wales charts to record food and fluid intake. The Assembly Government has also developed an *Improving Nutritional Care* training programme for ward managers to support local training. These approaches support the *Free to Lead, Free to Care* initiative, which is designed to empower ward sisters to take greater control of events on their ward. Best practice in nutritional care is further embedded through specific *Healthcare Standards* (Standard 14 – Nutrition)[1] and the *Fundamentals of Care Standards* (Standard 9 – Eating and Drinking)[2].
4. Work by the Audit Commission in Wales in 2001-02 showed that whilst there were some encouraging examples of good practice in relation to hospital catering across Wales, these needed to be replicated more widely and practices strengthened in a number of areas. Since 2001-02, annual data on facilities performance collected by Welsh Health Estates has highlighted significant variations between hospitals in the daily costs of feeding a patient, and continued problems with food wastage – some 880,000 meals were left untouched in 2008-09. Welsh Health Estates data also suggested that the rollout of recognised good practice such as protected mealtimes and nutritional analysis of menus is patchy.

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[1] Welsh Assembly Government, *Doing Well, Doing Better, Standards for Health Services in Wales*, 2010

[2] Welsh Assembly Government, *Fundamentals of care: guidance for health and social care staff: improving the quality of fundamental aspects of health and social care for adults,* 2003

5. The Wales Audit Office decided, therefore, that it would be timely to undertake further audit work on hospital catering to review progress since the work by the Audit Commission in Wales in 2001-02, and to examine the extent to which practices set out in the *Hospital Nutritional Care Pathway* are being embedded.

6. Our review sought to determine whether hospitals in Wales are providing efficient catering services that meet recognised good practice. We considered the whole of the hospital catering 'food chain' from planning and procurement, through to the delivery of food to the ward and patients and the management of mealtimes.

7. Our work at Cwm Taf Health Board (the Health Board) in April 2010 focused on an examination of hospital catering arrangements at the Prince Charles Hospital (PCH) and the Royal Glamorgan Hospital (RGH) but, as part of our fieldwork, we also visited the Central Production Unit (CPU) in Treorchy.

8. Our findings relate specifically to PCH and RGH and are informed by an analysis of financial data relating to patient and non-patient elements of the catering services, observations of mealtimes, a case note review of 35 patient records and a patient survey that captured the views of 139 patients about their experience of hospital food. Other than in terms of the Health Board's overall strategy and plans, we did not examine the detail of local arrangements and any possible variances across other sites. Further details of the audit approach are provided in Appendix 1, including the seven wards where we carried out the audit activities.

9. Our overall conclusion is that the arrangements for catering services are generally sound, although the cost of catering services is considerably higher than average, and while patient satisfaction is high aspects of the patient experience and nutritional screening need to improve. We reached this conclusion because:

- the redesign of catering services is progressing well:
  - plans for rolling out the cook-freeze system at PCH are progressing well but the timescales for discontinuing the plated service are not yet finalised; and
  - policies and procedures in relation to catering and nutrition are being developed or updated, with roles and responsibilities of staff clearly set out while lines of accountability and reporting arrangements are in place.
- the arrangements for food production and cost control are generally robust, however, poor recovery of non-patient catering costs in 2008-09 resulted in higher than average net costs, with those for RGH the highest in Wales:
  - food production is effectively controlled using standard costed recipes that have been nutritionally assessed;
  - although un-served food is actively monitored, gaps in information may underestimate the full extent of waste and its cost to the Health Board; and
  - despite a differential pricing policy for non-patient catering services the Health Board recovered only 59 per cent of the total cost in 2008-09, and consequently the cost of catering services per patient day was considerably higher than average, with those for RGH the highest.

- the arrangements for delivery of food to wards and patients are generally effective but there is scope to provide simple guidance on basic food hygiene and to improve certain aspects of patients' experience at mealtimes:
  - food is well presented and received in good condition with patients receiving the meal of their choice;
  - patients are served quickly and efficiently with catering staff and nursing staff working well together;
  - although ward staff comply with basic food hygiene practice, there is scope to provide simple guidance;
  - compliance with the protected mealtime policy is not always observed; and
  - not all patients have the opportunity to prepare for their meals.
- the Health Board's catering service is flexible and innovative to ensure most patients receive the nutrition that they require but nutritional screening on admission and care plans to manage nutritional risks are not comprehensive:
  - patients are not always screened on admission in relation to nutritional risk and the information recorded as part of the screening process is not always comprehensive;
  - nutritional care plans are not in place for all patients;
  - all patients identified as high risk are referred for a nutritional assessment by a dietician;
  - the menu provides a wide choice of food to meet patients' dietary requirements and innovations like the puree meal service and pictorial menu ensure patients with special dietary needs are not neglected;
  - replacement meals are available for patients who miss meals but the availability of snacks between meals is limited to patients at risk; and
  - help is readily available for patients needing assistance at mealtimes.
- patients' views are actively sought and overall satisfaction with catering services is relatively high:
  - patients' views are actively sought but more could be done to publicise how their views contribute to service improvements; and
  - patients are generally satisfied with the food they receive.

10. Each section of the detailed report that follows identifies the good practice that we looked for when undertaking our fieldwork and what we found. The work is also supported by detailed analysis of costs (Appendix 2) and a survey of patients (Appendix 3).

Recommendations

11. A number of recommendations have arisen from this review. These are listed below.

The Health Board should ensure its arrangements for catering and nutrition services address the following:	
R1	Examine the reasons for the higher than average catering costs per patient day by: • benchmarking numbers and costs of catering staff; • assessing the cost effectiveness of the opening hours of the staff/visitor restaurant at RGH; • checking the robustness of the formula used to price products for staff and visitors; and • reviewing pricing structures in the staff/visitor restaurant and in doing so making a clear decision about the level of costs to be recovered from non-patient catering services.
R2	Review the assumptions underpinning the roll out of the cook-freeze model at PCH to compare projected costs with those presented in this report.
R3	Assess the systems for monitoring and recording waste by: • improving the completion of ward temperature sheets for all food products and not just those regenerated on the ward; and • examining reasons for regenerating too much if wastage levels exceed an agreed threshold.
R4	Improve the patient experience by: • ensuring bed plans are completed at least daily; • continuing to promote the protected mealtime policy amongst wider groups of staff; • ensuring ward staff make time to help prepare patients for their meals; • rolling out the enhanced role for ward-based catering staff if the pilot scheme is successful; • ensuring patients have access to the patient information booklet and understand the information setting out arrangements for catering services, such as the use or otherwise of menu cards, and the availability of snacks; • revising the patient information booklet in due course to reflect the reasons why patients are discouraged from bringing in their own food; and • taking account of, and addressing, the less favourable views expressed by patients responding to our survey.
R5	Ensure compliance with food safety procedures by: • ensuring that all catering staff and food handlers receive the necessary training in food hygiene; and • developing guidance on basic food hygiene for ward staff that underpins policies and procedures in relation to ward-based catering services.

The Health Board should ensure its arrangements for catering and nutrition services address the following:	
R6	Improve compliance with nutritional screening and care planning by: • exploring the reasons for non-compliance with nursing staff; • providing simple guidance on how to use the nutritional risk screening tool; • recording more detail about patients' nutritional health on the Admission/24-hour Nursing Assessment form; and • considering regularly auditing compliance with nutritional screening and the comprehensiveness of care plans.

Strategic planning and management arrangements

12. The redesign of catering services is progressing well. We have come to this conclusion because:
    - plans for rolling out the cook-freeze system at PCH are progressing well but the timescales for discontinuing the plated service are not yet finalised; and
    - policies and procedures in relation to catering and nutrition are being developed or updated, with roles and responsibilities of staff clearly set out while lines of accountability and reporting arrangements are in place.
13. The following table summarises the findings supporting the conclusion.

Strategic planning and management arrangements

Expected practice	In place?	Further information
Service planning		
The Health Board has clear strategies and policies for catering and nutrition	✓	The Health Board is harmonising different arrangements for catering services across its hospital sites, by rolling out the cook-freeze model. The actions necessary to harmonise arrangements are set out in the Health Board's Facilities Strategic Plan and the Director of Corporate Services monitors progress monthly. In addition, plans to expand the CPU are in hand to increase production capacity to supply all of PCH and the Cynon Valley Hospital. Ward kitchens in the main PCH building are being refurbished in advance of the new cook-freeze model with wards moving over to cook-freeze once the kitchens are ready. The Health Board has not yet confirmed when it will be able to discontinue the traditional plated system and move over entirely to the cook-freeze system, a decision partly dependent upon the CPU's capacity to supply.

Expected practice	In place?	Further information
Service planning (continued)		
The Health Board has clear strategies and policies for catering and nutrition	✓	At the time of our audit, the Health Board was in the process of developing or updating a number of policies and procedures in relation to catering and nutrition to reflect its new structures and arrangements. These include: • a Nutrition and Catering Policy; • a Patient Catering Service Audit Tool procedure, which sets out the roles and responsibilities of different staff groups in relation to catering and nutrition service delivery, as well as supporting standards that ward-based catering staff need to maintain; and • a Food Safety Policy.
Menu design reflects the strategy and policy	✓	The menu currently provides a wide range of nutritional foods, which takes into account dietary preferences and special requirements. At the time of our audit, a comprehensive review of the patient menu was planned in order to standardise menus across all hospitals.
Dieticians and clinicians are fully involved in strategy and policy development and menu planning	✓	Dieticians and clinicians are involved in developing strategy and policy via the Catering and Nutrition Group, which has delegated responsibility for developing policies in relation to catering and nutrition. Dieticians have also been heavily involved in menu planning and nutritional analysis of recipes.
Evidence of workforce planning to match catering staff to demand	✓	The CPU matches the number of staff to production volumes. The move to the cook-freeze model at PCH will mean that many of the catering assistants working in the kitchen can be re-deployed to provide the ward-based catering service. The Health Board recognises that redeploying the chefs will be more problematic with only a few likely to transfer to the CPU. At the time of our audit, the Health Board had yet to have a complete solution.
Job descriptions and salary ranges for catering staff are harmonised across the Health Board	✓	Pay bands for PCH catering staff, who are predominantly ward based and patient facing, were recently harmonised in line with staff at RGH, increasing pay costs from Band 1 to Band 2. The previous differences in pay bands were a legacy from the previous Trust merger and were a particular issue for staff in ward-based catering roles.

Expected practice	In place?	Further information
Management arrangements		
Executive accountability for catering and nutrition is clearly identified	✓	The Director of Corporate Services is clearly identified as the executive lead for catering within the Health Board. The Executive Nurse takes the lead for patient nutrition while a non-executive officer also acts as a champion for patient nutrition.
The Board receives sufficient information on performance and practice in relation to catering and nutrition	✓	The Director of Corporate Services is responsible for producing reports, highlighting risks in relation to catering and nutrition. These reports are submitted to the Board through the Quality, Patient Safety and Public Health Committee and the Corporate Risk Committee. We found no evidence that the Board has given detailed consideration to catering and nutrition, other than those elements in the Healthcare Standards, but we would not expect it to do so given the arrangements for catering and nutrition are generally sound and corporate arrangements for scrutiny are in place.
A multi-disciplinary group is in place to oversee the delivery of the catering service	✓	The Facilities Division established a multidisciplinary Catering and Nutrition Group, with membership drawn from the Divisions and Directorates. The Catering and Nutrition Group also links with the strategic and operational nursing groups. For example, the Assistant Director of Facilities attends the Free to Lead, Free to Care strategic group while the catering managers attend the ward nurse forums to ensure that respective work in relation to catering and nutrition is aligned.

