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Hospital Catering and Patient Nutrition Follow-up Review

Powys Teaching Health Board

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Status of report

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Summary report

Background

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

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

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

4. In autumn 2011, the Welsh Government published the All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients. These standards supersede the 2002 nutrition and catering framework and provide technical guidance for staff responsible for meeting the nutritional needs of patients[3]. The standards also specify the nutrient content needed to provide for the diverse needs of the hospital population. NHS bodies were required to be fully compliant with the standards by April 2014.

5. To support the implementation of the standards, caterers and dieticians across Wales worked together to produce the All Wales Hospital Menu Framework, which was launched at the end of January 2014. The Framework consists of a database of an agreed set of menu items, a standardised set of recipes and cooking methods, nutritional analysis of each menu item and a range of snacks that are compliant with the standard, which are procured through all-Wales contracts.

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

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

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

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

Our main findings

7. Between March and June 2015, we undertook follow-up work at Powys Teaching Health Board (the Health Board) to assess the extent to which it had implemented the Auditor General's national recommendations[5]. We also assessed the extent to which the Health Board had addressed the recommendations made as part of the local audit in 2010 and again in 2014.

8. We concluded that the Health Board has made good progress in addressing recommendations to improve catering and nutrition services. More work is needed to strengthen some aspects of the mealtime experience, to control costs more effectively and to improve performance reporting. We reached this conclusion because:

- Arrangements for meeting patients' dietary and nutritional needs are improving but compliance with recommended beverage rounds needs to improve:
  - patients are nutritionally screened and changes to nursing documentation have improved the quality of information recorded;
  - compliance with the nutritional care pathway is routinely assessed with overall compliance generally good;
  - current arrangements ensure patients have access to food 24 hours a day but not all wards provide the recommended number of beverage rounds;
  - menu items are nutritionally assessed through the all-Wales menu framework with which the Health Board is compliant; and
  - written information for patients on what to expect in hospital is in place.
- There is still scope to improve mealtime experiences for patients:
  - patients are generally positive about food services;
  - patients are well supported at mealtimes but more could be done to prepare the ward environment; and
  - protected mealtime principles are not embedded everywhere.

[4] National Assembly for Wales, **Hospital Catering and Patient Nutrition**, February 2012

[5] Our audit approach is set out in Appendix 1. The scope of the audit work relates specifically to adult inpatients capable of eating and drinking normally.

- The cost of patient catering services is increasing despite reductions in meal orders and the gap between non-patient catering costs and income is still too big:
  - patient meal costs are increasing and exceed the daily target despite reductions in meal requests;
  - un-served food wastage meets the national target; and
  - non-patient catering services run at a loss and, although reducing, the level of subsidy is still too big.
- Arrangements for reporting on hospital catering and nutrition need to improve:
  - arrangements are in place to ensure national policies and standards are implemented but governance structures are being reviewed;
  - Board reporting relies on the annual Fundamentals of Care Audit; and
  - patient feedback to support performance reporting is limited.

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

Recommendations

10. The Health Board has fully achieved 24 recommendations out of 37 made in 2010, 2011 and 2013. Some recommendations were subsumed in the 2014 follow up, therefore listed below are 10 recommendations for the Health Board to focus upon.The Health Board needs to maintain focus on implementing the remaining recommendations where progress is reported to be on track but is not yet completed, or where we consider insufficient or no progress has been made. These recommendations are set out in Exhibit 1. A full list of the national and local recommendations, along with the status of each recommendation is set out in Appendix 2.

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

Recommendations
Ensuring patients' nutritional needs are met
R4 Ensure that the Health Board meets national e-learning nutrition training requirements. Issues such as access to IT and staff availability for training need to be resolved. (Local 2014)
Improving patients' mealtime experience
R3c We recommend that NHS bodies continue to roll out the protected mealtime policy to as wide a range of wards as possible, communicating its importance to all the relevant staff groups working in the hospital, and regularly reviewing compliance with the policy. (National)
Controlling the costs of the catering service
R2 Improve the ongoing reporting of catering costs at a Health Board site level to ensure that: • Overall costs and costs per patient are more consistent across sites and closer to target costing. • There is improved consolidation and co-ordination of product and resource cost centrally. • Total costs for catering do not exceed the planned budget and that cost improvements are achieved. Cost improvements should come from better control of expenditure, waste and efficiency, and not result in any detriment to the quality of nutrition provided to patients. (Local 2014)
R4b We recommend that NHS bodies introduce computerised catering information systems, supported by clear cost benefit analysis in comparison to existing manual based information systems.(National)
R7a We recommend set pricing policies and income generation targets that aim to ensure that non-patient catering services at least break even, or, if they do not, it is the result of a deliberate subsidy policy that is based on a detailed analysis of costs. (National)
R7b We recommend that NHS bodies regularly monitor income and expenditure of non-patient catering services to ensure that the financial performance of these services is as expected and that unacceptable deficits are not being incurred. (National)
Effective service planning and monitoring
R10a We recommend that NHS bodies develop a more comprehensive approach to reporting performance on catering services and patient nutrition to the Board, which brings together information on implementation of the nutritional care pathway, performance data on the costs of patient and non-patient services, food wastage and patient and relative feedback, and this information should be presented to the Board at least annually and should make appropriate use of the EFPMS data. (National)

Recommendations

Effective service planning and monitoring

R10b We recommend that NHS bodies systematically collate the information from nutritional screening on the number of patients identified with, or at risk of, nutritional problems to understand the scale of the problem and the likely impact on catering and nutrition services to meet these patients' needs. (National)

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

R11c We recommend that NHS bodies establish mechanisms to involve patients' in activities that assess the quality of catering and nutrition services. (National)

Detailed report

Arrangements for meeting patients' dietary and nutritional needs are improving but compliance with recommended beverage rounds needs to improve

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

12. At the Health Board, nutritional screening was in place, with most patients undergoing nutritional screening within 24 hours of admission and nutritional care plans in place for patients who needed them, with food and fluid intake monitored appropriately. However, arrangements at Victoria Memorial Hospital in Welshpool were found to be weak. Our follow-up audit work in 2014 found the Health Board had made good progress to address these issues, in particular implementing a team-led mealtime service, which ensured patients were prepared for meals and received the required support.

