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Hospital Catering and Patient Nutrition Follow-up Review

Velindre NHS Trust

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Status of report

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The person who delivered the work was Sara Utley.

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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 2013.

5. To support the implementation of the standards, caterers and dieticians across Wales worked together to produce the All Wales Hospital Menu Framework, which was launched at the end of January 2013. The Framework consists of a database of an agreed set of menu items, a standardised set of recipes and cooking methods, nutritional analysis of each menu item and a range of snacks that are compliant with the 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] http://www.wao.gov.uk/publication/hospital-catering-and-patient-nutrition

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

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 Velindre NHS Trust (the Trust) to assess the extent to which it had implemented the Auditor General's national recommendations[5]. We also assessed the extent to which the Trust had addressed the recommendations made as part of the local audit in 2010 and again in 2012.

8. We concluded that the Trust has made good progress in addressing recommendations to improve catering and nutrition services. More work is needed to strengthen some aspects of nutritional screening and to continue reducing the level of subsidy for non-patient catering. We reached this conclusion because:

- Arrangements for meeting patients' dietary and nutritional needs are generally good although there is scope to strengthen some aspects of nutritional screening:
  - patients are nutritionally screened but weight and height are not always recorded and there is confusion about the referral criteria for dietetic assessment;
  - compliance with the nutritional care pathway is routinely assessed and reported both locally and corporately;
  - current arrangements ensure patients have access to food and beverages 24 hours a day;
  - menu items are nutritionally assessed through the all-Wales menu framework with which the Trust is compliant; and
  - written information on what to expect in hospital is available at the patient's bedside.
- Patients are positive about mealtime experiences and the principles of protected mealtimes are generally adhered to:
  - patients are generally positive about food services and the Trust is working to increase choice;

[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.

  - nursing support is available at mealtimes for those patients needing help; and
  - protected mealtime principles are generally observed.
- Costs of patient catering services and levels of food waste compare favourably with other hospitals and the level of subsidy for non-patient catering continues to reduce:
  - the cost of patient catering services compares favourably with other hospitals;
  - food wastage is regularly monitored and is below the national target; and
  - the gap between income and cost for non-patient catering services is reducing.
- Arrangements for planning, monitoring and reporting on hospital catering and nutrition services are in place but could be more visible:
  - there are well-established arrangements through the Patient Nutrition Improvement Group to ensure national policies and standards are implemented;
  - corporate arrangements for monitoring the nutritional care pathway and food quality are in place but its profile could be raised further; and
  - effective mechanisms are in place to capture and act upon patient feedback.

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

Recommendations

10. The Trust has fully achieved 27 recommendations previously set out in our national and local reports. The Trust 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. In addition to continuing to address those recommendations still outstanding the Trust needs to review its contract for the provision of meals to ensure that it meets the needs of the Trust and provides value for money.

11. 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 recommendations still to be achieved at July 2015

Recommendations	
Controlling the costs of the catering service	
R4b	We recommend that NHS bodies introduce computerised catering information systems, supported by clear cost benefit analysis in comparison to existing manual based information systems (National).
R5b	We recommend that NHS bodies review their current cost control mechanisms to ensure that they are making full use daily food and beverage allowances for patients (National).
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 (National).
R7a	We recommend that set pricing policies and income generation targets that aim to ensure that non-patient catering services at least break even, or, if they do not, it is the result of a deliberate subsidy policy that is based on a detailed analysis of costs (National).
Effective service planning and monitoring	
R10b	We recommend that NHS bodies systematically collate the information from nutritional screening on the number of patients identified with, or at risk of, nutritional problems to understand the scale of the problem and the likely impact on catering and nutrition services to meet these patients' needs (*National*).

Detailed report

Arrangements for meeting patients' dietary and nutritional needs are generally good although there is scope to strengthen some aspects of nutritional screening

12. In 2010, many hospitals in Wales had improved their arrangements to ensure patients' nutritional needs were met but information was fragmented and did not allow for a quick overview of patients' nutritional problems or for reviewing nutritional status easily. The lack of standardised nursing documentation to record key assessment information may have contributed to the variation in quality of the nursing records. Not all NHS bodies regularly monitored compliance with the nutritional care pathway. At the Trust, patients were not always screened on admission in relation to nutritional risk, with an inconsistent approach to nutritional care plans and some patients at high risk of malnutrition not referred for dietetic assessment. Follow-up audit work in 2012 found that the Trust had made good progress on improving compliance with nutritional screening standards. Refresher training had been delivered to all nursing staff on the nutritional screening tool, including clarification of the trigger points/thresholds at which patients needed to be referred for assessment. All patients were being assessed in relation to dietary requirements on admission and individual nutritional care plans were being developed for patients who were assessed as at risk or having additional dietary requirements.