Food production and cost control

14. The arrangements for food production and cost control are generally robust; however, poor recovery of non-patient catering costs in 2008-09 resulted in higher than average net costs, with those for RGH the highest in Wales. We have come to this conclusion because:

- food production is effectively controlled using standard costed recipes that have been nutritionally assessed;
- although un-served food is actively monitored, gaps in information may underestimate the full extent of waste and its cost to the Health Board; and

- despite a differential pricing policy for non-patient catering services the Health Board recovered only 59 per cent of the total cost in 2008-09, and consequently the cost of catering services per patient day was considerably higher than average, with those for RGH the highest.

15. The following table summarises the findings supporting the conclusion.

Food production and cost control

Expected practice	In place?	Further information
Procurement		
Food is procured from approved suppliers, in line with arrangements set out in the all-Wales NHS Procurement Strategy	✓	The Health Board procurement arrangements for catering either use Welsh Health Supplies (WHS), all-Wales contracts or NHS Supply Chain contracts.
Sustainable procurement arrangements are in place	✓	The Health Board has not established its own sustainable procurement policy but the all-Wales and WHS contracts meet the Assembly Government guidance.
Production		
Patients order meals less than 24 hours in advance	✓	Meal ordering systems vary between and within hospitals because of the different catering models in place. Patients at the RGH and in Rhymney block (PCH) can chose their meal roughly three hours before mealtimes. Ward-based catering staff take patients' orders, based on the menu for that particular day, and regenerate the appropriate amount of food. However, one patient did not recognise these arrangements as an opportunity to 'order' food and commented that 'there was no menu so I couldn't order any food'. Patients staying on wards in the main block at PCH fill out a menu card each evening, for lunch and supper the following day. A catering clerk collates the menu cards each morning to give production totals to the chefs. Collating this information takes 2 to 2.5 hours each day, time that will be saved when the cook-freeze model is fully implemented. Any food cooked for patient meals at PCH, but not needed, is sold in the staff/visitors' restaurant so production waste is minimised.

Expected practice	In place?	Further information
Procurement		
The LHB operates a computerised catering system to facilitate production planning and control	✘	The CPU currently operates an effective paper driven process, which is time consuming. The CPU does use an old IT system but it was not designed as a bespoke catering system. The CPU would like to introduce a new computerised catering system to facilitate production planning and control, menu planning and nutritional analysis as part of its expansion.
Standard costed menus are in use to ensure consistency of quality and cost	✓	The CPU and catering staff at PCH use standard costed recipes. Every chef/cook is trained to use these recipes. Kitchen staff gather together the dry ingredients for each recipe the night before production ensuring adherence to the recipes is maintained. The CPU labels products with the following information: • product name; • production date and use by date; • ingredients and other special notes like 'may contain nuts or seeds'; • portion numbers; and • cooking instructions.
Nutritionally evaluated recipes are in use	✓	Recipes that are nutritionally evaluated are used. The dietetic department has IT software to assess the nutritional content of new recipes or changes to existing recipes. In the past, the dietetic department would place a dummy meal order to assess the weight of cooked portions in relation to nutritional values but it has not done this exercise in the last year.
A production plan is in place to guide the kitchen's tasks	✓	The CPU operates a two-week production cycle mirroring the menu cycle and production volumes are based on minimum and maximum stock levels within its storage freezers. Production volumes will vary depending upon changes or cancellations to standing orders from the RGH and the PCH. Kitchen staff at PCH and RGH also use production plans for patient meals and non-patient services, for which the CPU does not supply.

Expected practice	In place?	Further information
Procurement (continued)		
Portion controls are in place and supported by training	✓	Portion control is well established at RGH with portion size determined by the size of food foils. The number of portions per foil varies between patients and the staff/visitor restaurant. Portion control is monitored by catering supervisors at RGH, who visit wards during meal services. At PCH, at the end of the meal-plating process and before trays are loaded onto the food trolleys, a supervisor/chef checks that the plated meal reflects the order on the menu card, as well as the size of portion requested. Our patient survey found: • two-thirds of patients (63 per cent) were always able to choose their portion size compared with less than half (46 per cent) of patients across Wales; and • more than three-quarters (77 per cent) of patients reported being given enough to eat and a fifth (19 per cent) given too much compared with the average for Wales (73 per cent and 13 per cent respectively).
Quality of food is monitored at key stages in production	✓	Catering staff at RGH carry out taste testing sessions to assess appearance, taste, temperature and all-round quality. Quality monitoring could be strengthened by involving patients or patient representatives when taste testing meals. The PCH has convened taste test panels in the past. Catering supervisors also assess the food regenerated by ward-based catering staff to ensure it has been regenerated for the right length of time and it looks appetising. As part of our audit visits, we taste tested a number of left-over meals at RGH and PCH, which were of a high standard in relation to taste, smell, texture, temperature and appearance. We also tasted a number of reformed pureed meals that were of a very high quality and looked like the 'real thing'.

Expected practice	In place?	Further information
Food safety		
Robust arrangements in place to ensure food safety (eg, food temperature checks)	✓	Robust arrangements are in place throughout the food production process to check that the correct temperatures are achieved, from cooking to storage. Food probes are calibrated regularly. Ward-based catering staff were also responsible for monitoring stock levels, including 'use-by dates', of dry, fresh and frozen foods kept in ward kitchens. They also monitored ward fridges to ensure these operated at the appropriate temperature. Patients are also discouraged from bringing their own food into hospital as it cannot be stored safely, nor can it be reheated. However, this is not set out in the patient information booklet.
A Hazard Analysis Critical Control Points (HACCP) system is in place	✓	The HACCP systems are in place and revised in line with recommendations made by the Environmental Health Officer (EHO).
Catering facilities regularly inspected by local EHOs	✓	Local authority EHOs carry out routine inspections at the PCH and RGH hospitals and the CPU. No major contravention notices were issued during the EHOs' last visits in autumn 2009. Environmental health standard awards (Food Hygiene Awards) were presented as follows: • PCH – Bronze • RGH – Silver • CPU – Silver The CPU subjects its food safety arrangements to external scrutiny by Support, Training and Services (STS), a company specialising in food safety audits. The CPU retained its food safety certification following the recent STS audit in April 2010.
Action taken in response to EHO recommendations	✓	Most actions needed to comply with the law are taken immediately by catering staff. Requisition orders are placed where remedial work needs to be carried out by others, such as painting or installing new flooring. Or a business case is prepared where capital expenditure is needed to replace equipment.

Expected practice	In place?	Further information
Cost control		
Computerised catering system in place to support service management and monitoring	✓/✗	There is a heavy reliance on paper-based systems although Excel spreadsheets are used to monitor budgets, expenditure and waste.
Cost of catering service are known and monitored	✓/✗	The inpatient and staff/visitor restaurant services are separately identified and costs reconciled against budget lines. Although budgets, expenditure and income levels are monitored monthly, it is not clear that shortfalls in income or differences in costs are actively investigated. Catering services at PCH and RGH cost £5.1 million in 2008-09 with patient catering services accounting for just over three-fifths (£3.17 million) of the expenditure. There was a big difference in the split between staff and provision costs for patient services. Staff costs accounted for 64 per cent of the expenditure at RGH compared with 59 per cent at PCH while provisions accounted for 33 per cent and 39 per cent respectively. Provision costs per patient day were £5.23 at RGH, considerably more than the cost at PCH (£3.31), and the Welsh average (£3.18).

Expected practice	In place?	Further information
Cost control (continued)		
Ward wastage is monitored (un-served meals and plate waste)	✓	Catering staff monitor waste in relation to un-served portions and estimate the cost of this waste. Plate waste is not recorded but ward-based catering staff will ask patients why they did not eat their meal and feedback concerns to the catering manager or to the nurse in charge, if appropriate. However, this was not the experience of one patient responding to our survey, who commented: 'I did not eat any of the main meals and very little of the lunches but no one asked me why this was so.' Ward-based catering staff record the number of un-served portions on the 'ward temperature sheet' after each meal service. However, not all un-served meals were recorded during our visit (see Table 1 below). The reasons for this are not clear but could include simply forgetting to do so or perhaps to disguise the fact that too much food had been regenerated. Monthly audits at RGH have found un-served waste (all food products) fluctuates between five per cent and seven per cent with wastage fluctuating from day to day and ward to ward. The catering department estimates that this level of waste would cost £13,000 per year, or roughly four per cent of patient provision costs.

<table>
<tr><th>Expected practice</th><th>In place?</th><th>Further information</th></tr>
<tr><td colspan="3">Cost control (continued)</td></tr>
<tr><td>Ward wastage is monitored (un-served meals and plate waste)</td><td></td><td>The table below shows the level of waste recorded on six out of eight wards at the time of our visit. Although, patient orders were taken a few hours in advance of mealtimes, 22 per cent of total portions regenerated were not served.
Un-served food waste at lunchtime
<table>
<tr><th>RGH wards</th><th>Total portions regenerated (main meal food including vegetable)</th><th>Un-served portions</th><th>Un-served waste</th></tr>
<tr><td>1 and 2</td><td>96</td><td>20</td><td>21</td></tr>
<tr><td>8 and 9</td><td>112</td><td>35</td><td>31%</td></tr>
<tr><td>15 and 16</td><td>104</td><td>15</td><td>13%</td></tr>
<tr><td>19 and 20</td><td>128</td><td>not recorded</td><td>–</td></tr>
</table>
Source: Data recorded on ward temperature sheets at RGH
We estimate that the un-served portions equate to 28 meals and cost £25.[3] If the number of un-served portions remained constant on these six wards, waste would cost at least £9,000 per year.
Sandwiches and salads were available for patients who did not want a hot meal and although the number of these items was recorded on the ward temperature sheet the number of un-served sandwiches and salads was not.
We also estimated that plate waste,[4] food not eaten and left on plates, was 15 per cent (or one in six meals). Reasons for plate waste are complex because patients' medical conditions will influence appetite, taste and the volume of food that can be eaten. We observed good portion control during the meal service but a small number of patients responding to our survey told us they were given 'too much' to eat.</td></tr>
</table>

[3] Costs are estimated by multiplying the number of un-served protein portions by the provision costs per patient day at RGH in 2008-09 (£2.67) and dividing by the number of meals per day (3).

[4] Plate waste was measured by reversing the nutritional assessment documentation guidance contained in the *All Wales Food Record Chart Guide* so a meal recorded as 75 per cent eaten for nutritional monitoring equated to 25 per cent plate waste.

Expected practice	In place?	Further information
Cost control (continued)		
Ward wastage is monitored (un-served meals and plate waste)		Since the cook-freeze model was introduced on the Rhymney block (PCH) wastage fell to two per cent compared with 15 per cent for plated meals. During our visit, we observed the meal service on Ward 35 in Rhymney block (PCH), where ward-based catering staff regenerated food for patients, as well as patients on the adjoining Medical Assessment Unit (MAU) where the number of patients fluctuates throughout the day. On this particular day, waste from un-served meals was high – 10 out of 32 meals across both wards. The anticipated uptake of meals was not realised because the MAU was closed to new admissions due to an outbreak of diarrhoea and vomiting. Consequently, the catering manager arranged to meet the ward manager to discuss providing a sandwich lunch rather than a hot meal for patients referred to the MAU for assessment, while inpatients on the MAU would continue to receive a hot meal. Plate waste on Ward 35 was nine per cent. Kitchen staff at PCH randomly audit the number of un-served plated meals returned to the kitchen. If un-served waste is high, then ward staff are contacted to find out why. On our behalf, catering staff at PCH monitored the number of un-served plated meals returned to the kitchen on one day of our visit. One in five plated meals (56 out of 289) was un-served at an estimated cost of £56[5]. If the number of un-served meals remained constant, we estimate that wastage would cost at least £20,500 per year, which is higher than the catering department's own estimate for 2009-10 (£12,320).