Patients are nutritionally screened and changes to nursing documentation has improved the quality of information recorded

13. As part of our 2015 work, we reviewed a set of case notes at four of the Community Hospitals, 20 case notes in total. The hospitals that we visited were Llandrindod Wells County War Memorial Hospital, Brecon War Memorial Hospital, Victoria Memorial Hospital and Knighton Hospital. We assessed whether nursing staff nutritionally screened patients on admission and repeated it at least weekly, as well as the quality of the nutritional screening process. We found that nursing staff routinely screened and rescreened patients using the MUST nutritional screening tool.[6] We found that body mass index had not been recorded in two of the 20 case notes while one record of height was incomplete.

14. The All Wales Nutrition and Catering Standards make it clear that oral health and communication are part of nutritional care. Our review found information on oral health recorded in 19 out of 20 case notes and an assessment of communication in all 20 case notes. Our findings show a marked improvement on the findings from the 2014 Fundamentals of Care audit.[7] At that time, 78 per cent of patients' oral health needs had been assessed. This was a significant improvement on the previous year when only 36 per cent of patients had been assessed. Oral health continues to be an area of

[6] The Malnutrition Universal Screening Tool (MUST) is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

[7] The Fundamentals of Care Audit was carried out between October and November 2014.

improvement, and revised nursing documentation, launched in February 2015, has improved the focus on oral hygiene.

15. In February 2015, the Health Board introduced new nursing documentation to ensure key patient information was captured. This new documentation prompts for information in relation to nutrition, communication, and swallowing, as well as current appetite, dietary preferences, special, therapeutic or cultural dietary need. Ward staff told us that the new documentation was a big improvement. Our case note review found that the nursing documentation was generally well completed, which enabled information to be found quickly. We found that only one of the 20 case notes did not record a patient's current therapeutic, lifestyle or cultural requirements in relation to food and fluids and one of the 20 case notes did not record a patient's usual dietary intake.

16. A recent Dignity and Essential Care Inspection (DECI) by the Healthcare Inspectorate Wales (HIW) at Llanidloes War Memorial Hospital in February 2015 also found that nutritional assessments and nursing documentation were completed appropriately.

17. Template care plans designed specifically for nutrition and hydration are in place across all hospitals. Nursing staff used these care plan templates consistently on the wards that we visited. Our case note review found that nutritional care plans were in place for all but one of the patients identified as at risk. The all-Wales food chart was used for patients, where required, based on their nutritional assessment.

18. The Health Board has a range of mechanisms in place to identify those patients who need help with eating and drinking. These include the butterfly scheme for those patients with a cognitive problem and the 'at a glance' patient boards. The Health Board also uses 'red trays' to identify patients needing support at mealtimes or for whom food intake should be recorded.

Compliance with the nutritional care pathway is routinely assessed with overall compliance generally good

19. In 2010, not all NHS bodies monitored compliance with the nutritional care pathway and we recommended that the Health Board establish arrangements for routine assessment of compliance. By 2014, the Health Board had introduced 360-degree audits. A multidisciplinary team, comprised of nurses, dietetic and facilities staff, assesses compliance against a checklist of factors. Our latest review found that the Health Board has continued to strengthen the 360-degree audit methodology. Patient feedback is now part of the audit process and ward staff receive timely feedback.

20. The 360-degree audit tool assesses whether:

- snacks and beverages are available;
- patients are helped to prepare for mealtimes;
- all nursing staff make themselves available to help at mealtimes;
- nutritional screening is undertaken within 24 hours of admission;

- ward kitchen meets hygiene standards;
- food temperatures are recorded before meals leave the main kitchen;
- untouched food waste is recorded;
- protected mealtime principles are adhered to; and
- patient feedback.

A schedule of audits ensures adequate coverage across all hospital sites.

21. Dieticians, who are part of the 360-degree audit team along with nursing and facilities representatives, undertake compliance audits of nutritional screening. Overall compliance is good, although dieticians are concerned that nurses are not always getting an accurate record of the amount of food eaten by patients. Dieticians told us that they would like to carry out more reviews of the food charts to improve ward-based practice but few staff and the geographical spread of the hospitals make this difficult to implement.

22. Compliance with nutritional screening is monitored as part of the All Wales nursing dashboard, with all inpatient ward areas undertaking an assessment on a monthly basis. Overall compliance was 93 per cent during 2014-15 but compliance rates fluctuated between 86 per cent and 95 per cent with some hospitals regularly achieving full compliance. Locality nursing teams collate and review the results but information on compliance is not presented to the Board or the Quality and Safety Committee.

23. In 2010, there were no regular training programmes or refresher training for ward staff to maintain awareness on the use of nutritional screening tools and assessment documentation. The Welsh Government introduced an e-learning package for the all-Wales nutrition care pathway and all Wales food and fluid charts in September 2011. All ward-based nursing staff were required to complete the e-learning package within 12 months of this date while new staff should complete it within 12 months of appointment.

24. Recent data show that only 25 per cent of nursing staff are compliant with the training. The Health Board has indicated that local monitoring at ward level shows that compliance is higher than the figures captured and reported through the electronic staff record system. Ward staff told us that they have an increasing number of e-learning programmes to complete and finding the time and a computer to complete these programmes at work was proving difficult. Concerns were also expressed about the quality of the training and whether it was leading to positive changes in clinical practice. The Health Board recognises the importance of this training and nursing managers have plans in place to address poor compliance with actions under review at the time of audit.

25. The Health Board continues to ensure that catering staff receive training in food hygiene commensurate with their role. The Health Board is developing ‘toolbox talks’ on aspects of nutrition and food hygiene for ward-based nursing staff.

Current arrangements ensure patients have access to food 24 hours a day but not all wards provide the recommended number of beverage rounds

26. In 2010, we found that most hospitals had arrangements in place to provide snacks but many patients indicated that snacks were unavailable between meals. The All Wales Nutrition and Catering Standards indicate that snacks should be offered two to three times a day with evening snacks offered to all patients because of the long gap between the evening meal and breakfast.