13. A Healthcare Inspection Wales (HIW) review in 2014 also found that patients' nutritional needs were assessed appropriately. HIW reported a positive emphasis on ensuring that drinks were offered regularly with patients encouraged and assisted to eat their meals in accordance with their identified needs.

Patients are nutritionally screened but weight and height are not always recorded and there is confusion about the referral criteria for dietetic assessment

14. As part of our 2015 work, we reviewed a set of case notes on one ward that we visited as part of the audit, five case notes in total. 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 patients and rescreened patients using the Moreland Scale[6] nutritional screening tool but not all patients were weighed within 24 hours of admission, and patients' heights were not always recorded. The Moreland Scale is composed of six elements, such as appetite, diet and treatment, which nursing staff use to assess nutritional risk. Nursing staff use the same form for repeat assessments, making it difficult to see which score relates to which assessment and changes in risk status.

[6] The Moreland Scale is a nutritional assessment tool developed and validated by Velindre NHS Trust specifically for patients with cancer.

15. At the time of our audit, the Trust had made temporary changes to the criteria for referral for dietetic assessment. This was due to staff shortages within the dietetic department. These revised criteria included:

- a Moreland score of 35 or more;
- upper gastrointestinal or head and neck cancers;
- patients requiring enteral or parenteral feeding; and
- patients who have been 'nil by mouth' for more than five days.

16. Our fieldwork found that the temporary changes to the referral criteria could have been better communicated because nursing staff were unsure why the temporary changes had been made and were unsure which patients should be monitored using the all-Wales food charts. Meanwhile, dietetic staff told us that they visited patients where nursing staff had concerns irrespective of the referral criteria.

17. The All Wales Nutrition and Catering Standards make it clear that oral health and communication are part of nutritional care. The Trust has adopted the all-Wales oral health assessment and has adapted this assessment tool for use in the cancer care setting. Nursing notes are completed against the 12 fundamentals of care themes. Within these 12 criteria are three sections relating to catering and nutrition. These are oral health and hygiene, eating and drinking, and communication. Our review found information on oral health recorded in four of the five case notes we reviewed, while all case notes recorded communication difficulties. Findings from the 2014 Fundamentals of Care audit, which was completed in November 2014, also found good compliance with the assessment of oral health although performance was slightly down compared with 2013.

18. Nursing notes for the five patients reviewed recorded information on swallowing, as well as the patients' ability to feed themselves and mobility. We looked for and found evidence in the medical notes of referrals for and assessments of swallowing.

19. All case notes recorded the patients' current therapeutic, lifestyle or cultural requirements in relation to food and fluids, as well as their usual dietary intake. Nursing staff used the nursing notes to record care plans in relation to nutrition, and these were tailored to the patient needs. Food charts were in place and well completed, with the portion size consumed recorded. Fluid charts were also in place and used appropriately.

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

20. In 2010, not all NHS bodies monitored compliance with the nutritional care pathway, although arrangements were in place at the Trust to monitor routine compliance. By 2012, the Trust was monitoring regularly that nutritional screening was undertaken and care plans developed where appropriate.

21. The Trust continues to monitor compliance with nutritional screening. At ward level, the proportion of nutritional assessments completed within 24 hours of admission is captured monthly using the all-Wales nursing metrics system. This information is reported to the Welsh Government and also reported through the Trust's nursing dashboard.

22. These data are supplemented by a quarterly audit undertaken by dietetic staff, who assess compliance with nutritional screening, as well as checking that patients identified as at risk are referred for dietetic assessment. The audit assesses whether:

- nutritional screening is undertaken within 24 hours of admission;
- patients are referred to the dietician appropriately;
- patients' heights and weights are recorded; and
- patients are rescreened based on their nutritional risk.

23. Audit findings are shared immediately with ward staff and the size of the Trust means all wards participate in the quarterly audit. The audit findings are discussed at the Patient Nutrition Improvement Group.

24. In 2010, there were no regular training programmes or refresher training for ward staff to maintain awareness on using the nutritional screening tools and assessment documentation. The Welsh Government introduced an e-learning training package in the use of the all-Wales nutrition care pathway and all-Wales food and fluid charts in September 2011. All ward-based nursing staff were required to complete the e-learning training package within 12 months of this date, while new staff should complete it within 12 months of appointment. The Trust achieved good levels of compliance with more than 80 per cent of staff undertaking the training. Long-term sickness absence and maternity leave account for the non-compliance of the remaining staff. The Trust still aims to achieve 100 per cent compliance.