[5] Costs are estimated by multiplying the number of un-served meals (56) by the provision costs per patient day at PCH in 2008-09 (£3.01) and dividing by the number of meals per day (3).

Expected practice	In place?	Further information
Cost control (continued)		
There is an agreed approach to the contribution from non-patient services	✘	There is no overall agreed approach to the contribution from non-patient services in offsetting catering costs. Catering departments are expected to generate income that matches or exceeds the previous year's income but there is nothing explicit about the need to break even. Staff meals are not subsidised but a single pricing formula is in place, which includes differential pricing for staff and visitors. The pricing formula takes into consideration the cost of the item, overhead costs, wastage and VAT and there is an additional 45 per cent mark up on the price paid by visitors. We were told during our fieldwork that prices had not been uplifted since 2008 but Health Board staff have since indicated that prices have been uplifted annually in line with inflation. Although the income generated in the past has matched or exceeded expectations, in the future it is likely to get harder because of the current economic climate and falling revenues from vending machine sales. More than £1.13 million was generated in 2008-09 by the catering departments at PCH and RGH. However, the income was enough to recover only 59 per cent of the total cost of non-patient catering services. This shortfall was one of the biggest in Wales. In order to break even, catering services will need to double their income in future. Consequently, the net costs of catering services totalled £3.97 million in 2008-09 and net costs per patient day at RGH (£18.41) were above average (£11.08) and the highest in Wales. Since our fieldwork, Health Board staff indicated that they were reviewing service establishments and looking at ways of improving the recovery of non-patient meal costs. Data for 2009-10 show that the Health Board recovered 64 per cent of its non-patient meal service costs due to a substantial reduction in staff costs for this service.
Dining room wastage is monitored	✓	Catering staff monitor and record un-served waste in the staff/visitor restaurants. Waste is reportedly low but we did not validate these claims as part of this audit.

16. Appendix 2 provides detailed analysis of the financial data.

Delivery of food to the ward and patient

17. The arrangements for delivery of food to wards and patients are generally effective but there is scope to provide simple guidance on basic food hygiene and to improve certain aspects of patients' experience at mealtimes. We have come to this conclusion because:

- food is well presented and received in good condition with patients receiving the meal of their choice;
- patients are served quickly and efficiently with catering staff and nursing staff working well together;
- although ward staff comply with basic food hygiene practice, there is scope to provide simple guidance;
- compliance with the protected mealtime policy is not always observed; and
- not all patients have the opportunity to prepare for their meals.

18. The following table summarises the findings supporting the conclusion.

Delivery of food to the ward and patient

Expected practice	In place?	Further information
Meal service		
Food arrives at the ward at the right time	✓	The meal service generally started at the scheduled times, which had been agreed with ward managers. Regenerating food in ward kitchens at RGH and Rhymney block (PCH) does provide a little flexibility around meal start times. On the main wards at PCH, mealtimes are staggered because food trolleys are filled up in turn as patients' meals are plated up. Once the trolley is filled, it is delivered to the ward. Small changes to the start of mealtimes can be made by changing the ward's place in line when plating up the patients' meals.

Expected practice	In place?	Further information
Meal service (continued)		
Food arrives at the ward in a good state (eg, right temperature)	✓	Ward-based catering staff maintained temperature records for all food products regenerated or kept chilled. As part of the ward observation, we found temperatures greater than 80°C at the point of service on wards where food was regenerated (RGH wards and Rhymney block). Where we checked post service temperatures, these were greater than 65°C. Kitchen staff at PCH monitor and record food temperatures before plating up meals ready for delivery to wards. Heated trolleys and insulating dishes used in ambient trolleys keep the food hot. Food temperatures are not checked when the food trolley arrives on the ward. If the food trolleys are delivered at the agreed times and patients are served immediately, food is kept hot. Ward staff told us that complaints about cold food are not common. If patients do complain, then ward staff inform the kitchen immediately and the kitchen staff will replace meals and investigate why the problem occurred. Our patient survey found that: • more than two-thirds (67 per cent) told us that the food was always served at the temperature that they would expect compared with 53 per cent across Wales; and • a small number of patients (14 per cent) told us that they never or rarely received food at the temperature they would expect, which is similar to the average for Wales (16 per cent); several patients commented that the food could be warmer. These findings reflect the former Trust's 2009 baseline audit findings, where average temperatures of plated lunches at PCH were less than 65°C while those at suppertime were greater than 70°C. This compares with food temperatures of 74°C or greater at the end of service at the RGH.

Expected practice	In place?	Further information
Meal service (continued)		
Food is delivered to the patient quickly and efficiently	✓	Meal services were quick and efficient at both the RGH and the PCH. The time taken to serve meals ranged from 10 minutes to 30 minutes, regardless of the service model in place ie, ward-based catering staff serving meals or nursing staff serving the traditional plated meal. Our patient survey found that: • half of the patients who needed help with eating received it soon enough after their meal arrived.
Staff involved in serving food have been trained in food presentation	✓	Ward-based catering staff receive training in food presentation and the impact of this training was observed during mealtimes.
Dedicated staff (hostesses, housekeepers or ward-based caterers) are present to help serve the meals and are familiar with processes to meet patients' nutritional requirements	✓	Ward-based catering staff regenerate and plate up patient meals on wards at RGH and Rhymney block (PCH), assisted by nursing staff, while plated meals on the other wards at PCH are given out by nursing staff. The dietetic department works closely with the catering managers to ensure that ward-based catering staff have the necessary basic understanding about nutrition and the importance of different therapeutic or modified texture diets.

Expected practice	In place?	Further information
Meal service (continued)		
Staff involved in serving food have been trained in food hygiene	✓/✗	The Health Board recognises it needs to demonstrate compliance with safe food handling. One of the actions highlighted in the Facilities Action Plan/Scorecard is the need to 'carry out a catering service and food handlers training needs analysis to clearly identify the LHB's requirements'. At the time of our audit, the needs analysis had been undertaken at PCH where one-third of staff were found to need training. The needs analysis had yet to be applied at RGH and the CPU, where staff, in particular the ward-based catering staff, were reportedly up to date with training in relation to food hygiene. Nursing staff, who help by giving patients their meals, do not receive training or guidance in food hygiene. Awareness training is available for non-catering staff, who may be engaged in serving meals but advice from the local EHOs suggested that formal training in food hygiene for nursing staff was not necessary. Nursing staff reportedly have access to an e-learning package, which has a section on food safety and hygiene. We observed ward-based catering staff and nursing staff following safe food hygiene practices at mealtimes by hand washing and wearing aprons and gloves when handling food during the meal service.

Expected practice	In place?	Further information
The patient experience		
Arrangements are in place to ensure that patients receive the right meal	✓	A bed plan system is in place, whereby nursing staff identify the dietary requirements of each patient. Ward-based catering staff use the bed plans to take meal orders from those patients able to eat and to highlight those patients needing special diets. However, ward-based catering staff told us that bed plans were not always used nor were they updated. Bed plans identify the bed number but not the name of the patient. Consequently, bed plans should be updated before meal services to reflect changes in the number of patients eating, changes in patients' dietary requirements, patient discharges and bed moves within or between wards. We observed a bed plan compiled on the back of a scrap piece of paper by the ward-based catering assistant. However, we also observed a senior nurse updating ward-based catering staff about changes in the bed plan as meal preparations began. When ward-based catering staff do not have a bed plan, they rely on the ward 'white board' to check if a patient is 'nil by mouth' while waiting to check a patient's status with nursing staff. If there was any doubt about a patient's status, ward-based catering staff did not serve patients until a nurse became available to serve the meal. Where a ward consistently fails to complete a bed plan, the catering manager will raise the issue with the senior nurse manager to rectify it. Our patient survey found that: • Sixty-nine per cent of patients always got the meal that they ordered compared with 56 per cent across Wales.

Expected practice	In place?	Further information
The patient experience (continued)		
Protected mealtimes arrangements are in place	✓/✗	The patient information booklet provides patients with an explanation of protected mealtimes and sets out what they can expect, namely that they should be able to eat their meals in a relaxed environment and without interruptions. Wards are expected to comply with the protected mealtime policy and the policy was recently extended to cover breakfast time. At the RGH, protected mealtimes were introduced in late 2009 but had been operating longer at PCH. At the time of our audit, two of the four wards visited at the RGH did not display signage about protected mealtimes while one ward – Ward 15 – displayed signage on its outer ward doors and on the doors into patient bays. Despite the signage, medical staff were still trying to see patients during mealtimes. We did not observe any signage on the three wards we visited at the PCH but the application of protected mealtimes was more effective with medical staff apologising for the need to visit during mealtimes. In addition, the ward environment at PCH was quieter with activity centred on the meal service. Nursing staff at both hospitals were not afraid to enforce the protected mealtime policy and were observed challenging medical staff, ambulance crews, visitors or others if they were found entering the ward or interrupting patients during mealtimes. At RGH, ward-based catering assistants perceived that doctors were always on the wards during mealtimes while nursing staff commented that getting other departments to take protected mealtimes seriously was more difficult. For example, nursing staff cited examples of patients being called for diagnostic tests during mealtimes because the patients were 'nil by mouth' and protected mealtimes did not apply to them. Our patient survey found that: • two-thirds (63 per cent) of patients reported that their meals were always free from disturbance compared with 50 per cent across Wales; and • eighty-four per cent of patients were always given enough time to finish their meals compared with 77 per cent across Wales.

Expected practice	In place?	Further information
The patient experience (continued)		
The patient environment is prepared to receive the meals	✓/✗	The majority of wards try to de-clutter bedside tables, including removing potential clinical waste ie, urine bottles, before mealtimes. On two wards we visited, patients had returned from theatre shortly before mealtimes, necessitating some 'clutter'. On some wards, nursing staff were observed preparing the bedside environment in advance of the meal service but comments from the ward-based catering assistants at RGH suggest this was not usual practice. On one ward at RGH, we heard nursing staff say 'we had better follow procedures as the auditors are on the ward'. If ward-based catering staff have difficulty finding space to set a patient's meal on the table, they will ask patients to move their belongings or seek permission to move belongings or them or ask nursing staff for help. Our patient survey found that: • most (87 per cent) patients responding to our survey reported that the area in which they ate their food was always clean and tidy compared with 69 per cent across Wales.

Expected practice	In place?	Further information
The patient experience (continued)		
Patients have the opportunity to prepare for their meals by washing their hands before eating and getting into the correct position to eat (in bed or out of bed)	✓/✗	The wards we visited had different ways of organising their work to help patients get ready for mealtimes. For example, on Ward 10 at the PCH, nursing staff carry out a pressure care round between 4 pm and 5 pm and during this time, staff assist patients to sit up or get out of bed in readiness for supper. We observed nursing staff on other wards, systematically going round to help patients to sit up in bed or get out of bed prior to the meal service. We also observed patients being offered hand wipes or alcohol gel or encouraged to walk to the toilet or hand basin. Our patient survey found that: • three-quarters (76 per cent) of patients always had the chance to wash their hands before their meal compared with two-thirds (65 per cent) across Wales; and • three-fifths (61 per cent) of patients needed help to get comfortable before eating their meals and two out of three of these patients always received the help they needed; across Wales 64 per cent of patients needed help getting comfortable but only one in four always got the help they needed. An extended role for ward-based catering staff is being piloted on Wards 11 and 12 at PCH as part of the work to Free to Lead Free to Care. In addition to taking patient orders, regenerating food, and plating up meals on the ward, these staff will: • take over responsibility from the domestic staff for providing drinks; • take over tidying around the bedside in advance of patient meals, with the exception of handling clinical waste; • provide patients with hand wipes or alcohol gel to clean their hands before meals; and • complete the All Wales Food and Fluid Chart as they clear up after meals and drink rounds on the basis that they can see what patients have had to eat or drink; the lead nurse responsible for standardising care and procedures in relation to nutrition has given training to ward-based catering staff in advance of the pilot rolling out.