27. At the Health Board, snacks are available between meals and for patients who miss a meal. A range of snacks, such as biscuits, fresh fruit, yoghurts, cheese and crackers and sandwiches, as well as staples like bread, cereal and milk, is stored in ward kitchens. Snacks are offered during the mid-morning and mid-afternoon beverage rounds but patients can request snacks from nursing staff any time of the day. During our ward visits, we observed the availability of these snacks.

28. The 360-degree compliance audits monitor snack and beverage availability, and recent audits have not identified any issues. The 2014 Fundamentals of Care audit found ward areas complied fully with providing 'a range of snacks for patients who missed meals or were hungry between meals, with 97 per cent of patients always or usually provided with nutritious food and snacks.

29. The standards for patient food and fluid identify that seven to eight beverage rounds should take place each day, offering hot and cold beverages, and that water jugs should be changed three times a day. The 2014 Fundamentals of Care audit found that fresh drinking water was available and within patients' reach with four-fifths of wards changing water jugs three times a day. However, only 30 per cent of wards achieved the seven or more beverage rounds a day. During our ward visits, ward managers told us they were committed to providing seven to eight drinks per day and that typically water jugs were changed three times a day.

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

30. In 2010, we found that dieticians were involved in menu planning at all hospitals but not all hospital menus had been nutritionally assessed. At the Health Board, dietetic and catering services had worked together to ensure the menu reflected patients' needs and preferences. Since then, the Welsh Government published the All Wales Nutrition and Catering Standards, which specify the 12 minimum nutrients for analysis. The Health Board indicated that it is fully compliant with the all-Wales menu framework using the recipes in the database to design the patient menu. The Nutrition, Hydration and Catering Steering Group ensures menus meet energy and minimum nutrient requirements. The Health Board contributes to the all-Wales menu framework group where compliance with the menu framework and catering and nutrition standards is discussed, as well as how it is integrated into current reporting mechanisms with NHS organisations.

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

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

32. The 2011 All Wales Nutrition and Catering Standards make it clear that information should be provided to patients and their carers on what to expect in relation to meals and snacks while in hospital. In 2012, the Chief Medical Officer and Chief Nursing Officer for Wales issued a joint letter in relation to hospital catering and food provisions. It asked NHS bodies to provide patients with the information set out in the Auditor General's leaflet '**Eating Well in Hospital – What You Should Expect**'. The Health Board gives this leaflet to patients, and ward staff confirmed this. At Knighton, detailed information on the importance of nutrition and hydration was also displayed on the ward.

There is still scope to improve mealtime experiences for patients

33. In 2010, most hospitals provided an appropriate choice of meals and patients were generally satisfied with the food they received. However, not all patients got the help they needed at mealtimes and more could be done to embed protected mealtime principles on some wards. At the Health Board, different protected mealtime practices were in place while signage needed to improve. Mealtime assistance also varied. Catering services provided choice and responded effectively to meeting individuals' needs.

34. Our follow-up audit in 2014 found that the Health Board had implemented protected mealtimes at all sites but there was still variation in compliance. DECIs undertaken by HIW across the Health Board have raised similar issues with patient mealtime experiences. A recent DECI at Llanidloes and District War Memorial Hospital found no evidence of a routine or direction from the staff in charge at the time to ensure that patients were adequately prepared for mealtimes.

Patients are generally positive about food services

35. Currently, the Health Board operates a two-week menu cycle, with the exception of Knighton Hospital where a three-week menu cycle is in place. The 2014 Fundamentals of Care report found that patients were very satisfied with the availability and quality of food and drink; 97 per cent of patients felt that they were always or usually provided with nutritious food and snacks during their hospital stay. And, the Health Board did not receive any formal complaints about food during 2014-15.

36. The Health Board does not currently provide hardcopy printed menus at patients' bedsides. Instead, a printed version is available for nurses to read to the patient.

Patients are well supported at mealtimes but more could be done to prepare the ward environment

37. Our follow-up work in 2014 identified significant progress regarding the catering and nutritional support arrangements in Welshpool. A DECI undertaken at the hospital in January 2015 found that progress had been maintained, with good support from staff at patient mealtimes and help offered to patients who needed it. However, preparation of the ward environment prior to mealtimes could be improved. In February 2015, HIW's DECI at Llanidloes and District War Memorial Hospital highlighted issues with the level of help for patients to prepare for mealtimes. In particular, patients were not offered hand wipes or encouraged to wash hands before meals, while meals were not placed within easy reach.

38. We observed lunchtime meal services at the four community hospitals, where we carried out the case note review. We found that:

- Nursing staff managed the meal service and demonstrated knowledge of patients' nutritional needs and dietary preferences and helped to cut up food and open packaging. Nursing staff also encouraged patients to eat, tempting them with different meal options when they refused a hot meal.
- Meal services were calm and ran smoothly creating a positive environment for patients. Good use was made of day rooms for meal services, although the Welshpool day room could be improved as it is not welcoming for patients.
- Support from domestic staff was appropriate, enabling nursing staff to support patients needing assistance, with the exception of Knighton where domestic staff were not engaged. The policy within Powys is for domestic staff to support mealtimes as there are no catering assistants working at ward level.
- The red-tray system to identify patients needing help was in use on all wards visited. Senior nurses ensured that a member of nursing staff delivered these meals to provide timely assistance.

39. The 2014 Fundamentals of Care audit found that that all members of the nursing team were engaged in mealtime services on 80 per cent of wards, while a registered nurse co-ordinated the meal service 90 per cent of the time. The audit also reported that all wards had systems in place to allow family or friends to assist with meal times. On the four wards we visited, nursing staff told us they welcomed and encouraged family and friends to help patients at mealtimes. We observed families helping their relatives with eating at three of the four community hospitals that we visited.

40. Exhibit 2 sets out the results of our mealtime visits to four community hospitals. Our observations are based on the activities that we expected to see and whether these activities applied to all, most, some, or no patients. Food temperatures are not recorded at ward level but temperatures are checked and recorded before meals leave the kitchen. The risk of these meals falling below the required temperature is low. Food trolleys were plugged in as soon as they arrived on the wards to maintain food temperatures. All meal services commenced promptly.