25. At the Trust in 2010, all catering staff were trained in food hygiene, in addition, dietetics staff worked closely with ward-based staff to ensure they had a basic understanding about nutrition and the importance of different therapeutic or modified texture diets. Our latest audit found these arrangements are still in place and that dietetic staff continue to support catering staff with regular training.

Current arrangements ensure patients have access to food and beverages 24 hours a day

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

27. At the Trust, 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 and ward-based catering staff anytime of the day.

28. The standards for patient food and fluid identify that seven to eight beverage rounds should take place each day, offering hot and cold beverages and that water in jugs should be changed three times a day. The 2014 Fundamentals of Care audit found that drinking water was always available and within patients' reach. All wards achieved seven or more beverage rounds a day and water jugs were replenished three times a day. Most (94 per cent) of patients responding to the Fundamentals of Care patient experience survey reported that they were provided with fresh drinking water and plenty of drinks when needed. Our ward visit found that water was always available. Ward staff confirmed that water jugs are changed at least three times a day and the ice machines available on each ward help make water more appealing.

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

29. In 2010, we found that dieticians were involved in menu planning at all hospitals but not all hospital menus had been nutritionally assessed. Since then, the Welsh Government published the All Wales Nutrition and Catering Standards, which specify the 12 minimum nutrients for analysis. The Trust indicated that it is fully compliant with the all-Wales menu framework using the recipes in the database to design the patient menu. One of the Trust's criteria for tendering for catering services is the need for suppliers to demonstrate that meals are nutritionally assessed and comply with the all Wales nutrition and catering framework. The Trust's meal provider continues to provide meals that are nutritionally assessed and meet the standards set out in the all-Wales nutrition and catering standards.

30. Dieticians from the Trust also attend meetings in respect of the All Wales Menu. The Trust 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 Trust 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 on what to expect in hospital is available at the patient's bedside

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 asking NHS bodies to provide patients with the information set out in the Auditor General's leaflet **Eating Well in Hospital – What You Should Expect**. Ward staff told us that patients do receive information about how their nutritional or dietary needs or preferences will be met while in hospital. A folder at each patient's bedside contains a printed menu, as well as the Wales Audit Office information sheet on 'eating well in hospital'.

Patients are positive about mealtime experiences and the principles of protected mealtimes are generally adhered to

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 Trust, patients received their meals in good condition, and were helped to prepare for meals, and the ward environment was well prepared for mealtime. The Trust's catering service was flexible enough to ensure adequate choice but arrangements for sharing information between nursing and catering staff needed to improve. Our follow-up audit work in 2012 found that the introduction of 'at a glance' patient notice boards on each ward had helped to improve communication between nursing and ward-based catering staff. The findings from our most recent work are summarised below.

Patients are generally positive about food services and the Trust is working to increase choice

34. Currently, the Trust operates a one-week menu cycle and it would like to move to a two-week menu cycle.

35. The Trust has a menu-planning group comprised of nursing staff, dieticians, catering staff and a patient representative. The Group meets when required and its aim is to ensure menus are appealing, as well as nutritionally appropriate.

36. Regular feedback is sought quarterly on operational services, with catering being a key component. Overall results are good, although there have been some comments on the lack of choice available at mealtimes. Annual results for 2014-15 were that 92 per cent of patients were satisfied with catering services.

37. Trained survey staff undertake patient experience and feedback surveys on a one-to-one basis each month. These surveys ask patients about their care, and if they have any general concerns. The catering department acts upon any relevant information provided by patients. For example, an enhanced light-meal service is now in place in the day unit, with more frequent drinks rounds, snacks and sandwiches available following patient feedback.

Nursing support is available at mealtimes for those patients needing help

38. Nursing staff compile bed plans, which highlight the dietary requirements of patients to aid catering staff when taking patients' food and drink orders. This is supplemented by verbal communications between nursing and catering staff.

39. We observed a lunchtime meal service on one ward at the Trust. From our observations, we found that:

- There was a clear commitment from catering staff to encourage patients to eat and provide appetising meals that patients would enjoy. Ward-based catering staff were knowledgeable about patients' nutritional needs and dietary preferences and helped cut up food and open packaging. They also encouraged patients to eat, tempting them with different meal options when they refused to eat a hot meal.
- At the time of our visit, no patients needed assistance with eating so nursing staff did not accompany the ward-based catering staff during the meal service. The small ward size meant that nursing staff were able to monitor patients more easily from a distance and make themselves available to support patients if required. Our observations reflect the findings of the Trust's 2014 Fundamentals of Care audit, which found that only half the time did a registered nurse co-ordinate mealtimes and were all nursing staff engaged in helping at mealtimes.
- Information on patients' nutritional needs or preference was in the kitchen area for the catering staff. It was clear there was an understanding of the needs of patients, and alternative items had been sourced for patients on their request. However, we were told by one person from the catering team that they were not always informed of changes to patients' nutritional needs and that bed plans were sometimes not up to date.