19. Appendix 3 provides detailed analysis of responses to our patient survey.

Meeting patients' nutritional needs and supporting recovery

20. The Health Board's catering service is flexible and innovative to ensure most patients receive the nutrition that they require but nutritional screening on admission and care plans to manage nutritional risks are not comprehensive. We have come to this conclusion because:

- patients are not always screened on admission in relation to nutritional risk and the information recorded as part of the screening process is not always comprehensive;
- nutritional care plans are not in place for all patients;
- all patients identified as high risk are referred for a nutritional assessment by a dietician;
- the menu provides a wide choice of food to meet patients' dietary requirements and innovations like the puree meal service and pictorial menu ensure patients with special dietary needs are not neglected;
- replacement meals are available for patients who miss meals but the availability of snacks between meals is limited to patients at risk; and
- help is readily available for patients needing assistance at mealtimes.

21. The following table summarises the findings supporting the conclusion.

Meeting patients' nutritional needs and supporting recovery

Expected practice	In place?	Further information
Nutritional screening and care planning		
Patients are weighed and undergo nutritional screening within 24 hours of admission, supported by a validated nutritional screening tool	✓/✗	The Health Board has adopted the MUST[6] as its standard nutritional screening tool for use across its hospitals. The lead nurse, with support from dietetic staff, provided training for MUST.

[6] The Malnutrition Universal Screening Tool (MUST) has been designed by the Malnutrition Advisory Group (MAG) of the British Association for Parenteral and Enteral Nutrition (BAPEN) as an effective way of identifying adults (particularly the elderly) who are malnourished, at risk of malnutrition, or obese. The tool also includes guidelines for introducing an effective and suitable treatment plan.

Expected practice	In place?	Further information
Nutritional screening and care planning (continued)		
Patients are weighed and undergo nutritional screening within 24 hours of admission, supported by a validated nutritional screening tool	✓/✗	Our case note review found that: • Thirty-one out of 35 patients had been screened on admission using the MUST or the Birmingham Heartland's[7] screening tools. • Thirty-three out of the 35 patients were weighed within 24 hours of admission, or shortly thereafter, if their condition permitted. • Only 20 out of the 35 nursing records reviewed included any measurement of height sometimes because of a lack of equipment or the condition of patient precluded physical measurement. • Four out of the seven wards we visited had a stadiometer, with three relying on a tape measure. In many cases, height was self-reported with no evidence that alternative calculations for height were used. The MUST monitoring form developed by the Health Board records whether the BMI is estimated or actual. Although BMI was recorded for all but one patient, it was not clear that this measurement was seen as relevant. Our case note review found that the level of detail recorded about 'Nutrition' on the 'Admission/ 24-hour Nursing Assessment' form was variable. Although the form prompts nurses to describe the problem on admission, descriptions were weak. For example, some forms simply stated 'normal diet'. A further eight items, such as any assistance required for 'eating and drinking' require nurses to circle yes or no without necessarily prompting for a description of the problem and what help is needed. Our patient survey found that: • nearly half (48 per cent) the patients told us that hospital staff had talked to them about their dietary needs compared with 41 per cent across Wales; • seven out of ten (71 per cent) patients reported being weighed during their hospital stay compared with 66 per cent of patients across Wales; and • Forty per cent of patients reported having their height measured compared with 31 per cent across Wales.

[7] The Birmingham Heartland's nutrition screening tool was being withdrawn from use on wards at RGH at the time of our audit and the MUST tool introduced.

Expected practice	In place?	Further information
Nutritional screening and care planning (continued)		
A nutritional care plan is prepared and implemented, informed by a patients' nutritional risk score	✓/✗	The Health Board developed a nursing care plan, which sets out a number of prescribed actions depending upon the MUST risk score. The care plan is used for all patients, even when classified as at low risk of malnutrition. However, we found that a care plan was in place for only 23 of the 35 case notes reviewed and care plans included little information to assess a patient's progress. There was evidence, gleaned from the MUST monitoring form, that patients were rescreened weekly if at low risk and more frequently if at medium or high risk, even in the absence of the care plan. Although we did not audit the completion of the all-Wales food charts, we did observe staff completing these for those patients whose food intake was being monitored.
Where appropriate, patients are referred to a dietician	✓	There was evidence that all patients identified as at high risk of malnutrition were referred to the dietician. Ward staff told us that they have good working relationships with dietetic staff and can ask for advice about patients whose risk score does not trigger a referral.

Expected practice	In place?	Further information
Food choice and availability (continued)		
Menu provides patients with a good choice of food	✓	The Health Board operates a two-week menu cycle with at least three main choices – two meat options and one vegetarian option. According to dietetic staff, the choice of meals has expanded in recent years, with more choice for patients with special dietary needs, such as vegetarian or gluten-free diets. Patients, however, had mixed views. Our patient survey found that: • sixty-five per cent of patients told us that there was always enough choice compared with 46 per cent across Wales; one patient commented that there was not enough choice for diabetic patients; and • forty per cent of patients reported that the menu always changed often enough compared with 29 per cent across Wales. All patients are encouraged to choose foods from the daily menu but patients are offered alternatives by ward-based catering staff and nursing staff to encourage eating. If necessary, food from the staff/visitor dining room can be sent to the wards for patients. A new breakfast system was introduced on the main wards at PCH, whereby catering staff assist nursing staff to serve breakfast by making toast, porridge or scrambled eggs in the wards' kitchens.

Expected practice	In place?	Further information
Food choice and availability (continued)		
Menu contains options for patients with specific religious, cultural, lifestyle or medical needs	✓	The menu provides options to meet the needs of patients with specific dietary requirements. Our patient survey found that: • forty-nine per cent of patients reported needing a special diet and of these patients, more than two-thirds (47 out of 68) were always given food suitable for their dietary needs; a similar proportion of patients across Wales (48 per cent) needed a special diet but just under half told us that they were always given food suitable for their dietary requirements; • nine per cent of patients needed a vegetarian meal and two-thirds (8 out of 12 patients) told us that there was always enough choice to meet their needs; across Wales 14 per cent of patients needed a vegetarian diet but only one in three reported enough choice to meet their needs; • twenty-nine per cent of patients required a diet suitable for their religious beliefs and most of these patients (29 out of 39) told us that there was always enough choice to meet their needs; 35 per cent of patients across Wales required a diet suitable for their beliefs and, of these patients, nearly three-quarters always had enough choice to suit their needs; and • sixteen per cent of patients had a food allergy and more than half of these patients (12 out of the 21) told us that there was always enough choice to meet their needs; 16 per cent of patients across Wales had a food allergy but less than half had enough choice to meet their needs. At PCH, colour-coded menu cards are used to indicate specific dietary requirements, eg, blue for high protein.

Expected practice	In place?	Further information
Food choice and availability (continued)		
Menu contains options for patients with specific religious, cultural, lifestyle or medical needs	✓	In addition, a 14-day menu coded folder is available on every ward at RGH and Rhymney block (PCH), which ward-based catering staff can use to check the ingredients of the different foods produced by the CPU and their suitability for patients with special dietary needs, such as nut allergies, wheat intolerances, diabetes, etc. Several years ago, the dietetic department at PCH was successful in getting funds to develop a puree meal service for patients recovering from strokes. The funds funded the development of a range of puree meals and desserts formed to look like their pre-puree state. A pictorial menu was designed to help patients with communication difficulties choose meals that look appetising. The Health Board is currently trialling ways of regenerating these meals so patients can receive the same high standard of meals at any of the Health Board's hospitals. When the CPU expands, it hopes to provide the same puree meal service across the whole Health Board.

Expected practice	In place?	Further information
Food choice and availability (continued)		
Patients are able to get snacks outside of mealtimes	✓	Arrangements are in place to provide snacks outside of mealtimes but these tend to be for patients with special dietary requirements, such as diabetics, or those screened as at high risk of malnutrition. At RGH, a range of sandwiches is available on wards for patients needing a snack or hot meals can be obtained from the dining room. At PCH, if the dining room is still open, hot meals can be obtained or outside these hours ward staff can get snacks for patients using a free vending fob. If patients miss a meal, nursing staff are meant to record this using the incident reporting system. However, we were told that few, if any, of these types of incident had been recorded so far. The patient information booklet also sets out what patients should do if they are hungry outside of mealtimes. Our patient survey found that: • the majority (71 per cent) of patients who missed a meal were able to get a replacement; this varied by hospital with a greater number of patients at PCH able to get a replacement meal despite the limited opening hours of the restaurant; • half the patients told us that never or rarely were snacks available between mealtimes but a couple of patients commented that they did not get snacks when others did; and • more than three-quarters (77 per cent) were happy with the time meals were served compared with 59 per cent across Wales but a couple of patients commented on the long a gap between supper at 5 pm and breakfast the next morning at 8 am.

Expected practice	In place?	Further information
Help with eating		
Arrangements are in place to identify patients who may need specific help eating their food	✓	The Health Board does not operate a red-tray system, common in other hospitals. Instead, nursing staff use the nutritional care plan to identify patients who need help at mealtimes. The care plan sets out a number of prescribed actions seen as routine care for all patients, regardless of the MUST risk score. However, care plans were not always used, there was little detail on admission assessment forms about the help needed and care plans lacked information to assess a patient's progress.

Expected practice	In place?	Further information
Help with eating (continued)		
Patients are given assistance to eat if required	✓	The patient information booklet sets out what patients can expect in relation to their care, such as 'should they require assistance at mealtimes, this will be quickly provided to ensure they are able to enjoy a warm appetising meal'. We observed staff assisting those patients who needed help on the wards we visited. By assisting ward-based catering staff with the meal service, nursing staff were able to assist patients at the point of service, from simply cutting up food or with help eating. We also observed ward-based catering staff assisting patients by opening food packaging and cutting up food. Ward-based catering staff would also alert nursing staff if patients did not eat or drink regardless of whether these patients were identified as needing help or a special diet. Our patient survey found: • Seventeen per cent of patients needed help when eating and most (14 out of 17 patients) reported that they always got the help they needed but three patients never or rarely got the help they needed. Across Wales, 18 per cent of patients needed help with eating but less than half of these patients got the help they needed. The Health Board has also been piloting a volunteer scheme at mealtimes to help patients who do not have complex swallowing problems. Volunteers provide encouragement to patients to eat, assist with cutting up food or opening packaging, ensure they are ready to eat and help them wash their hands if necessary. The Health Board would like to expand the scheme and at the time of our audit was putting in a bid for lottery money in order to recruit and train more volunteers.

Gathering views from patients

22. Patients' views are actively sought and overall satisfaction with catering services is relatively high. We have come to this conclusion because:

- patients' views are actively sought but more could be done to publicise how their views contribute to service improvements; and
- patients are generally satisfied with the food they receive.

