Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyfrifon Cyhoeddus
The Public Accounts Committee

Dydd Mawrth, 8 Tachwedd 2011
Tuesday, 8 November 2011

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Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir cyfieithiad Saesneg o gyfraniadau yn y Gymraeg.

These proceedings are reported in the language in which they were spoken in the committee. In addition, an English translation of Welsh speeches is included.

Aelodau’r pwyllgor yn bresennol
Committee members in attendance

Mohammad Asghar	Ceidwadwyr Cymreig Welsh Conservatives
Mike Hedges	Llafur Labour
Andrew R.T. Davies	Ceidwadwyr Cymreig (yn dirprwyo ar ran Darren Millar) Welsh Conservatives (substitute for Darren Millar)
Julie Morgan	Llafur Labour
Gwyn R. Price	Llafur Labour
Jenny Rathbone	Llafur Labour
Aled Roberts	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Leanne Wood	Plaid Cymru The Party of Wales

Eraill yn bresennol
Others in attendance

Matthew Mortlock	Swyddfa Archwilio Cymru Wales Audit Office
David Sissling	Cyfarwyddwr Cyffredinol, Iechyd, Gwasanaethau Cymdeithasol a Phlant/Prif Weithredwr, GIG Cymru Director General, Health and Social Services/Chief Executive, NHS Wales
Dave Thomas	Swyddfa Archwilio Cymru Wales Audit Office
Huw Vaughan Thomas	Archwilydd Cyffredinol Cymru Auditor General for Wales
Andrew Walker	Pennaeth Cyfalaf, Ystadau a Chyfleusterau, Llywodraeth Cymru Head of Capital, Estates and Facilities, Welsh Government
Jean White	Prif Swyddog Nyrsio/Cyfarwyddwr Nyrsio Cymru Chief Nursing Officer/Nurse Director for NHS Wales

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Sarah Beasley	Clerc Clerk
Dan Collier	Dirprwy Glerc Deputy Clerk
Joanest Jackson	Uwch-gynghorydd Cyfreithiol Senior Legal Adviser

Dechreuodd y cyfarfod am 9.15 a.m.
The meeting started at 9.15 a.m.

Cynnig i Ethol Cadeirydd Dros Dro
Motion to Elect Temporary Chair

[1] **Ms Beasley:** Good morning. Item 1 on the agenda is the appointment of a temporary Chair. Under Standing Order No. 17.22, I would like to invite nominations. Are there any

nominations?

[2] **Mohammad Asghar:** I propose Andrew R.T. Davies.

[3] **Ms Beasley:** Are there any other nominations? I see that there are none. Therefore, I declare Andrew R.T. Davies appointed as temporary Chair of the committee.

Penodwyd Andrew R.T. Davies yn Gadeirydd dros dro.
Andrew R.T. Davies was appointed temporary Chair.

9.15 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[4] **Andrew R.T. Davies:** I will refer to the general housekeeping and health and safety rules to start with. This is a bilingual institution, so there is Welsh-to-English translation available for anyone who requires it via the headsets. Channel 0 is for amplification and Channel 1 is for the translation. Please turn off mobile phones and BlackBerrys as they interfere with the microphones. I see the Auditor General for Wales shaking his head; he has done this a couple of times, no doubt. If the fire alarm goes off, it is not a practice, so please follow the directions of the ushers who will escort you out of the building. Darren Millar sends his apologies. He has broken his ankle, regrettably, but he is making good progress and sends his best wishes to fellow Members and others who have sent best wishes to him while he is not with us. Are there any other apologies? I see that there are none.

[5] **Mike Hedges:** Shall we send our best wishes to him?

[6] **Andrew R.T. Davies:** Thank you, Mike; that would be a nice gesture.

9.16 a.m.

Trafodaeth am yr Amcangyfrif Diwygiedig o Incwm a Gwariant Swyddfa’r Archwilydd Cyffredinol ar gyfer y Flwyddyn a Ddaw i Ben ar 31 Mawrth 2013
Consideration of the Amended Estimate of Income and Expenses of the Office of the Auditor General for the Year Ending 31 March 2013

[7] **Andrew R.T. Davies:** May I welcome you, Mr Thomas, the Auditor General for Wales, and your team, and thank you for coming along today? Committee members will be aware that this estimate has been discussed before in committee and, subject to some changes, the committee found agreement over the estimate. I invite the auditor general to address the changes that have been made and then committee members may question him on the matter, if they wish to do so.

[8] **Mr H. Thomas:** Thank you, Chair. May I apologise? My normal hearing aid has packed up, so I am not aware at which level I am speaking. If you want me to raise my voice, I will do so.