40. The 2014 Fundamentals of Care audit found that all wards had systems in place to allow family or friends to assist with meal times. Ward staff told us that they encouraged relatives to support patients at mealtimes but they felt this needed to be managed carefully so as to not affect other patients who are uncomfortable eating in front of visitors.

41. Exhibit 2 sets out our observations of the lunchtime meal service based on the activities that we expected to see and whether these activities applied to all, most, some, or no patients.

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

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

Source: Wales Audit Office observations of lunchtime services

Protected mealtime principles are generally observed

42. Our 2010 report found the Trust has good arrangements for protected mealtimes. The policy was actively promoted and clear signage was evident, indicating that mealtimes were not meant to be interrupted. Although there is no specific policy, the Trust monitors compliance through regular audits.

43. During our ward visit, we found signage at ward entrances explaining the times protected meal times operated. However, there was no other information on the sign setting out the reasons and principles, or encouraging relatives to support mealtimes. At the time of our visit, temporary ward refurbishment work was underway, which meant some areas were not in use. One area of the ward that we visited had been set aside for patients undergoing surgery. Unfortunately, this area was at the far end of the ward, which meant that patients were transferred between the ward and theatre during mealtimes. Staff acknowledged this situation was not ideal but worked to minimise disruption to other patients and the Trust is taking steps to put in alternative arrangements.

44. During our ward visits, we found:

- Healthcare professional staff were not present on the ward, with the exception of those staff supporting patients transferred between the ward and theatre.
- Cleaning activities were restricted to ward corridors during the meal service and not near the patients' bedsides. No cleaning activities impeded the food trolley or meal service.

Costs of patient catering services and levels of food waste compare favourably with other hospitals and the level of subsidy for non-patient catering continues to reduce

45. In 2010, we found that 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 to computerise hospital catering systems and most catering information management 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. In 2010, we reported that the Trust was actively managing costs, but more needed to be done to control these costs, in particular reducing the level of subsidy and waste from un-served meals. In addition, wastage monitoring arrangements needed to be improved. At the time of our follow-up work in 2012, the level of subsidy was reducing and changes had been made to arrangements for ordering patient meals and monitoring un-served waste.

The cost of patient catering services compares favourably with other hospitals

48. The Trust's EFPMS data submissions show fluctuations between 2011-12 and 2014-15 in the cost of patient catering services (Exhibit 3). Across all NHS bodies, the cost of patient catering services reduced by five per cent. A four-year contract for the provision of meals was put in place with the provider in 2008, but has not been formally renegotiated by the Trust: there may be opportunities for the Trust to renegotiate its current contract.

49. Our analysis of the EFPMS data for patient catering services shows that provision and other non-consumable costs had reduced while at the same time the number of patient meals requested was also reducing. The number of patient meals requested reduced by 14 per cent from 44,165 meals in 2011-12 to 37,890 meals in 2013-14, compared with a four per cent reduction across Wales.

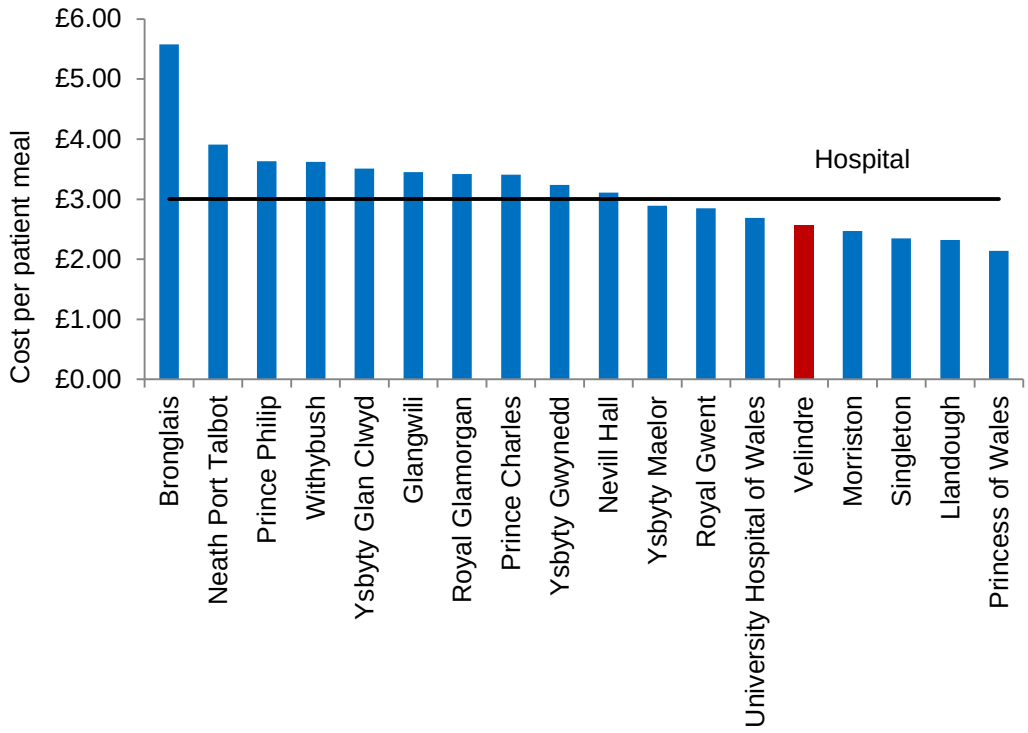
Exhibit 3: Patient catering service costs have fluctuated over the last three years