23. The following table summarises the findings supporting the conclusion.

Gathering views from patients

Good practice	In place?	Further information
There are regular activities to capture patients' views and experiences of catering services	✓	There are a number of formal and informal mechanisms in place to capture patients' views. The frequency of gathering patient feedback at both hospital sites differed prior to the former Trust merger in 2008, with patient satisfaction surveys conducted annually at PCH and quarterly at RGH. A baseline audit was conducted in early 2009 and reported to the Catering and Nutrition Group. The findings stated that from the patient perspective the overall service and mealtime experience were of a very good quality and standard. At the time of our audit in April 2010, the Health Board intended rolling out its catering service audit tool procedure to cover 20 per cent of wards on a monthly basis. The audit tool includes questions for patients about their views on the choice and quality of food available, the environment in which they eat their meals, interruptions to mealtimes and the help available at mealtimes. Less formal mechanisms included: • Feedback from ward-based catering staff to their supervisors or the catering manager on the quality of the food served. For example, ward-based catering staff raised concerns about the sinew in the roast beef served to patients. The catering manager raised their concerns with the CPU manager, who subsequently changed the cut of meat used in the recipe. • Ward visits by catering managers and supervisors to ask nursing staff for their views about the catering service or any concerns raised by patients. • Routine ward visits by catering supervisors during mealtimes to assess ward-based catering staff at work, assess the quality of service, check whether food is consumed, and if not why not, and gather any informal feedback from patients.

Good practice	In place?	Further information
There are regular activities to capture patients' views and experiences of catering services	✓	If a patient complains about the food, nursing staff can, and will, contact the catering department to give the catering managers or their staff an opportunity to meet with the patient to resolve their concerns and provide alternatives. The management arrangements for the patient experience team had been revised at the time of our audit and the patient experience manager now reports to the lead nurse responsible for Fundamentals of Care and Healthcare Standards instead of reporting to the Human Resource department. In future, the patient experience team will take a more active role in supporting audits on Fundamentals of Care, catering services, patient surveys and patient stories to ensure patients' experiences drive service improvements. Our patient survey found that overall satisfaction with the catering service was high and: • sixty-three per cent said the taste of food was good or excellent while 27 per cent felt the taste was acceptable; and • sixty-eight per cent said the appearance of food was good or excellent while 27 per cent felt it was acceptable.
There are effective and co-ordinated arrangements in place to use patients' views and all staff group experiences to support service improvement	✓/✗	Although there are a number of mechanisms in place to get patients' views, it is not clear how these views are currently used to support service improvement. However, patients' views and experiences are shared between staff groups through attendance at various meetings, like the catering and nutrition group.
Service users are represented on catering planning groups	✓	The Community Health Council (CHC) represents patients on the Catering and Nutrition Group but catering staff told us that CHCs have been less visible because of the recent reorganisation of CHCs.
Service users participate in quality reviews of the service	✓	The CHC currently represents patients in relation to quality reviews of the catering services.

Appendix 1

Audit approach

The audit sought to answer the question: 'Are hospitals in Wales providing efficient catering services that meet recognised good practice?' in particular:

- Are strategic planning arrangements relating to catering effective?
- Are procurement arrangements effective and is food sourced from safe suppliers?
- Is food production well controlled?
- Are there efficient arrangements to deliver the food to the ward, and to the patient?
- Do the arrangements at ward level help meet patients' nutritional needs and support their recovery?
- Are there effective arrangements in place to consult patients about the catering service they receive?

We carried out a number of audit activities to address these questions, which are set out in the table below. We carried out the ward-based audit activities on Wards 1, 8, 15 and 20 at RGH and Wards 10, 11 and 35 at PCH.

Audit activities

Questions	Audit activities
1. Strategic planning arrangements	Analysis of financial data Documentation review Case note review Patient experience survey Interviews with staff
2. Procurement arrangements	Process walkthrough Documentation review Interviews with staff
3. Production control	Process walkthrough Analysis of financial data Observation of wastage – un-served meals and plate waste Patient experience survey Interviews with staff
4. Ward delivery arrangements	Observation of the meal service Taste testing a meal Patient experience survey Interviews with staff

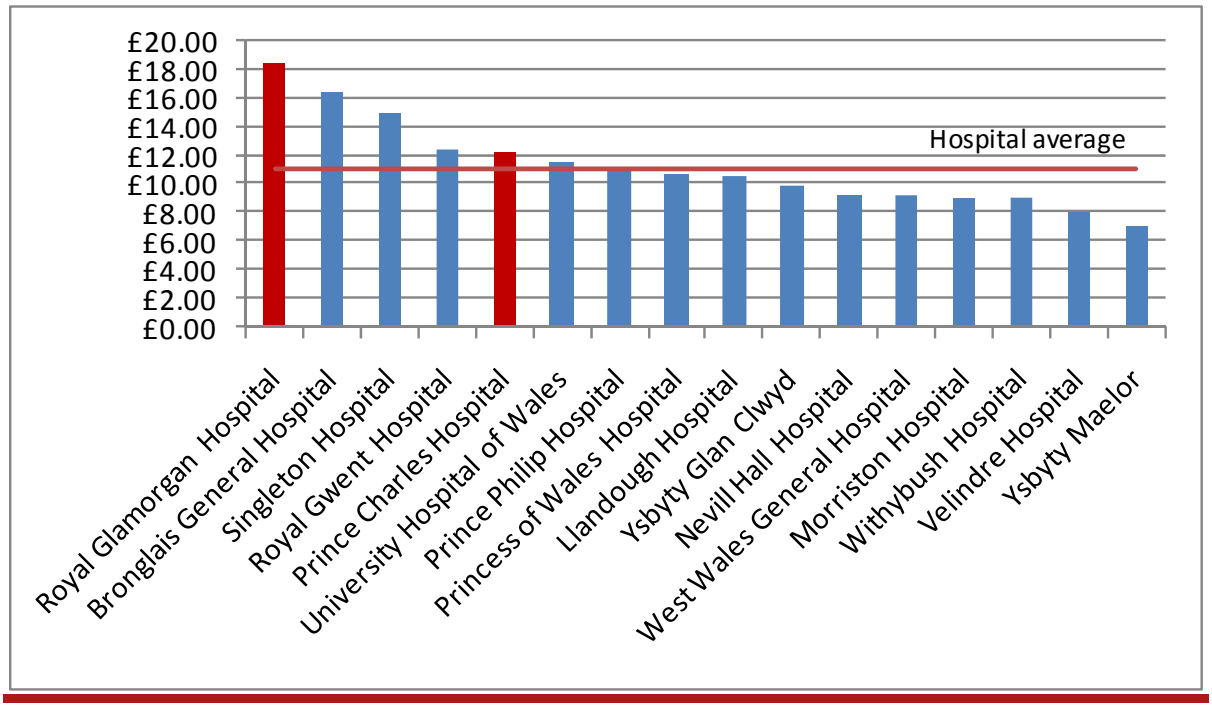
Questions	Audit activities
5. Supporting recovery	Observation of the meal service Observation of wastage – un-served meals and plate waste Taste testing Case note review Patient experience survey Interviews
6. Patient engagement	Patient experience survey Interviews

Financial data

The gross cost of catering services at PCH and RGH was £5.10 million in 2008-09 with patient catering services accounting for just three-fifths (£3.17 million) of the expenditure[8]. Staff costs are the biggest driver of costs for patient and non-patient catering services, comprising more than three-fifths (62 per cent) of expenditure.

The gross cost of catering services was offset by income totalling £1.13 million generated from non-patient catering services, namely the staff/visitors' restaurant, hospitality and vending machines. Net costs of catering services totalled £3.97 million in 2008-09. Net costs per patient day at RGH (£18.41) were the highest in Wales, considerably higher than the Welsh average (£11.08) while net costs per patient day at PCH were £12.27.

Exhibit 1: Net costs of hospital catering services per patient day in 2008-09



Source: Wales Audit Office analysis of financial and activity data provided by Health Boards and Velindre NHS Trust

[8] CPU staff costs in relation to food production totalled £490,000 in 2008-09; 45 per cent of these costs were added to the overall costs reported by RGH on the basis of the number meals produced for RGH in 2008-09. Meals were not produced for PCH during 2008-09.

Although both hospitals generated substantial income, it was only enough to recover 59 per cent of the total cost of non-patient catering services (Exhibit 2). The cost of provisions – food and beverages – and consumables was fully met but not the cost of staff providing the service.

Exhibit 2: Cost of non-patient catering services in 2008-09 and income generated

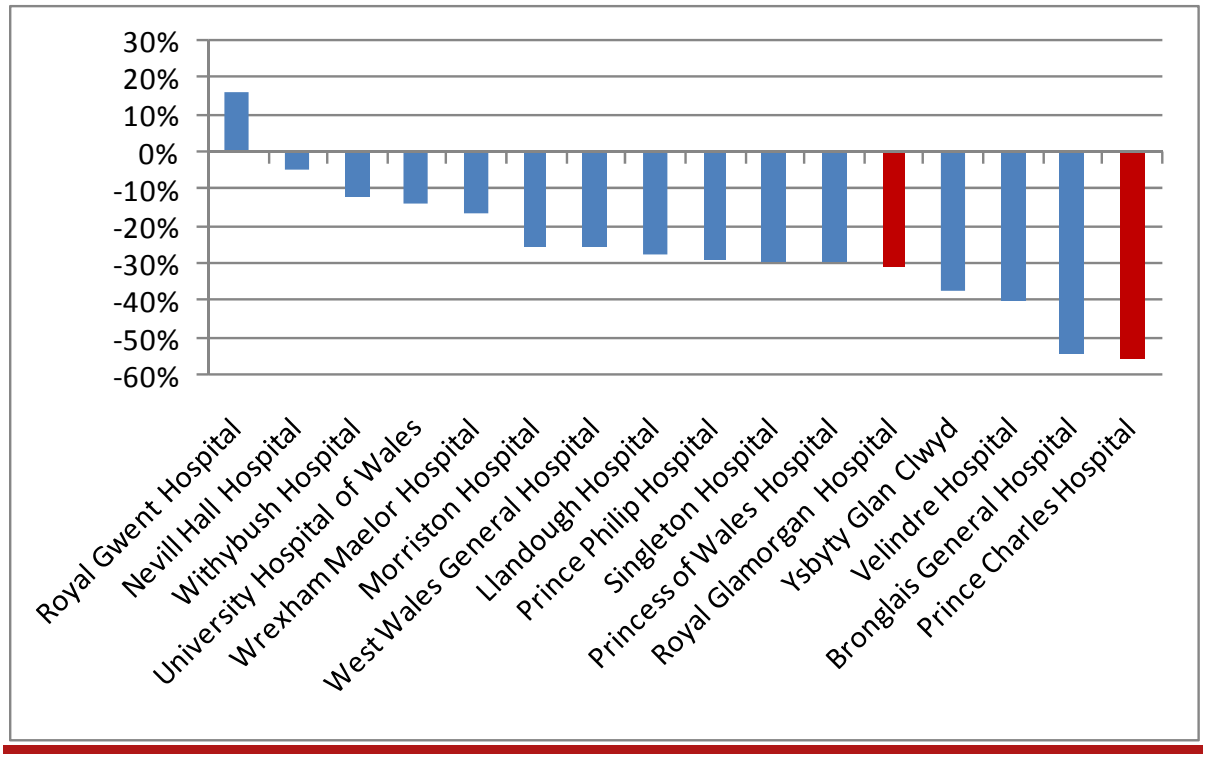
Costs and income	PCH	RGH	Both hospitals
Staff	*£538,334*	*£706,481*	*£1,244,815*
Provisions	*£263,630*	*£363,395*	*£627,025*
Other consumables	*£11,189*	*£44,724*	*£55,913*
Total costs	**£813,153**	**£1,114,600**	**£1,927,753**
Income	**£364,451**	**£770,722**	**£1,135,173**
Gap	**-£448,702**	**-£343,878**	**-£792,580**

Source: Wales Audit Office analysis of financial and activity data provided by the Health Board

The catering departments are expected to generate at least the same level of income as the preceding year but the current economic climate is likely to make it harder in future. Requests for internal hospitality are reportedly falling as other NHS staff look to cut costs, while the implementation of the NHS Wales healthy vending machine policy has contributed to falls in income from vending machine sales. In addition, there has been a reliance on income generation to meet budget shortfalls but this strategy is not sustainable because non-patient catering services do not break even.