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

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

Source: Wales Audit Office observations of lunchtime services

41. Our lunchtime observations, set out above, resonate with the findings from the multidisciplinary 360-degree audits.

Protected mealtime principles are not embedded everywhere

42. The Health Board does not currently have a protected mealtime policy, although there are plans to develop one to reinforce the message to staff about its importance. Compliance with protected mealtimes is monitored through the 360-degree audit process and no issues have been identified.

43. At the four community hospitals where we observed meal services, we found signage at ward entrances explaining the purpose of protected mealtimes and the times they operated. However, signage was different at each site and was not explicit that visitors were welcome during mealtimes to help patients with eating.

44. We observed compliance with protected mealtimes with non-essential clinical activity 'winding down' just before the meal service commenced. The ward managers that we met were confident protected mealtimes worked well with professional colleagues supportive of the principles. We did observe a number of issues at Knighton Hospital (see below), which need to be addressed. During our ward visits, we found:

- Healthcare professional staff for the most part left the ward areas at the start of the meal service, and, if these staff remained on the ward, interactions with patients and nursing staff were minimised.
- Wards were closed to visitors during mealtimes. At Knighton, visitors were able to enter the ward during the meal service as the door to the ward was not closed.

- Cleaning activities stopped during the meal service. At Knighton, cleaning activities continued in ward corridors but not near patients' bedsides.
- At Knighton a medication round took place during the meal service. We made the ward manager aware, as patients were interrupted during mealtime to be given their medication. At the same, another nurse needing assistance in caring for a sick patient had to wait while the medicine round was completed. All other staff were helping patients with eating.

The cost of patient catering services is increasing despite reductions in meal orders, and the gap between non-patient catering costs and income is still too big

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

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

47. Our review in 2010 recommended that the Health Board introduce a subsidy policy and strengthen performance and financial management arrangements because financial information was not good enough to support effective day to day management. In 2014, we found that overall corporate-wide information on catering costs had improved. However, the management of catering services had been devolved to locality management teams, which resulted in less timely comparative information on cost efficiency. We also found that the Health Board had introduced a new approach to non-patient food pricing and that patient catering costs had increased above inflation.

Patient meal costs are increasing and exceed the daily target despite reductions in meal requests

48. The Health Board's EFPMS data submissions show year-on-year increases between 2011-12 and 2013-14 with costs for patient meal services increasing by 9.5 per cent, from £1.33 million to £1.47 million (Exhibit 3). Across all NHS bodies, the cost of patient catering services reduced by five per cent. Our analysis of the EFPMS data suggests patient catering costs increased because of a rise in patient provision costs. However, the number of patient meals requested reduced by eight per cent from 257,471 meals in 2011-12 to 237,308 million meals in 2013-14. Across Wales, the number of meals requested reduced by four per cent. The Health Board indicated that arrangements whereby Locality Business Managers are responsible for catering budgets make it difficult to differentiate provision costs. Provision costs are based on provisions procured rather than what was used to produce the meals.

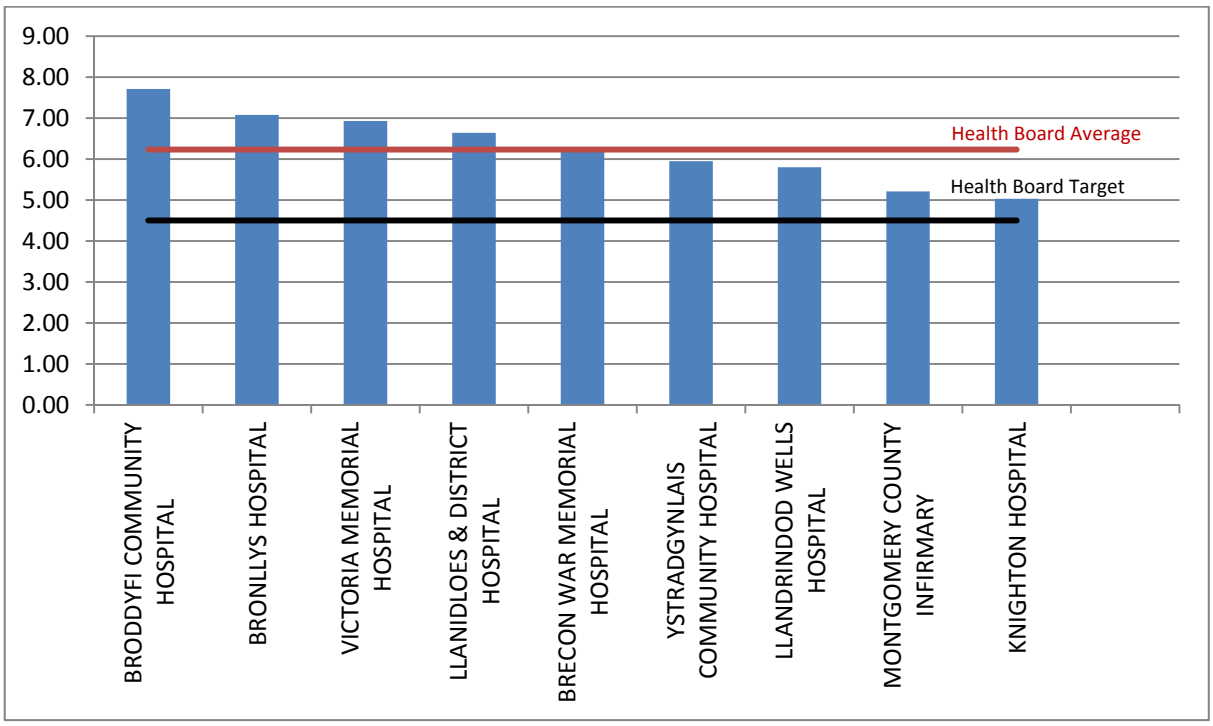
Exhibit 3: Patient catering service costs are increasing

Year	Cost of catering services (£ million)	
	Powys	Wales
2011-12	1.33	38.95
2012-13	1.42	37.26
2013-14	1.47	36.97

Source: Wales Audit Office analysis of NHS Estates in Wales Facilities Performance Report 2012-13 and the 2014-15 supplementary data

49. Our most recent audit work found that the Health Board is working to a daily target meal cost of no more than £4.50 per patient. However, the cost per patient meal increased from £5.19 in 2011-12 to £6.23 in 2013-14, exceeding the target by 38 per cent. The cost per patient meal varies across hospital sites and none of the hospitals is close to the daily target cost (Exhibit 4).