Year	Cost of catering services	
	Velindre	**Wales**
2011-12	£96,492	£38,950,000
2012-13	£101,248	£37,260,000
2013-14	£88,022	£36,970,000

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

50. The Trust has not set a daily fixed patient meal cost. The EFPMS data for 2013-14 show that the cost per patient meal was £2.56, having increased slightly from £2.35 in 2012-13. The cost per patient meal is below the hospital average (Exhibit 4).

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



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

51. In 2010, the Trust's food production arrangements relied heavily on manual paper systems rather than an IT solution. In his national report, the Auditor General recommended that NHS bodies should introduce computerised catering information systems, and NHS Wales Informatics Service and NHS Shared Services Partnership have developed an outline business case to procure a national catering IT solution. Our latest audit found that NHS bodies, including the Trust, have commented on the outline business case and the Trust is awaiting the outcome before making any decisions to invest in a local IT solution. The Trust has purchased a system to improve stock control, and electronic point of sales cash tills are in place. For the most part, however, the Trust relies on manual paper systems.

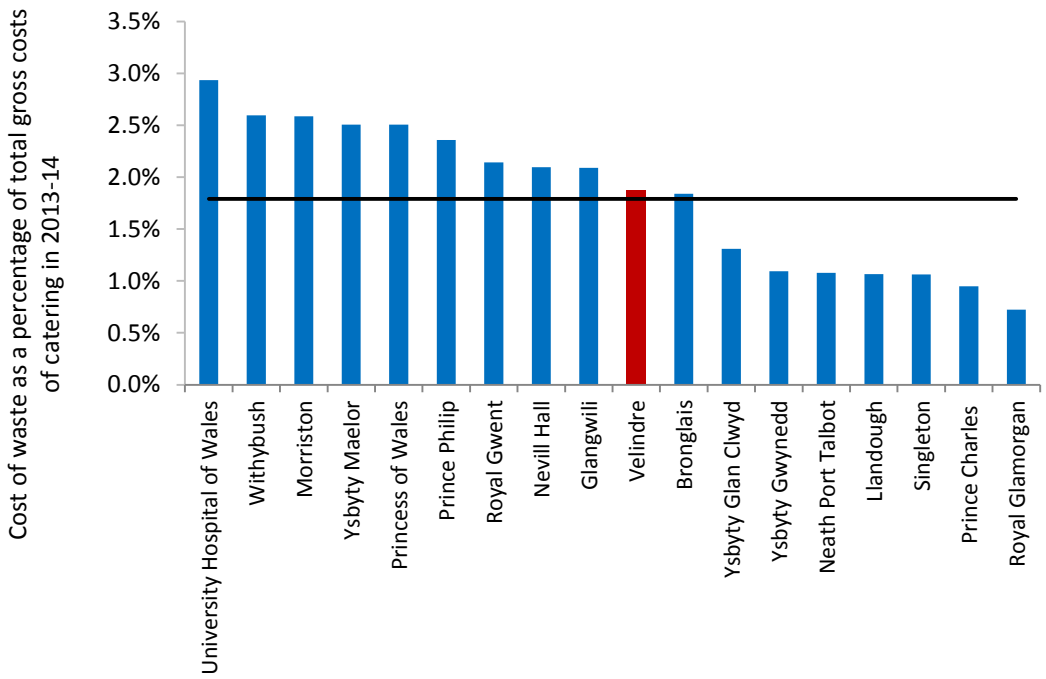
52. To support the implementation of the 2011 nutrition and catering standards, the All Wales Hospital Menu Framework was launched in January 2013. Recipes within the menu framework are costed. All Trusts jointly funded the appointment of a procurement dietician working in the NHS Shared Services Partnership – Procurement Service to support the development of all-Wales procurement contracts to source provisions commodities for the dishes on the menu framework. The Trust 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.