Across Wales, only one hospital (RGH) was able to recover all non-patient catering costs and make a surplus. The PCH had the biggest shortfall in income and it will need to double its income in order break even in future (Exhibit 3).

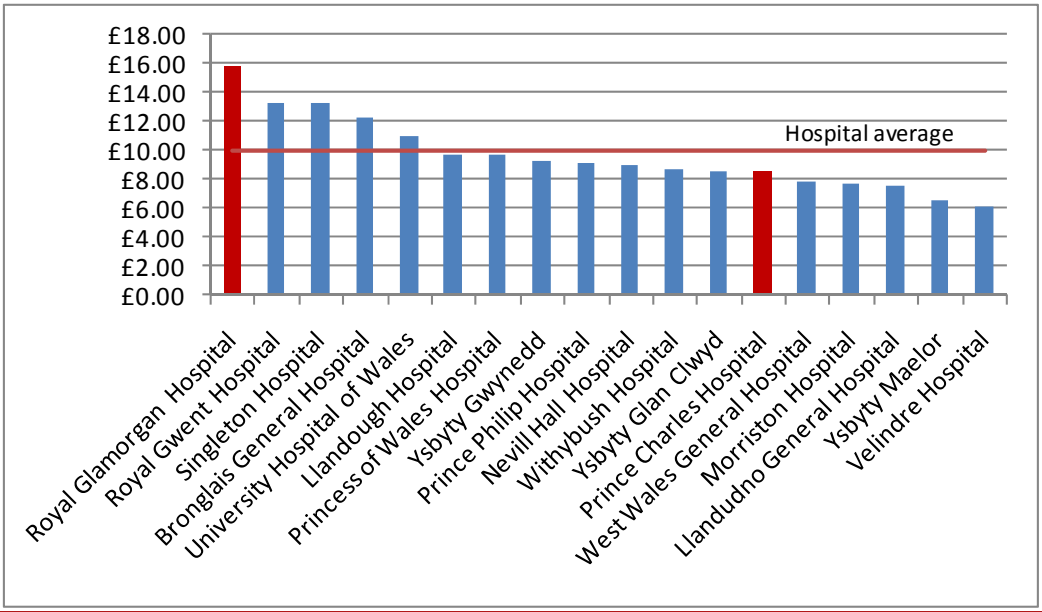
Exhibit 3: Percentage difference in income and costs for non-patient catering services in 2008-09



Source: Wales Audit Office analysis of financial and activity data provided by Health Boards and Velindre NHS Trust

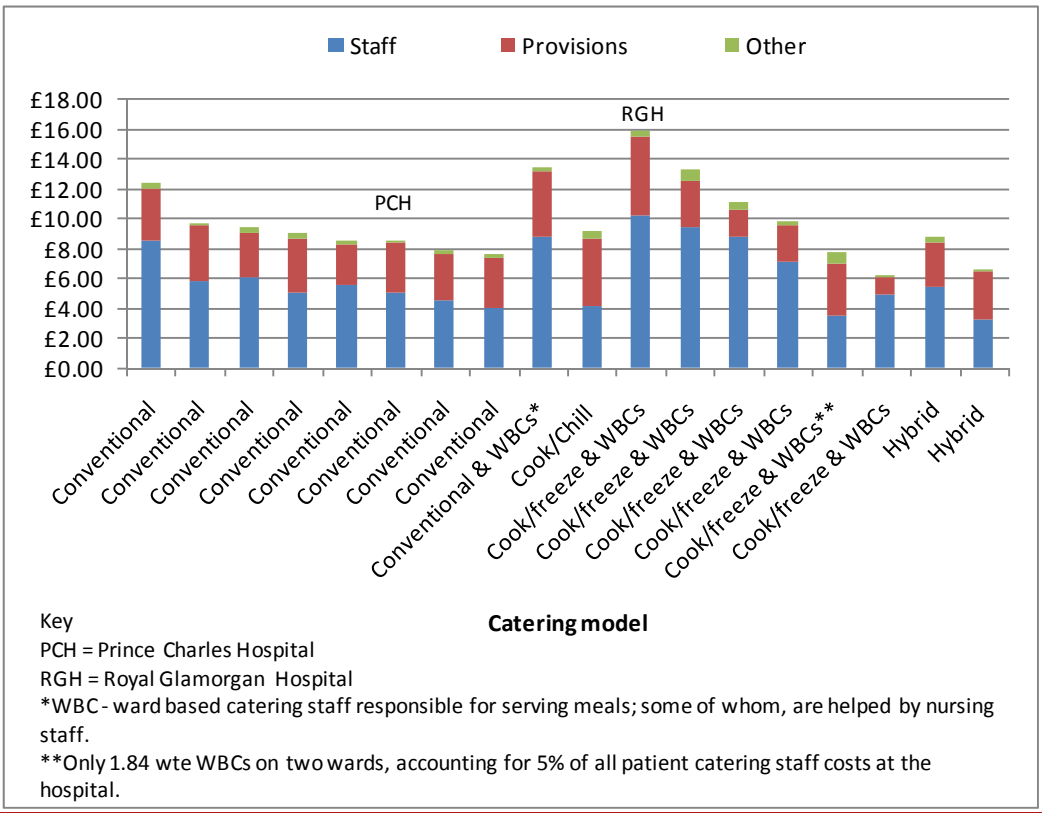
The average cost of catering services for patients per patient day was £10.04 across hospitals in 2008-09, ranging from £6.12 to £15.87 per patient day (Exhibit 4). Costs per patient day at RGH (£15.87 per patient day) were the highest in Wales while those at PCH were lower than the average (£8.52 per patient day). However, there are big differences across hospitals, which are not easily explained by the different service models (Exhibit 5). The higher costs associated with staff at RGH are likely to reflect the long-established ward-based catering service and the longer opening hours of the staff/visitor restaurant compared with the arrangements at PCH. Equally, the impact of changes to the pay bands of catering staff at PCH had not taken effect in 2008-09 and in the future differences in staff costs may narrow as the ward-based catering service is established across PCH. Provision costs per patient day at RGH (£5.23) were considerably more compared with PCH (£3.31).

Exhibit 4: Cost of catering services for patients per patient day in 2008-09



Source: Wales Audit Office analysis of financial and activity data provided by Health Boards and Velindre NHS Trust

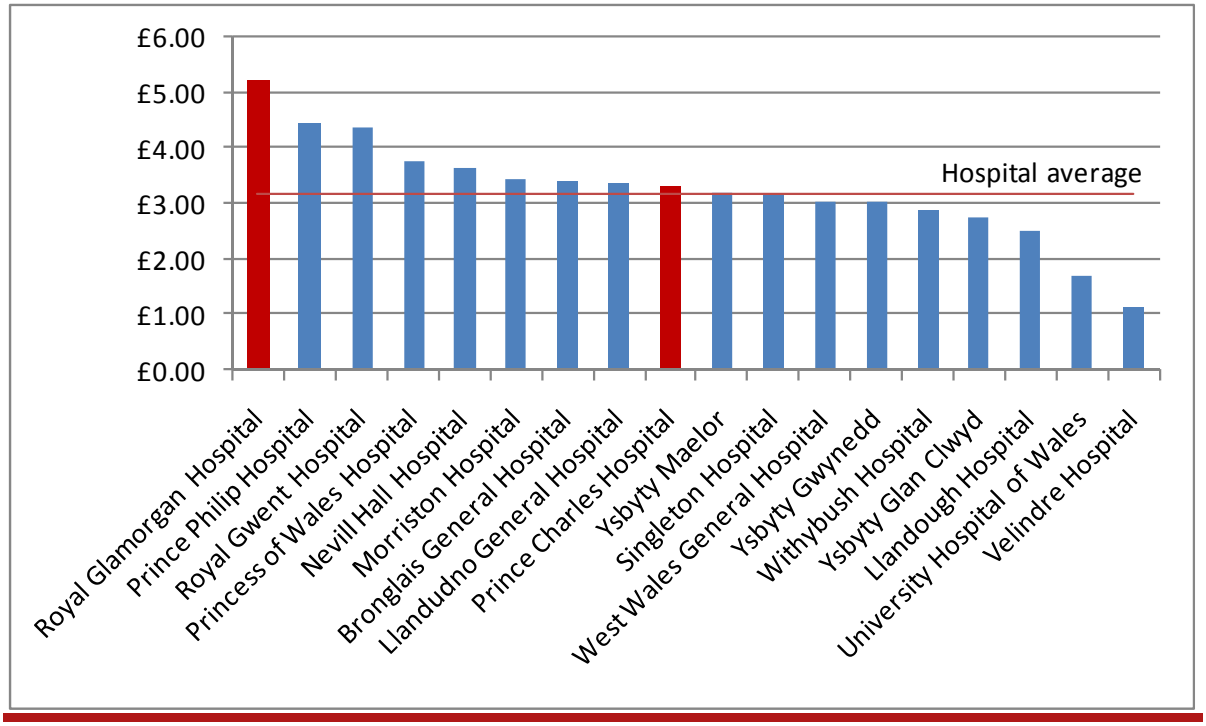
Exhibit 5: Breakdown of costs of catering services for patients per patient day with models of provision in 2008-09



Key
PCH = Prince Charles Hospital
RGH = Royal Glamorgan Hospital
*WBC - ward based catering staff responsible for serving meals; some of whom, are helped by nursing staff.
**Only 1.84 wte WBCs on two wards, accounting for 5% of all patient catering staff costs at the hospital.

Source: Wales Audit Office analysis of financial and activity data provided by Health Boards and Velindre NHS Trust

Exhibit 6: Costs of provisions per patient day in 2008-09



Source: Wales Audit Office analysis of financial and activity data provided by Health Boards and Velindre NHS Trust

Appendix 3

Patient experience

As part of this audit, we conducted a questionnaire survey to gather patients' views about the food they received during their stay in hospital. We specifically targeted patients on the seven wards where we carried out observations of the meal service and reviewed patients' case notes. At the request of the Health Board, we widened the survey to include patients in the community hospitals.

We relied upon ward staff to give each patient, where appropriate, the questionnaire survey and a reply-paid envelope for return to the Wales Audit Office. At the time of the audit, we had also publicised the survey in the local press inviting anyone who had been a patient in the last 12 months, or cared for someone who had been in hospital, to give their views on the food they received, via our on-line survey.

We received 694 responses from people across Wales, who were patients at the time of our audit or who had been a patient in the last 12 months. Of these, 139 questionnaires relate to the Health Board. The breakdown of responses across the Health Board is:

- Prince Charles Hospital – 80 responses
- Royal Glamorgan Hospital – 37 responses
- Community Hospitals – 22 responses

The tables below show a breakdown in the number of responses to each question by individual hospital. Percentages are not shown because total response is less than 100 for each hospital. Numbers and percentages are given when comparing the Health Board with the all-Wales response. [Please note that non-response to some questions means that the number of responses presented is less that the total number of questionnaires returned.]

Question 3: How long did you stay in hospital for?