Exhibit 4: The Health Board's costs per patient meal are well above target



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

50. In 2010, the Health Board's food production arrangements relied heavily on manual paper systems rather than an IT solution, although it was working to implement a system. Our follow-up work in 2014 found that the Health Board had taken the decision not to implement the IT system. In his 2011 national report, the Auditor General recommended that NHS bodies should introduce computerised catering information systems, and NHS Wales Informatics Service and NHS Shared Services Partnership have developed an outline business case to procure a national catering IT solution. Our latest audit found that NHS bodies, including the Health Board, have commented on the outline business case and the Health Board is awaiting the outcome before making any decisions about future investment in a local IT solution.

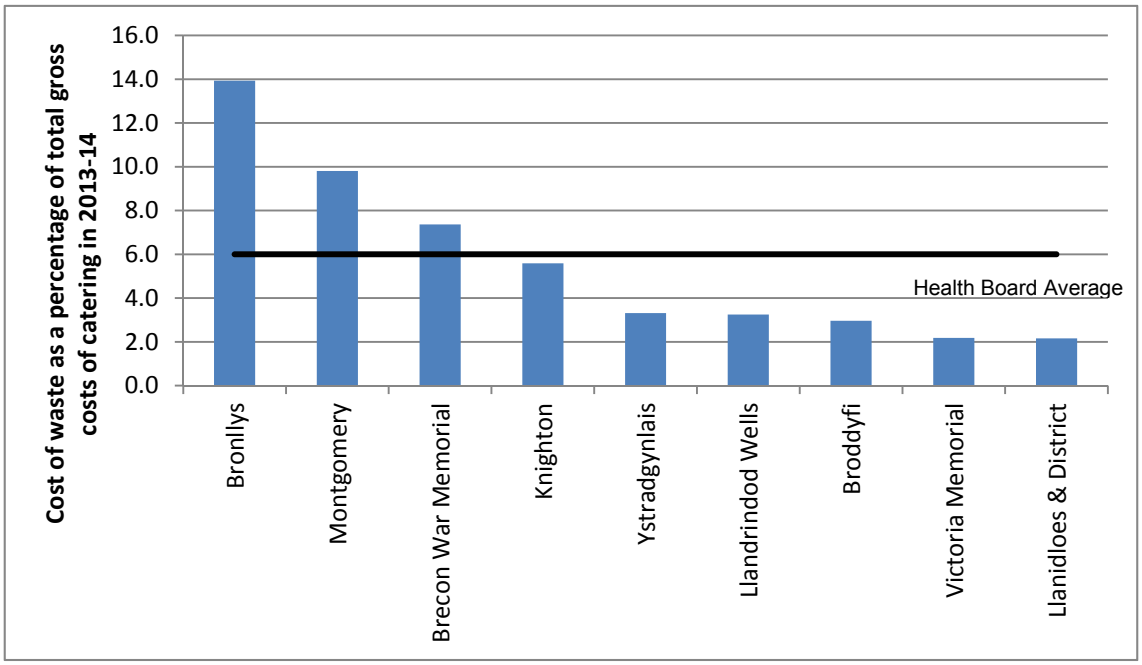
51. To support the implementation of the 2011 nutrition and catering standards, the All Wales Hospital Menu Framework was launched in January 2014. Recipes within the menu framework are costed. All health boards jointly funded the appointment of a procurement dietician working in the NHS Shared Services Partnership – Procurement Service to support the development of all-Wales procurement contracts to source provisions for the dishes on the menu framework. The Health Board contributes to the all-Wales menu framework group and the all-Wales commodity group to progress procurement issues, including developing contracts to source local produce from local suppliers.

Un-served food wastage meets the national target

52. In 2010, levels of un-served food waste were high on some wards across the Health Board with improvements needed to measure accurately un-served food waste. Levels of waste are reviewed as part of the 360-degree audit tool. The audit tool examines waste across the whole food chain starting with meal production to the endpoint of patient service. Plate waste is also included. Staff are trained to observe waste, and maintain close working relationships with wards. Due to the size of many of the hospital sites, this is achieved through close working relationships between ward staff and catering. Waste is expressed as a percentage of all food prepared.
The Health Board's 2014-15 survey of food waste found wastage was 9.9 per cent, which meets the national target for un-served waste. The Health Board also carries out a waste survey on a sample of wards to support the EFPMS data submission.
The survey provides a snapshot based on un-served portions for the main food dish.

53. Analysis of the 2013-14 EFPMS data shows that the cost of un-served meals was £97,793, which equates to six per cent of the Health Board's total catering costs. Across Wales, the cost of un-served meals accounted for two per cent of total catering costs. There were big variations in waste cost between the Health Board's hospitals. (Exhibit 5). At Bronllys, the cost of un-served meals was £35,000, more than a third (36 per cent) of the Health Board's overall cost for waste.

Exhibit 5: The cost of food waste varies seven fold across the Health Board's hospitals



Source: Wales Audit Office analysis of NHS Estates in Wales Facilities Performance supplementary data 2014-15

Non-patient catering services run at a loss and although reducing, the level of subsidy is still too big