Food wastage is regularly monitored and is below the national target

53. In 2010, levels of un-served food waste were high on some wards across the Trust with improvements needed to measure accurately un-served food waste. By the time of our follow-up work in 2012, the Trust had developed arrangements to monitor food waste, and waste was reducing. Improvements had been made to patient ordering processes, with patients now asked for their choice approximately two hours prior to meal times. This had helped prevent regenerating too many food portions.

54. The Trust has clear guidelines about what constitutes un-served meal waste. Un-served waste (known as trolley waste) is food not served from the food trolley but the Trust does not record plate waste. The Trust continues to monitor food waste from un-served meals. In 2014-15, the volume of food waste from un-served meals was less than 8.6 per cent compared with 38 per cent at the time of our 2010 audit. This is below the national target of 10 per cent. The multidisciplinary approach to mealtime audits also ensures issues around waste are tackled collectively. Analysis of the 2013-14 EFPMS data shows that the cost of un-served meals at the Trust was £5,263, which equates to 1.8 per cent of its total catering costs, just above the hospital average (Exhibit 5).

Exhibit 5: The cost of food waste at the Trust accounts for 1.8 per cent of total catering costs



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

55. The Trust is signed up to the Waste and Resources Action Programme (WRAP). The disposal of food waste is managed through an anaerobic digestion system, which was installed 18 months ago in the hospital kitchen. Waste is taken from ward level and placed into the digester to be broken down. This has replaced maceration of food at ward level. Although the machine converts waste into certified grey water, this will not meet the requirements of the Environmental Bill, as the end product cannot be treated. Costs of this equipment are minimal, as the machine is now owned by the Trust. Discussions are ongoing with the Welsh Government in respect of the machine.

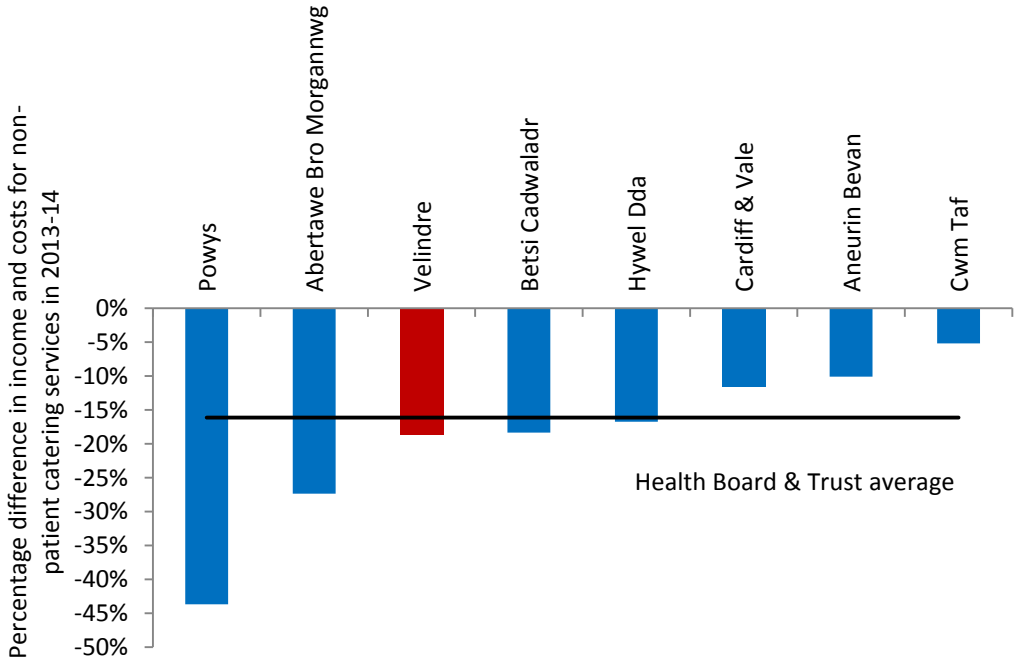
The gap between income and cost for non-patient catering services is reducing

56. In 2010, the Trust did not have a subsidy policy in place, but was explicit about the need for non-patient catering services to break even by 2012. Although the catering service generated a substantial sum of income, it was only enough to recover 60 per cent of the total cost and the Trust was subsidising non-patient meals by £106,000 in 2008-09. At that time, we recommended that the Trust introduce clear plans to reduce the level of subsidy used to support non-patient catering services.

57. By the time of our follow-up audit in 2012, the Trust had reduced the non-patient subsidy by 25 per cent to £80,000 in 2011-12. A paper had been prepared by the Trust's financial stability group to consider the potential options on reducing the subsidy further. The paper recommended four potential options, with the only option that would achieve cost neutral status being the closing of the Parkside restaurant. A decision was taken to keep a small level of subsidy and to pursue efficiency savings.