Cwm Taf Hospitals	Less than one day	2-3 days	4-7 days	8-14 days	More than two weeks	Number of responses
Prince Charles Hospital	3	5	22	23	27	80
Royal Glamorgan Hospital	0	2	11	8	15	36
Community Hospitals	0	0	3	1	15	19
Cwm Taf Health Board	2%	5%	27%	24%	42%	135
Wales	2%	15%	28%	24%	32%	654

Source: Wales Audit Office Survey of Hospital Patients

Question 4: Were you weighed during your stay in hospital?

Cwm Taf Hospitals	Yes	No	Not sure	Number of responses
Prince Charles Hospital	49	26	4	79
Royal Glamorgan Hospital	34	2	1	37
Community Hospitals	22	0	0	22
Cwm Taf Health Board	76%	20%	4%	138
Wales	67%	30%	3%	685

Source: Wales Audit Office Survey of Hospital Patients

Question 5: Was your height measured during your stay in hospital?

Cwm Taf Hospitals	Yes	No	Not sure	Number of responses
Prince Charles Hospital	35	37	8	80
Royal Glamorgan Hospital	12	18	7	37
Community Hospitals	9	9	4	22
Cwm Taf Health Board	40%	46%	14%	139
Wales	32%	59%	9%	681

Source: Wales Audit Office Survey of Hospital Patients

Question 6: Did a member of the hospital staff talk to you about your dietary requirements?

Cwm Taf Hospitals	Yes	No	Not sure	Number of responses
Prince Charles Hospital	31	41	7	79
Royal Glamorgan Hospital	21	15	0	36
Community Hospitals	13	6	2	21
Cwm Taf Health Board	48%	46%	7%	136
Wales	41%	54%	5%	675

Source: Wales Audit Office Survey of Hospital Patients

Question 7: Were you given food that was suitable to your dietary needs?

Cwm Taf Hospitals	I did not require a special diet	Yes, always	Yes, most of the time	Rarely	Never	Don't know	Number of responses
Prince Charles Hospital	44	26	8	0	1	1	80
Royal Glamorgan Hospital	16	13	4	2	1	0	36
Community Hospitals	10	8	2	0	1	1	22
Cwm Taf Health Board	51%	34%	10%	1%	2%	1%	138
Wales	353 (52%)	154 (23%)	12%	4%	5%	3%	679

Source: Wales Audit Office Survey of Hospital Patients

Question 8a: Could you understand the menu?

Cwm Taf Hospitals	Yes, always	Yes, most of the time	Rarely	Never	Number of responses
Prince Charles Hospital	70	7	1	0	78
Royal Glamorgan Hospital	26	5	0	1	32
Community Hospitals	10	8	1	0	19
Cwm Taf Health Board	82%	16%	2%	1%	129
Wales	76%	19%	1%	3%	631

Source: Wales Audit Office Survey of Hospital Patients

Question 8b: Did you recognise the food options on the menu?

Cwm Taf Hospitals	Yes, always	Yes, most of the time	Rarely	Never	Number of responses
Prince Charles Hospital	67	8	1	0	76
Royal Glamorgan Hospital	24	5	0	1	30
Community Hospitals	10	7	0	1	18
Cwm Taf Health Board	81%	16%	1%	2%	124
Wales	74%	21%	3%	2%	609

Source: Wales Audit Office Survey of Hospital Patients

Question 8c: Was there enough choice on the menu?

Cwm Taf Hospitals	Yes, always	Yes, most of the time	Rarely	Never	Number of responses
Prince Charles Hospital	61	11	2	2	76
Royal Glamorgan Hospital	19	4	7	2	32
Community Hospitals	4	8	5	5	22
Cwm Taf Health Board	65%	18%	11%	7%	130
Wales	46%	27%	18%	9%	621

Source: Wales Audit Office Survey of Hospital Patients

Question 8d: Were you able to choose your portion size?

Cwm Taf Hospitals	Yes, always	Yes, most of the time	Rarely	Never	Number of responses
Prince Charles Hospital	53	7	3	12	75
Royal Glamorgan Hospital	24	3	3	5	35
Community Hospitals	5	9	2	5	21
Cwm Taf Health Board	63%	15%	6%	17%	131
Wales	46%	19%	8%	27%	623

Source: Wales Audit Office Survey of Hospital Patients

Question 9: Did the menu change often enough?

Cwm Taf Hospitals	Yes, always	Yes, most of the time	Rarely	Never	I was not in hospital long enough to tell	Number of responses
Prince Charles Hospital	34	31	5	3	7	80
Royal Glamorgan Hospital	15	6	7	2	7	37
Community Hospitals	4	8	5	5	0	22
Cwm Taf Health Board	38%	32%	12%	7%	10%	139
Wales	29%	39%	12%	5%	15%	670

Source: Wales Audit Office Survey of Hospital Patients

Question 10: Was there enough menu choice to suit your religious beliefs?

Cwm Taf Hospitals	Yes, always	Yes, most of the time	Rarely	Never	I have no beliefs which require a special diet	Number of responses
Prince Charles Hospital	16	3	0	0	61	80
Royal Glamorgan Hospital	8	2	0	0	24	34
Community Hospitals	5	2	1	2	11	21
Cwm Taf Health Board	21%	5%	1%	1%	71%	135
Wales	24%	6%	1%	3%	65%	658

Source: Wales Audit Office Survey of Hospital Patients

Question 11: If you are a vegetarian or vegan, was there enough choice to meet your needs?

Cwm Taf Hospitals	Yes, always	Yes, most of the time	Rarely	Never	I am not a vegetarian or a vegan	Number of responses
Prince Charles Hospital	4	1	0	0	73	78
Royal Glamorgan Hospital	3	0	0	0	28	31
Community Hospitals	1	1	2	0	15	19
Cwm Taf Health Board	6%	2%	2%	0%	91%	128
Wales	4%	4%	3%	3%	86%	628

Source: Wales Audit Office Survey of Hospital Patients

Question 12: If you have a food allergy, was there enough choice to meet your needs?

Cwm Taf Hospitals	Yes, always	Yes, most of the time	Rarely	Never	I do not have a food allergy	Number of responses
Prince Charles Hospital	7	3	0	1	68	79
Royal Glamorgan Hospital	2	3	0	0	26	31
Community Hospitals	3	1	1	0	14	19
Cwm Taf Health Board	9%	5%	1%	1%	84%	129
Wales	7%	5%	2%	2%	84%	630

Source: Wales Audit Office Survey of Hospital Patients

Question 13: How did you choose what meals to eat?

Cwm Taf Hospitals	I filled in a form	I chose food from a trolley	I told a member of staff	A family member chose for me	There was no choice	Other	Number of responses
Prince Charles Hospital	58	1	17	3	0	0	79
Royal Glamorgan Hospital	3	4	27	0	0	0	34
Community Hospitals	0	2	18	0	1	1	22
Cwm Taf Health Board	45%	5%	46%	2%	1%	1%	135
Wales	43%	15%	35%	2%	4%	2%	676

Source: Wales Audit Office Survey of Hospital Patients

Question 14: When did you choose what to eat?

Cwm Taf Hospitals	Before the day of a meal	On the day of the meal	From the trolley	There was no choice	Number of responses
Prince Charles Hospital	65	13	1	0	79
Royal Glamorgan Hospital	8	24	2	0	34
Community Hospitals	6	14	1	1	22
Cwm Taf Health Board	59%	38%	3%	1%	135
Wales	49%	30%	17%	4%	671

Source: Wales Audit Office Survey of Hospital Patients

Question 15: Were you given the chance to wash your hands before you ate food?

Cwm Taf Hospitals	Yes, always	Yes, most of the time	Rarely	Never	Number of responses
Prince Charles Hospital	62	9	4	5	80
Royal Glamorgan Hospital	29	5	2	0	36
Community Hospitals	14	3	2	3	22
Cwm Taf Health Board	76%	12%	6%	6%	138
Wales	65%	19%	8%	8%	685

Source: Wales Audit Office Survey of Hospital Patients

Question 16: Did a member of staff help you get comfortable before you ate your food?

Cwm Taf Hospitals	Yes, always	Yes, most of the time	Rarely	Never	I did not need help to get comfortable	Number of responses
Prince Charles Hospital	33	12	3	1	30	79
Royal Glamorgan Hospital	12	4	2	1	17	36
Community Hospitals	8	4	1	3	6	22
Cwm Taf Health Board	39%	15%	4%	4%	39%	137
Wales	28%	19%	7%	9%	36%	677

Source: Wales Audit Office Survey of Hospital Patients

Question 17: Where did you eat most of your meals?

Cwm Taf Hospitals	In a chair near my bed	In a communal dining area	In bed	Other	Number of responses
Prince Charles Hospital	67	0	13	0	80
Royal Glamorgan Hospital	23	0	14	0	37
Community Hospitals	12	6	4	0	22
Cwm Taf Health Board	73%	4%	22%	0%	139
Wales	68%	3%	28%	1%	689

Source: Wales Audit Office Survey of Hospital Patients

Question 18: Was the area where you ate your food clean and tidy?

Cwm Taf Hospitals	Yes, always	Yes, most of the time	Sometimes	Never	Number of responses
Prince Charles Hospital	70	9	0	0	79
Royal Glamorgan Hospital	28	7	1	0	36
Community Hospitals	21	1	0	0	22
Cwm Taf Health Board	87%	12%	1%	0%	137
Wales	70%	25%	5%	1%	687

Source: Wales Audit Office Survey of Hospital Patients

Question 19: If you needed eating aids, were you provided with them?

Cwm Taf Hospitals	Yes, always	Yes, most of the time	Rarely	Never	I did not need them	Number of responses
Prince Charles Hospital	1	4	0	2	71	78
Royal Glamorgan Hospital	0	2	1	0	32	35
Community Hospitals	8	4	1	3	6	22
Cwm Taf Health Board	3%	6%	2%	2%	88%	133
Wales	6%	5%	1%	4%	83%	671

Source: Wales Audit Office Survey of Hospital Patients

Question 20: If you needed help when eating, were you given it?

Cwm Taf Hospitals	Yes, always	Yes, most of the time	Rarely	Never	I did not need help	Number of responses
Prince Charles Hospital	8	4	2	1	64	79
Royal Glamorgan Hospital	1	0	0	0	32	33
Community Hospitals	5	2	0	0	13	20
Cwm Taf Health Board	11%	5%	2%	1%	83%	132
Wales	9%	5%	2%	2%	82%	667

Source: Wales Audit Office Survey of Hospital Patients

Question 21: If someone helped you to eat your food, who was it?

Cwm Taf Hospitals	Carer/ volunteer	Family member	Friend	Nurse	I did not need help	Number of responses
Prince Charles Hospital	0	1	2	6	68	77
Royal Glamorgan Hospital	0	1	0	1	33	35
Community Hospitals	1	1	0	4	15	21
Cwm Taf Health Board	1%	5%	1%	6%	87%	133
Wales	1%	5%	1%	6%	87%	657

Source: Wales Audit Office Survey of Hospital Patients

Question 22: If someone helped you to eat, was this soon enough after your food arrived?

Cwm Taf Hospitals	Yes, always	Yes, most of the time	Rarely	Never	I did not need help	Number of responses
Prince Charles Hospital	6	5	0	0	68	79
Royal Glamorgan Hospital	1	0	0	0	32	33
Community Hospitals	3	3	0	1	15	22
Cwm Taf Health Board	7%	6%	0%	1%	86%	134
Wales	7%	5%	2%	1%	85%	658

Source: Wales Audit Office Survey of Hospital Patients

Question 23a: Were you happy with the time your meals were served?