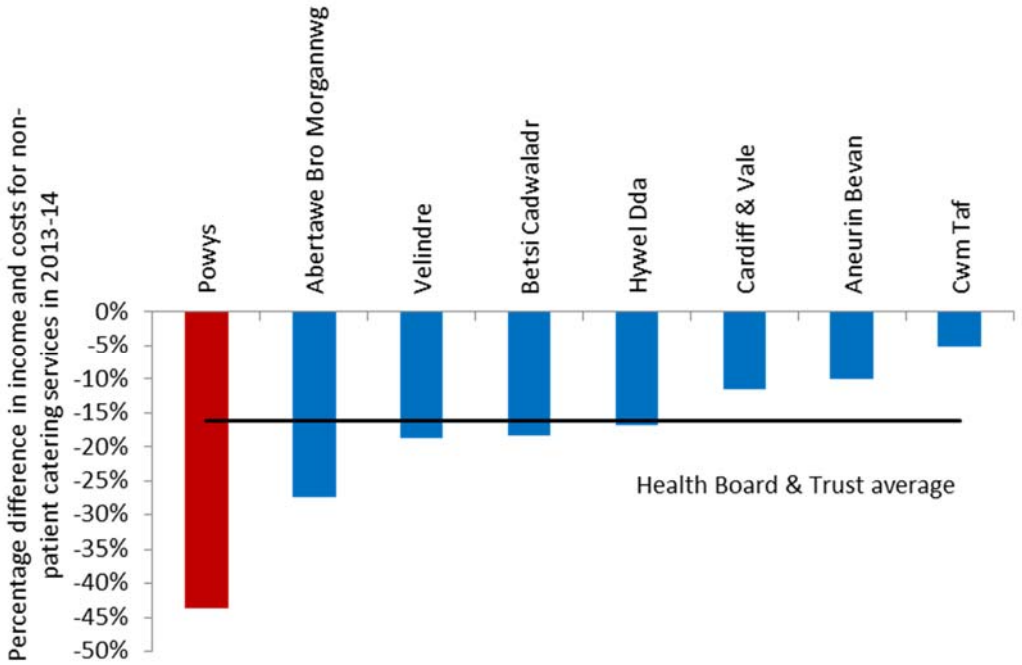
54. In 2010, the Health Board did not have a subsidy policy in place for non-patient catering services. At that time, catering services subsidised staff meals by £73,000 for provisions alone. However, staff costs were not included in the total cost of providing staff meals and the subsequent sale price. At that time, we recommended the Health Board make a decision on the approach to staff meal subsidy and staff meal pricing.

55. By the time of our follow-up work in 2014, the Health Board had implemented a new approach to non-patient food pricing that ensured that prices were regularly re-calculated. Seven hospital sites have remotely managed electronic cash tills, which can update prices automatically. A non-patient catering tariff policy set out clear expectations that non-patient catering services should at least break even or make a profit to offset patient catering costs ensuring the Health Board did not knowingly subsidise these services.

56. Across Wales, the income generated from non-patient catering services was insufficient to recover costs (Exhibit 6). At Powys, the cost of non-patient catering services was £139,212 in 2013-14 and just over half (56 per cent) of these costs were recovered. The shortfall in income equates to a subsidy of around £60,000 but accounts for a very small proportion (three per cent) of the overall shortfall across Wales. The gap between the costs of non-patient catering services and the income generated is reducing (Exhibit 7).

57. Analysis of the EFPMS data suggests that provision costs for non-patient catering services reduced by 15 per cent from £52,844 in 2012-13 to £44,797 in 2013-14 while non-patient staff costs reduced by 20 per cent from £106,674 to £85,191. The Health Board has indicated that it is exploring ways to improve profitability and reduce the level of subsidy.

Exhibit 6: NHS organisations do not generate enough income to recover the cost of non-patient catering services; although Powys has the biggest gap in income, it makes up only three per cent of the overall shortfall across Wales



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

Exhibit 7: Income and costs from the Health Board's non-patient catering service are reducing

Year	Powys		
	Cost of non-patient catering services	Income achieved	% of cost not recovered
2011-12	263,838	80,966	69%
2012-13	163,846	79,273	52%
2013-14	139,212	78,400	44%

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

Arrangements for reporting on hospital catering and nutrition need to improve

58. In 2010, the existence of up-to-date strategies and plans to give effect to national policies in relation to hospital catering and patient nutrition was patchy, while in several NHS bodies arrangements needed to be harmonised following NHS re-organisation in 2009. A more comprehensive and co-ordinated approach was needed to seek the views of patients and families to inform plans and developments. NHS boards received limited information on the delivery and performance of catering services and issues relating to patient nutrition. Information from nutritional screening was not collated to understand the scale of the problem and likely impact on services. In some NHS bodies, executive accountabilities for catering and nutrition could be clearer.

59. In the Health Board at that time, executive accountability for catering and nutrition was clear. However, there was no overarching framework for nutrition and catering services. The Board received little information on these services. Mechanisms for gathering patient feedback were mostly informal with no arrangements in place to involve patient groups in planning, while patient involvement in menu testing and quality reviews was also very limited. Our follow-up work in 2014 found that the Health Board had implemented a three-year Nutrition and Catering Strategy in 2011, which was aligned to the national framework. However, there were still opportunities to include patient feedback as part of the new 360-degree audits undertaken at ward level.

Arrangements are in place to ensure national policies and standards are implemented but governance structures are being reviewed

60. Over the last year, the Health Board has reviewed its Nutrition and Catering Strategy, which it expects to be approved in September. The Strategy sets out how it will provide high quality nutrition and catering services. The Health Board supports a multidisciplinary approach to meeting patients' nutrition and hydration needs and this approach is emphasised in the Strategy.

61. The multidisciplinary Nutrition, Hydration and Catering Steering Group continues to provide assurance and oversight of the delivery of nutrition and catering services. The Head of Facilities and Transport Services chairs the Group and is supported by a Senior Locality Nurse, who acts as vice chair. The Group is responsible for overseeing the implementation of the all-Wales Nutrition and Catering Standards, as well as other national policies, Welsh Government directives and recommendations from external regulators. The Group co-ordinates actions and improvements in relation to nutritional care and catering. It currently reports to the Quality and Safety Committee through the Improving Patient Involvement and Experience sub-committee. Meetings of the sub-committee have been suspended while the Health Board reviews its arrangements for oversight and reporting of patient experience. The Group is preparing an annual report for the Quality and Safety Committee, which is due to be presented by the end of the year.

62. Lines of accountability are clear with final accountability for all aspects of patient care lying with the Chief Executive and the Board. The Director of Nursing is the designated executive board member accountable for patient nutrition. This role ensures reporting to the Board in liaison with the Director of Primary and Community Care who has operational responsibility for Powys-wide catering services. These Executive Directors are responsible for ensuring appropriate systems and processes are in place to achieve high standards of care and service delivery. The Head of Facilities and Transport Services reports to the Director of Primary and Community Care and the senior locality nurse reports to the Director of Nursing.