[9] As you said, the estimate has been before the task and finish group and one particular aspect of that estimate was of concern to the group, namely the cost of a new human resources payroll system, which I had put in under the capital element. In view of that concern, I have resubmitted an estimate taking that element out. So, it is the same estimate, but obviously the figures then had to be reworked as regards the amounts sought for resources

and so on. It also gave me a chance to reflect on the presentation of estimates in future years.

[10] As the committee will be aware, we have established within the Wales Audit Office two new governance committees, including one looking after resources. It seems to me that, in future years, estimates ought to be presented after the resources committee has seen them, and that Members may wish to ask not just me and my staff for their views on items within the estimate, but also the chair of the resources committee at that time.

[11] **Andrew R.T. Davies:** May I invite anyone to put questions or points specific to this item to the auditor general?

[12] **Mike Hedges:** It is an agreement, not a question. It is an excellent idea for it to go before the resources committee. I was going to ask that question to the auditor general, but he has answered it before I have asked it. It would be useful for that to happen so that we have some additional comfort when we deal with it.

[13] **Andrew R.T. Davies:** It is nice to have a forward-looking auditor general who can pre-empt the questions that Members are going to ask. If there are no questions or observations, thank you for laying this paper before us. I will close this session and invite you back in when we come out of our closed session.

9.19 a.m.

Cynnig Gweithdrefnol
Procedural Motion

[14] **Andrew R.T. Davies:** There is a request that we now move into private session to consider the report on the estimate of the auditor general. I ask a Member to move the appropriate motion.

[15] **Mike Hedges:** I move that

the committee resolves to temporarily exclude the public from the meeting in accordance with Standing Order No. 17.42(vi).

[16] **Andrew R.T. Davies:** I see that it is agreed.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 9.20 a.m.
The public part of the meeting ended at 9.20 a.m.

Ailymgynullodd y pwyllgor yn gyhoeddus am 9.37 a.m.
The committee reconvened in public at 9.37 a.m.

Arlwyo a Maeth Cleifion mewn Ysbytai: Tystiolaeth gan Brif Weithredwr GIG Cymru
Hospital Catering and Patient Nutrition: Evidence from the Chief Executive of NHS Wales

[17] **Andrew R.T. Davies:** We are now back in public session. I welcome back the Auditor General for Wales and his team and I extend a warm welcome to David Sissling, Jean White and Andrew Walker. I extend a particularly warm welcome to David Sissling, as I

think that this is his first meeting as director general and chief executive of the Welsh national health service. Am I correct in saying that?

[18] **Mr Sissling:** That is right; thank you.

[19] **Andrew R.T. Davies:** Members will be aware that we have had quite extensive discussions about the auditor general's report with regard to hospital catering and patient nutrition. Various papers have been circulated to Members over the weekend and at previous meetings. We will move straight into questions, because I think that most Members know what points they would like to raise. I will ask question 1, which relates to the all-Wales nutritional care pathway. In the report, there is evidence that the standards are not being met across the NHS in Wales. What is the department doing to try to get better consistency in the delivery of this package?

[20] **Mr Sissling:** By way of introduction, I welcome the opportunity to discuss the report. It was a very helpful report and it is good to hear that progress is being made, but it is also very important that we act upon the 32 recommendations, which we accept and which we are taking action to address. There is an important issue about consistency in the adoption of the pathway. We believe that we are making progress in every hospital in Wales. We produced the pathway in 2009, which was supported by the relevant documentation. In September 2011, we produced an e-learning tool to ensure that all staff are trained in its use. Over the next 12 months, all existing and new staff will have the benefit of receiving the training through that particular learning tool. We are also monitoring the adoption of the pathway in every hospital on a real-time basis. Perhaps I could ask Jean White to explain how that works.

[21] **Ms White:** Several years ago, we introduced the fundamentals of care audit tool. Within that, there are specific questions that look at nutrition and hydration in hospitals. It covers matters relating to compliance with the assessment of people's nutritional status when they come into hospital. This audit tool is used in every in-patient area throughout Wales. The ward sisters complete the report. Importantly, they also ask patients and their carers about their experience as part of the data collection. These reports can be used for local action plans at ward level. The senior staff check to ensure that the audits are being undertaken at a local level. They are then collated at board level, so the boards have a view of what the hospitals in their health board areas are like. These reports are then submitted to me annually, and I compare compliance around Wales. From that annual review, we determine whether there are some national actions to be taken. For example, in the last two full audits we have had, issues around oral health and hygiene have been shown to be the areas doing least well in Wales. So, we have initiated an all-Wales group to look at coming up with tools to assess people's oral health. If you have problems with your dentures or you have bad teeth, it makes it more difficult to eat and drink while you are in hospital. From early next year, there will be a tool set out for Wales to help ensure that that aspect of a person's care is dealt with.

[22] **Mr Sissling:** Just to conclude, the sort of levels of compliance that we are now seeing in health boards range from the high 80s, to 90 per cent and up to 100 per cent.