Cwm Taf Hospitals	Yes, always	Yes, most of the time	Rarely	Never	Number of responses
Prince Charles Hospital	66	8	1	3	78
Royal Glamorgan Hospital	27	9	1	0	37
Community Hospitals	13	8	1	0	22
Cwm Taf Health Board	77%	18%	2%	2%	137
Wales	59%	34%	4%	2%	685

Source: Wales Audit Office Survey of Hospital Patients

Question 23b: Were your meals free from disturbance by nurses or doctors treating or assessing you?

Cwm Taf Hospitals	Yes, always	Yes, most of the time	Rarely	Never	Number of responses
Prince Charles Hospital	55	13	5	3	76
Royal Glamorgan Hospital	17	16	1	1	35
Community Hospitals	12	7	1	1	21
Cwm Taf Health Board	64%	27%	5%	4%	132
Wales	50%	38%	9%	3%	672

Source: Wales Audit Office Survey of Hospital Patients

Question 23c: Were you given enough time to finish your meal?

Cwm Taf Hospitals	Yes, always	Yes, most of the time	Rarely	Never	Number of responses
Prince Charles Hospital	68	8	2	0	78
Royal Glamorgan Hospital	28	7	1	0	36
Community Hospitals	17	3	0	0	20
Cwm Taf Health Board	84%	13%	2%	0%	134
Wales	76%	21%	3%	0%	680

Source: Wales Audit Office Survey of Hospital Patients

Question 23d: If you missed a meal, was a replacement provided?

Cwm Taf Hospitals	Yes, always	Yes, most of the time	Rarely	Never	Number of responses
Prince Charles Hospital	56	11	1	2	70
Royal Glamorgan Hospital	21	7	4	1	33
Community Hospitals	11	6	3	1	21
Cwm Taf Health Board	71%	19%	6%	3%	124
Wales	55%	25%	11%	9%	583

Source: Wales Audit Office Survey of Hospital Patients

Question 23e: Did you always get the meal you ordered?

Cwm Taf Hospitals	Yes, always	Yes, most of the time	Rarely	Never	Number of responses
Prince Charles Hospital	47	21	2	3	73
Royal Glamorgan Hospital	30	4	0	1	35
Community Hospitals	11	7	0	1	19
Cwm Taf Health Board	69%	25%	2%	4%	127
Wales	56%	34%	5%	4%	641

Source: Wales Audit Office Survey of Hospital Patients

Question 23f: Was fresh fruit available?

Cwm Taf Hospitals	Yes, always	Yes, most of the time	Rarely	Never	Number of responses
Prince Charles Hospital	64	9	3	1	77
Royal Glamorgan Hospital	20	9	2	2	33
Community Hospitals	4	5	8	2	19
Cwm Taf Health Board	68%	18%	10%	4%	129
Wales	51%	22%	16%	11%	651

Source: Wales Audit Office Survey of Hospital Patients

Question 23g: Were drinks available between mealtimes?

Cwm Taf Hospitals	Yes, always	Yes, most of the time	Rarely	Never	Number of responses
Prince Charles Hospital	65	8	1	2	76
Royal Glamorgan Hospital	29	3	1	1	34
Community Hospitals	15	6	1	0	22
Cwm Taf Health Board	83%	13%	2%	2%	132
Wales	69%	21%	7%	3%	665

Source: Wales Audit Office Survey of Hospital Patients

Question 23h: Were snacks available between mealtimes?

Cwm Taf Hospitals	Yes, always	Yes, most of the time	Rarely	Never	Number of responses
Prince Charles Hospital	22	11	7	32	72
Royal Glamorgan Hospital	15	8	4	7	34
Community Hospitals	4	4	6	8	22
Cwm Taf Health Board	32%	18%	13%	37%	128
Wales	23%	15%	26%	35%	615

Source: Wales Audit Office Survey of Hospital Patients

Question 23i: Was fresh water available throughout the day?

Cwm Taf Hospitals	Yes, always	Yes, most of the time	Rarely	Never	Number of responses
Prince Charles Hospital	75	1	1	0	77
Royal Glamorgan Hospital	32	5	0	0	37
Community Hospitals	18	1	0	2	21
Cwm Taf Health Board	93%	5%	1%	1%	135
Wales	85%	13%	2%	1%	673

Source: Wales Audit Office Survey of Hospital Patients

Question 23j: Was your food served at the temperature you would have expected?

Cwm Taf Hospitals	Yes, always	Yes, most of the time	Rarely	Never	Number of responses
Prince Charles Hospital	49	12	7	9	77
Royal Glamorgan Hospital	29	6	2	0	37
Community Hospitals	14	7	0	1	22
Cwm Taf Health Board	68%	18%	7%	7%	136
Wales	53%	30%	10%	7%	677

Source: Wales Audit Office Survey of Hospital Patients

Question 24: Were you given enough food to eat?

Cwm Taf Hospitals	Yes	Yes, too much	No, not enough	Number of responses
Prince Charles Hospital	59	16	3	78
Royal Glamorgan Hospital	26	9	1	36
Community Hospitals	19	1	1	21
Cwm Taf Health Board	77%	19%	4%	135
Wales	73%	14%	13%	681

Source: Wales Audit Office Survey of Hospital Patients

Question 25a: How would you rate the taste of the food you were given?

Cwm Taf Hospitals	Excellent	Good	Acceptable	Poor	Very poor	Number of responses
Prince Charles Hospital	17	37	18	5	1	78
Royal Glamorgan Hospital	13	14	7	3		37
Community Hospitals	1	10	9	2	0	22
Cwm Taf Health Board	23%	45%	25%	7%	1%	137
Wales	17%	37%	28%	11%	6%	678

Source: Wales Audit Office Survey of Hospital Patients

Question 25b: How would you rate the appearance of the food you were given?

Cwm Taf Hospitals	Excellent	Good	Acceptable	Poor	Very poor	Number of responses
Prince Charles Hospital	17	33	22	5	0	77
Royal Glamorgan Hospital	9	18	6	1	1	35
Community Hospitals	2	11	8	0	0	21
Cwm Taf Health Board	21%	47%	27%	5%	1%	133
Wales	17%	39%	28%	9%	7%	667

Source: Wales Audit Office Survey of Hospital Patients

Question 25c: How would you rate the healthiness of the food you were given?

Cwm Taf Hospitals	Excellent	Good	Acceptable	Poor	Very poor	Number of responses
Prince Charles Hospital	15	37	21	5	0	78
Royal Glamorgan Hospital	12	12	9	1	1	35
Community Hospitals	2	11	6	1	0	20
Cwm Taf Health Board	22%	45%	27%	5%	1%	133
Wales	18%	39%	30%	9%	5%	667

Source: Wales Audit Office Survey of Hospital Patients

Question 25d: How would you rate your overall satisfaction with the food you received?

Cwm Taf Hospitals	Excellent	Good	Acceptable	Poor	Very poor	Number of responses
Prince Charles Hospital	17	36	21	2	1	77
Royal Glamorgan Hospital	13	10	9	2	1	35
Community Hospitals	1	10	9	0	0	20
Cwm Taf Health Board	23%	42%	30%	3%	2%	132
Wales	19%	37%	27%	10%	8%	665

Source: Wales Audit Office Survey of Hospital Patients

Action Plan

Audit recommendations	Improvement	Action	Person responsible	Completion date
R1 Examine the reasons for the higher than average catering costs per patient day by: • benchmarking numbers and costs of catering staff; • assessing the cost effectiveness of the opening hours of the staff/visitor restaurant at RGH; • checking the robustness of the formula used to price products for staff and visitors; and • review pricing structures in the staff/visitor restaurant and in doing so making a clear decision about the level of costs to be recovered from non-patient catering services.	Catering service establishment and service delivery model benchmarking reviews being carried out at time of audit to balance catering cost per patient across the Health Board. A review of patient and non patient meal cost and pricing structure to be carried out to improve total cost recovery.	Take forward action from service establishment and service model reviews. Take forward action from patient and non patient meal cost review. A review of the processes in place to monitor provisions cost and stock control for patient and non patient catering services to be carried out.	Acting Assistant Director of Facilities Head of Hotel Services	December 2010

Audit recommendations	Improvement	Action	Person responsible	Completion date
R2 Review the assumptions underpinning the roll out of the cook-freeze model at PCH to compare projected costs with those presented in this report.	Catering service establishment and service delivery model reviews being carried out at time of audit to test the service delivery model and balance catering cost per patient across the Health Board.	Take forward action from service establishment and service model reviews.	Acting Assistant Director of Facilities Head of Hotel Services	December 2010
R3 Assess the systems for monitoring and recording waste by: • improving the completion of ward temperature sheets for all food products and not just those regenerated on the ward; and examining reasons for regenerating too much if wastage levels exceed an agreed threshold.	Reduce waste and provide more accurate recording of meal temperatures.	A review of systems used for monitoring and recording waste to be carried out.	Acting Assistant Director of Facilities Head of Hotel Services	December 2010

Audit recommendations	Improvement	Action	Person responsible	Completion date
R4 Improve the patient experience by: • ensuring bed plans are completed at least daily; • continuing to promote the protected mealtime policy amongst wider groups of staff; and • ensuring ward staff make time to help prepare patients for their meals.	Continue to promote protected mealtimes policy among wider groups of staff. 64% always protected 27% most of the time Make time to help prepare patients for their meals. Improve upon current 76% patients always offered. 12% patients offered most of the time. Consistency across all wards- achieve 100% compliance.	Empower nursing staff to enforce protected mealtimes. Raise awareness among multi disciplinary team. Re enforce among nursing team. Ensure 'Impy'- individual wipes available at bedside. Develop volunteer role to assist in some ward areas.	Senior Nursing Team	December 2010 Immediate effect Volunteer role Summer 2011

Audit recommendations	Improvement	Action	Person responsible	Completion date
R4 Improve the patient experience by: • rolling out the enhanced role for ward-based catering staff if the pilot scheme is successful; • providing explicit information for patients that sets out the arrangements for ordering meals and the availability of snacks and how these can be ordered; and • taking account of, and addressing, the less favourable views expressed by patients responding to our survey.	Provide cost effective and quality catering service to the patient at ward level using the revised model and a service that is consistent across the Health Board. Information will be provided in the Health Board patient bed side information booklet. Improve upon the patient meal experience.	Take forward action from service establishment and service model reviews. Ensure relevant information is included in the patient bed side information booklet. Develop the patient satisfaction audit tool and monitor levels.	Acting Assistant Director of Facilities Head of Hotel Services	December 2010

Audit recommendations	Improvement	Action	Person responsible	Completion date
R5 Ensure compliance with food safety procedures by: • checking that all catering staff and food handlers have the necessary training in food hygiene; and • developing guidance on basic food hygiene for ward staff that underpins policies and procedures in relation to ward-based catering services.	All Catering staff have the necessary training in food hygiene. Ward staff to be trained in basic food hygiene and guidance procedures to be developed for ward staff.	Check and ensure compliance. Carry out training needs analysis and discuss with catering manager ways to deliver basic training at ward level.	Head of Hotel Services Senior Nursing Team and Catering Managers	December 2010 Ongoing

Audit recommendations	Improvement	Action	Person responsible	Completion date
R6 Improve compliance with nutritional screening and care planning by: • exploring the reasons for non-compliance with nursing staff; • providing simple guidance on how to use the nutritional risk screening tool; • recording more detail about patients' nutritional health on the Admission/24 hour Nursing Assessment form; and • considering regularly auditing compliance with nutritional screening and the comprehensiveness of care plans.	Nursing Documentation in process of development during inspection. All wards to use MUST nutritional screening tool.	Planned roll out of revised nursing documentation to all wards. Audit Compliance to completion of MUST tool and care plans. All Wards to have identified Nutritional care champion to ensure 100% compliance to use and understanding MUST.	Senior Nursing Team	December 2010

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