63. At the time of our audit, the Health Board was launching a consultation on the management structure of facilities. The last major structural review saw many of the functions within facilities, primarily hotel services, operating almost independently of the Head of Facilities and Transport Services. This has led to fragmentation in how services are co-ordinated and controlled.

Board reporting relies on the annual Fundamentals of Care Audit

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

65. The Health Board is now taking steps to update the Board on progress made in relation to nutrition, hydration and catering services amongst Board members. The Nurse Director has drafted a report to update the Board on work to improve patient care with respect to nutrition, hydration and catering, including findings from the 360-degree audits. Although the report provides a comprehensive description of the activities undertaken, it lacks specific performance measures or information on patient feedback or outcomes.

66. Compliance with nutritional screening is monitored by locality nursing teams but it is not included within the Health Board's performance dashboard. The Health Board is refreshing the quality indicators it presents to the Quality and Safety Committee and compliance with nutritional screening is being considered as one of the indicators. Information on food waste and costs of catering services are also not reported at a corporate level. Instead, costs and waste continue to be monitored and reported at locality level outside of the direct control of the Head of Facilities and Transport services.

67. The Health Board, as in other NHS bodies, has yet to collate regularly information from nutritional screening to understand the number of patients identified with nutritional problems on admission.

Patient feedback to support performance reporting is limited

68. The Health Board has recently introduced patient satisfaction questionnaires as part of the 360-degree audits and these will be undertaken this year. However, most patients' views are gathered through informal arrangements, such as issues highlighted by nursing staff or through patients on wards. The Health Board has yet to put in place arrangements to involve patient groups in planning catering services or to involve patients in menu testing and quality reviews. There is continued reliance on the Fundamentals of Care patient experience survey for board reporting.

69. We were told that catering and nursing staff within local hospitals work closely, which means any concerns are easily addressed. The Head of Facilities and Transport Services is well known amongst hospital staff, and regular hospital visits provide opportunities for face-to-face communication.

70. At the time of our fieldwork, the all-Wales menu framework group was conducting a questionnaire survey of inpatients across all NHS bodies about the choice and quality of food. The Head of Facilities and Transport Services distributed 70 surveys to patients across all hospital sites. The Health Board is waiting for the analysis of the survey findings, which were expected mid-summer. Across Wales, the response rate to the survey was 54 per cent compared with 46 per cent at the Health Board. Once the survey results are available, the Health Board plans to revise the menu cycle and menu options.

Appendix 1

Audit approach

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

Interviews and document review

We undertook a number of interviews with key individuals at the Health Board, including officers, a patient representative and ward managers. We also reviewed a number of documents, including reports from other relevant external organisations and the Health Board's response to these reports.

Data analysis

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

Ward observations

We undertook observations of the lunchtime mealtime service at four community hospitals, which we selected, to assess whether:

- patients and the ward environment were prepared for mealtimes;
- patients received the right meal;
- patients were helped with eating if necessary; and
- protected mealtimes were complied with.

We visited:

- Llandrindod Wells County War Memorial Hospital – Claerwyn Ward;
- Brecon War Memorial Hospital – Epynt Ward;
- Victoria Memorial Hospital Welshpool – Maldwyn Ward; and
- Knighton Hospital – Panpwnton Ward.

Case note review

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

- nutritional screening is undertaken using a validated screening tool when patients are admitted to hospital;

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

The five sets of case notes reviewed in each ward were selected by the ward managers.

Appendix 2

National and local recommendations

Table 1 sets out the seven local recommendations set out in our report, which summarised the findings from our 2010 audit work on hospital catering and patient nutrition services at the Health Board.

As part of our follow up in 2014, a number of recommendations were subsumed from 2010 into 2014 recommendations. Therefore these have not been repeated in our recommendations at the front of this report. The status of each recommendation[8] is also set out in Tables 1, 2 and 3.

Table 1 – 2010 local recommendations

Recommendation		Status at July 2015
Strategic planning and management arrangements		
R1	By March 2011, develop a new nutrition and catering plan to meet the Powys Teaching Health Board's future strategic requirements. This plan should: • respond to current and future financial pressures; • identify opportunities for integrated working with Powys County Council, both in regard of catering provision, but also in nutritional assessment and support in the wider health and social care community; and • increase focus on meeting nutritional needs of patients, particularly longer-term inpatients and Powys Teaching Health Board patients transferred in from district general hospitals out of county.	A
R2	By October 2010, commence implementation of the Catering Improvement Plan in Welshpool. Review catering staff demand versus supply to determine if efficiencies can be achieved.	A
Procurement production and cost control		
R3	By January 2011, develop performance and financial management arrangements for catering and nutrition. The arrangements should: • include fit-for-purpose and efficient mechanisms to report on quality of the catering and mealtime service that includes direct patient views and internal peer reviews; and • include basic financial costing and financial management processes to enable monitoring, reporting and management of inventory, actual cost of provisions used, staff demand based on activity versus supply.	O
R4	By November 2010, make a decision on the approach to staff meal subsidy and staff meal pricing.	A

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

Recommendation		Status at July 2015
Procurement production and cost control		
R5	Ensure that the catering IT system implementation is delivered as a formal project and that appropriate multi-disciplinary representatives are involved so that the system: • supports effective and efficient operational service delivery; • provides improved patient ordering to meet patients nutritional needs; and • improves management intelligence/information and reporting.	N/A
Meeting patients' nutritional needs and supporting recovery		
R6	By January 2011, ensure protected mealtimes and effective mealtime patient support is provided at all sites.	O
R7	By January 2011, improve the range of food available out of hours and ensure that there is stock rotation of the food between the ward and the main kitchen stock to limit food waste.	A