58. Across Wales, the income generated from non-patient catering services was insufficient to recover operating costs in 2013-14 (Exhibit 6). At Velindre, the cost of non-patient catering services was £183,150 in 2013-14 with the income generated enough to recover 81 per cent of these costs. This equates to a subsidy of around £34,000. At the time of our fieldwork, the Trust was compiling the 2014-15 EFPMS data to submit to the NHS Shared Services Partnership. These data show that the level of subsidy continues to fall, and had reduced to £22,278. The continued improvement suggests that the Trust's work to deliver efficiency savings is having an impact (Exhibit 7).

Exhibit 6: NHS organisations do not generate enough income to recover the cost of providing non-patient catering services; there is a 19 per cent shortfall in income at the Trust



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

Exhibit 7: Costs of the Trust's non-patient catering service are reducing

Year	Velindre		Wales	
	Cost of non-patient catering services	Income achieved	Cost of non-patient catering services	Income achieved
2011-12	£200,149	£134,985	£15,050,000	£11,200,000
2012-13	£184,903	£148,988	£14,500,000	£11,530,000
2013-14	£183,150[1]	£148,964	£13,430,000[1]	£11,260,000

[1] Includes rental costs for vending machines

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

Arrangements for planning, monitoring and reporting on hospital catering and nutrition services are in place but could be more visible

59. 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.

60. In the Trust at that time, executive accountability for catering and nutrition was clearly identified and sound strategies and policies, developed by appropriate multidisciplinary staff, were in place. The Board received information on catering and nutrition services and there were different mechanisms for seeking patient feedback. However, we recommended that the Trust assess the arrangements for reviewing performance and potential service risks. Our 2012 follow-up work found that the Trust had reviewed its arrangements for reporting the performance of catering services and risks, with indicators monitored by relevant groups and committees.

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

61. Executive responsibilities are clearly defined with the Executive Director of Nursing and Service Improvement responsible at Board level for catering and nutrition, supported by the Cancer Centre's Director of Nursing.

62. The Trust established a Patient Nutrition Improvement Group, which is responsible for developing policies in relation to catering and nutrition, as well as reviewing tenders for catering services. Group membership is drawn from catering, nursing, dietetics and the Patient and Carer Liaison Group. The Group, which meets quarterly to discuss and resolve issues relating to catering and nutrition, reports to the Quality and Safety Committee.

63. The Patient Nutrition Improvement Group is chaired by the Head of Facilities. Issues are reported to the Cancer Centre Division Infection Control Group, Organisational Learning Committee and the Trust's Quality and Safety Committee. Performance on catering, in terms of satisfaction, is reviewed by the Quality and Safety Forum.

Corporate arrangements for monitoring the nutritional care pathway and food quality are in place but its profile could be raised further

64. Board reports on catering and nutrition are by exception now that the 2011 all-Wales standards for catering and nutrition and the all-Wales menu framework are embedded within the Trust. The Board continues to receive the annual self-assessment against the standards for health and care services and the findings from the Fundamentals of Care audit. Those elements related to eating and drinking and nutrition show there is scope for improvement, which the Trust is addressing. Improvement against any actions plans is monitored by the Trust board.

65. The Trust is looking to strengthen its reporting arrangements. Work is underway to integrate performance metrics on catering and nutrition within the quarterly performance storyboard reports. This would help raise the profile of catering services further.

66. Information on food waste and costs of catering services is less visible at a corporate level and is instead monitored and reported at an operational level.

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

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

Effective mechanisms are in place to capture and act upon patient feedback

69. The Trust has continued to demonstrate the importance upon which it places obtaining patient views. Patient participation is good, and there are a number of mechanisms in place to capture patient's feedback, including:

- a quarterly catering satisfaction survey, which shows high levels of patient satisfaction;
- patient experience surveys as part of the Fundamentals of Care audits with members of the Patient Liaison Group supporting the process by distributing surveys and helping patients to complete the survey if required;
- reporting of complaints and concerns; and
- attendance at meetings of the Patient Liaison Group by the Head of Facilities to discuss any specific catering issues.

70. The Trust believes that involving the Patient Liaison Group in gathering patient feedback enhances the process, while the Patient Liaison Group reported that catering services are responsive to their comments.

71. 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 Trust included additional questions on menu choice of relevance to its local services. Dietetic staff distributed surveys to 60 patients across the hospital, with a 43 per cent rate. Meanwhile, the Trust has not received any formal complaints in relation to catering services.