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

Table 2 – 2011 national recommendations

Recommendation		Status at July 2015
Ensuring patients' nutritional needs are met		
R1b	We recommend that NHS bodies use the results presented in our local audit reports as a basis for ensuring that they are effectively implementing the all-Wales Nutritional Care Pathway, in particular, ensure that nutritional screening effectively identifies all patients who have nutritional problems, or are at risk of developing them, and that appropriate care plans and monitoring activities are instigated.	A
R1c	We recommend that NHS bodies regularly audit compliance with all aspects of the nutritional care pathway across all their hospital sites and share the results of these monitoring exercises with all the relevant staff groups involved in catering and patient nutrition services.	A
R1d	Where poor compliance with nutritional care pathway requirements is identified, we recommend that NHS bodies should establish the reasons for this, and implement clear plans of action to address the problem and include provision of necessary training to staff.	A

Recommendation		Status at July 2015
Ensuring patients' nutritional needs are met		
R1e	We recommend that NHS bodies have arrangements in place to ensure that patients have access to food 24 hours a day; provision of snacks should be part of these arrangements and patients should be made aware of what snacks are available to them, and when.	A
R2a	We recommend that NHS bodies take steps to ensure that all menus in use across hospital sites have been nutritionally assessed by dieticians.	A
Improving patients' mealtime experience		
R3a	We recommend that NHS bodies ensure that their menus provide an appropriate choice of food and that the arrangements for ordering and serving food support adequate patient choice.	A
R3b	We recommend that NHS bodies review their practices at ward level to make sure that patients are helped to get comfortable in readiness for their meals, and are given the opportunity to wash their hands before the meal is served.	A
R3c	We recommend that NHS bodies continue to roll out the protected mealtime policy to as wide a range of wards as possible, communicating its importance to all the relevant staff groups working in the hospital, and regularly reviewing compliance with the policy.	O
Controlling the costs of the catering service		
R4b	We recommend that NHS bodies introduce computerised catering information systems, supported by clear cost benefit analysis in comparison to existing manual based information systems.	N
R5a	We recommend that NHS bodies review their current cost control mechanisms to ensure that they are making full use of standard costed recipes.	A
R5b	We recommend that NHS bodies review their current cost control mechanisms to ensure that they are making full use of daily food and beverage allowances for patients.	A
R5c	We recommend that NHS bodies review their current cost control mechanisms to ensure that they are making full use of standardised local catering contracts for the same or similar products across all their hospital sites.	A
R6a	We recommend that local and national targets are set for food wastage; as a guide NHS organisations should aim to ensure that wastage from un-served meals does not exceed 10 per cent.	A

Recommendation		Status at July 2015
Controlling the costs of the catering service		
R6b	We recommend that NHS bodies routinely monitor food wastage according to clear guidelines of what constitutes an un-served meal, and that this information is used to generate meaningful comparisons locally and nationally.	A
R6c	We recommend that monitoring of food waste should include identification of the reasons for the wastage that is observed, and this information should be used to identify priorities for improvements in systems and processes that are causing the waste.	A
R6d	We recommend that NHS bodies emphasise to their staff that controlling food waste is a collective responsibility and that catering and ward-based staff should work together to tackle the problem.	A
R7a	We recommend set pricing policies and income generation targets that aim to ensure that non-patient catering services at least break even, or, if they do not, it is the result of a deliberate subsidy policy that is based on a detailed analysis of costs.	O
R7b	We recommend that NHS bodies regularly monitor income and expenditure of non-patient catering services to ensure that the financial performance of these services is as expected and that unacceptable deficits are not being incurred.	O
Effective service planning and monitoring		
R8b	We recommend that NHS bodies ensure that they have up-to-date plans and procedures that set out the local arrangements for implementing national policy requirements and to ensure that as far as possible, catering and nutritional services are standardised, particularly where NHS re-organisation has brought together a number of different service models under one organisation.	A
R8c	We recommend that NHS bodies ensure that executive director accountabilities for catering and nutrition are clearly defined, and where two or more executive directors are involved, there are well defined arrangements for the co-ordinated planning and monitoring of services.	A
R9c	We recommend that NHS bodies should ensure that they make full use of Estates and Facilities Performance Management System data as a tool in managing and monitoring their catering and nutritional services.	A

Recommendation		Status at July 2015
Effective service planning and monitoring		
R10a	We recommend that NHS bodies develop a more comprehensive approach to reporting performance on catering services and patient nutrition to the Board, which brings together information on implementation of the nutritional care pathway, performance data on the costs of patient and non-patient services, food wastage and patient and relative feedback and this information should be presented to the Board at least annually and should make appropriate use of the EFPMS data.	O
R10b	We recommend that NHS bodies systematically collate the information from nutritional screening on the number of patients identified with, or at risk of, nutritional problems to understand the scale of the problem and the likely impact on catering and nutrition services to meet these patients' needs.	N
R11a	We recommend that NHS bodies ensure that there are effective arrangements in place for sharing information on patients' views about catering services between ward sisters/charge nurses and the catering service.	A
R11b	We recommend that NHS bodies demonstrate how they have taken patients' views into account when developing catering and nutrition services.	N
R11c	We recommend that NHS bodies establish mechanisms to involve patients' in activities that assess the quality of catering and nutrition services.	N

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

Table 3 – 2014 local recommendations

Recommendation		Status at July 2015
Ensuring patients' nutritional needs are met		
R1	Strengthen 360 degree° audit approaches by: • following up the 360 degree° audits to ensure that any identified improvement actions are both implemented and embedded; • ensuring requirements set out in the Trusted to Care report are implemented; and • introduce patient feedback approaches to inform the assessment.	A

Recommendation		Status at July 2015
Ensuring patients' nutritional needs are met		
R4	Ensure that the Health Board meets national e-learning nutrition training requirements. Issues such as access to IT and staff availability for training need to be resolved.	O
Controlling the costs of the catering service		
R2	Improve the ongoing reporting of catering costs at a Health Board site level to ensure that: • Overall costs and costs per patient are more consistent across sites and closer to target costing. • There is improved consolidation and co-ordination of product and resource cost centrally. • Total costs for catering do not exceed the planned budget and that cost improvements are achieved. Cost improvements should come from better control of expenditure, waste and efficiency, and not results in any detriment to the quality of nutrition provided to patients.	O
Effective service planning and monitoring		
R3	Review the Catering and Nutrition strategy to ensure that it aligns with any emerging nutritional strategy and framework requirements and the recommendations identified in trusted to care.	A

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