Appendix 1

Audit approach

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

Interviews and document review

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

Data analysis

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

Ward observations

We undertook observations of the lunchtime mealtime service on one ward, to assess whether:

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

We visited wards on the first floor.

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 six 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 Trust. The status of each recommendation[7] is also set out in Tables 1, 2 and 3.

Table 1 – 2010 local recommendations

Recommendation		Status at July 2015
Effective service planning and monitoring		
R1	Assess whether the current arrangements for reviewing performance and potential service risks via the Trust's Infection Control Group and the Divisional Risk Management group are adequate, and, if not, expand the scope of report to the Trust Board to include performance indicators and potential service risks.	A
Controlling the costs of the catering service		
R2	Complete its plans to reduce the level of subsidy used to support non-patient catering services.	A
R3	Review the current arrangements for monitoring food waste by: • examining the reasons for regenerating too many portions, if wastage levels exceed an agreed threshold; • recording the reasons for regenerating too many portions to seek solutions to over production; and • checking that one day each month used to compile annual wastage is typical for that month.	A
Ensuring patients' nutritional needs are met		
R4	Improve arrangements for communication in relation to patients' dietary requirements by: • developing and agreeing a format for identifying the dietary requirements of each patient so that ward-based catering staff can take patients' orders and prepare meals efficiently, effectively and safely.	A

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

Recommendation		Status at July 2015
Ensuring patients' nutritional needs are met		
R5	Improve compliance with nutritional screening by: • exploring the reasons for non-compliance with nursing staff; • ensuring that reasons for not screening patients in relation to nutritional risk are recorded in the nursing care notes; and • providing guidance for using the Moreland nutritional screening tool, including re-enforcing the threshold at which patients should be referred for dietetic assessment.	A
R6	Agree an approach for nutritional care plans that sets out a basic number of actions for the different levels of risk depending upon the Moreland risk score.	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 their menus provide an appropriate choice of food and that the arrangements for ordering and serving food support adequate patient choice.	A
R3b	We recommend that NHS bodies review their practices at ward level to make sure that patients are helped to get comfortable in readiness for their meals, and are given the opportunity to wash their hands before the meal is served.	A
R3c	We recommend that NHS bodies continue to roll out the protected mealtime policy to as wide a range of wards as possible, communicating its importance to all the relevant staff groups working in the hospital, and regularly reviewing compliance with the policy.	A
Controlling the costs of the catering service		
R4b	We recommend that NHS bodies introduce computerised catering information systems, supported by clear cost benefit analysis in comparison to existing manual based information systems.	N
R5a	We recommend that NHS bodies review their current cost control mechanisms to ensure that they are making full use of standard costed recipes.	A
R5b	We recommend that NHS bodies review their current cost control mechanisms to ensure that they are making full use daily food and beverage allowances for patients.	O
R5c	We recommend that NHS bodies review their current cost control mechanisms to ensure that they are making full use of standardised local catering contracts for the same or similar products across all their hospital sites.	O

Recommendation		Status at July 2015
Controlling the costs of the catering service		
R6a	We recommend that local and national targets are set for food wastage; as a guide NHS organisations should aim to ensure that wastage from un-served meals does not exceed 10 per cent.	A
R6b	We recommend that NHS bodies routinely monitor food wastage according to clear guidelines of what constitutes an un-served meal, and that this information is used to generate meaningful comparisons locally and nationally.	A
R6c	We recommend that monitoring of food waste should include identification of the reasons for the wastage that is observed, and this information should be used to identify priorities for improvements in systems and processes that are causing the waste.	A
R6d	We recommend that NHS bodies emphasise to their staff that controlling food waste is a collective responsibility and that catering and ward-based staff should work together to tackle the problem.	A
R7a	We recommend that set pricing policies and income generation targets that aim to ensure that non-patient catering services at least break even, or, if they do not, it is the result of a deliberate subsidy policy that is based on a detailed analysis of costs.	O
R7b	We recommend that NHS bodies regularly monitor income and expenditure of non-patient catering services to ensure that the financial performance of these services is as expected and that unacceptable deficits are not being incurred.	A
Effective service planning and monitoring		
R8b	We recommend that NHS bodies ensure that they have up-to-date plans and procedures that set out the local arrangements for implementing national policy requirements and to ensure that as far as possible, catering and nutritional services are standardised, particularly where NHS re-organisation has brought together a number of different service models under one organisation.	A
R8c	We recommend that NHS bodies ensure that executive director accountabilities for catering and nutrition are clearly defined, and where two or more executive directors are involved, there are well defined arrangements for the co-ordinated planning and monitoring of services.	A
R9c	We recommend that NHS bodies should ensure that they make full use of Estates and Facilities Performance Management System data as a tool in managing and monitoring their catering and nutritional services.	A

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

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