[23] **Andrew R.T. Davies:** I want to take you up on two points. You talk about board level. How does the board take ownership of this audit trail to ensure that what is delivered on the ward is consistent and addresses the concerns that a doctor highlighted in this report? You touched on the issue of training. The Royal College of Nursing report last week highlighted that, sadly, there are big deficits in people's ability to access training. How confident are you that staff will be able to use this portal in their training?

[24] **Mr Sissling:** I will start on the board level insight and connections, and then Jean can talk specifically about the nursing training issues. All boards have an executive point of leadership. So, at the board table, there is an executive director who is identified as being

responsible and who would, therefore, be able to report to the board about issues of progress or concern. There would normally be a non-executive, non-officer member of the board taking a particular interest. It would be the case that that would be discharged through a quality and safety committee that has the opportunity to look in detail at relevant aspects. At least once a year—from personal experience, that would be more than once a year—the full board would receive a series of reports highlighting issues of compliance or variation from practice. The board would not just receive reports. Good practice would say that, through its own activities, such as visiting wards and areas where care is being provided, the board would observe first-hand how these particular aspects were being delivered. It is fine to have the reports, but at times there is no substitute for seeing practice, listening to patients and listening to staff to hear their personal concerns.

[25] The other area that we are particularly developing at the moment is the whole issue of patient and user feedback. Boards will hear the voice of the patient first-hand through satisfaction surveys, which are increasing in number and in the degree to which they provide a comprehensive picture of the quality of the food and catering services provided.

[26] **Ms White:** I will deal with the aspect of education and training. I have brought some examples with me of the charts that have been developed for every clinical area in Wales. These show food and fluid and describe the nutritional care pathway. So that Members can see what the charts look like, perhaps the deputy clerk can circulate those. This is the first step of trying to explain to clinical staff exactly how they should comply with the tool. I think that it was difficult for them to understand, when asking a patient what they had eaten that day, what a plate of food looked like—whether it was a large plate, a small plate and so on. There was inconsistency in the way that people were recording what people were eating and drinking. This was the first step of giving tools to the clinical staff to enable them to understand the importance of consistency in gathering data. The mantra that we have been trying to instil is that food and fluid are as important as the drugs and treatments that we give in hospital, so we should be recording them appropriately.

9.45 a.m.

[27] The next step this year, once the charts had been circulated—you will find them on notice-boards everywhere that you go—was to develop an e-learning tool. This is going to be accessible from the ward, so that people can do it in work time, but they will also have passwords, so that they can use it at home if they want to do some extra reading after work. There are a number of ways in which people can do it: they can do it at one sitting or they can do it in small bits and pieces. In the next 12 months, the expectation is that every single clinical nurse or nursing assistant on the ward will complete the training and, in future, anybody who is new in post will have 12 months to undertake the training. These things are very visual and backed up by education. It is about getting a consistency of approach, rather than people interpreting what they think is a good idea.

[28] **Aled Roberts:** Pa mor bendant yw hyn? Mewn cyfarfod blaenorol, cafwyd tystiolaeth nad oedd pob bwrdd iechyd yn derbyn gwybodaeth ynglŷn â bwydo a maeth. A yw hyn yn bolisi newydd, ynteu a yw'r byrddau bellach yn derbyn y wybodaeth nad oedd tystiolaeth amdani ar gyfer yr adroddiad blaenorol?

Aled Roberts: How definite is that? In a previous meeting, evidence was taken that not all health boards received information about feeding and nutrition. Is this a new policy, or are the boards now receiving the information for which there was no evidence for the earlier report?

[29] Hefyd, o ran profiad personol, mae gennyf fodryb 85 oed sydd yn yr ysbyty yn Wrecsam. Cafwyd tystiolaeth gan yr

Also, with regard to personal experience, I have an 85-year-old aunt who is in hospital in Wrexham. We had evidence from the auditor

archwilydd cyffredinol nad yw cleifion Bwrdd Iechyd Lleol Prifysgol Betsi Cadwaladr yn cael eu pwyso wrth fynd i'r ward yn y lle cyntaf. Sut mae staff yn gallu dweud bod claf yn cael ei fwydo'n iawn oni nodir ei bwysau yn y lle cyntaf?

general that patients in the Betsi Cadwaladr University Local Health Board are not weighed on first being admitted to a ward. How are staff able to tell that a patient is being fed properly if their weight is not recorded in the first place?

[30] **Mr Sissling:** I will take the first question about the extent to which this represents a new approach. It is certainly a requirement on all health boards that, at least once a year—that would be the minimum; the expectation is that it would be more—the board receives a detailed report on the fundamentals of care, covering matters relating to catering, food and patient nutrition. The expectation, as I said, is that that would be a minimum and that there would be more frequent reporting to board committees, but it would be at least once a year to the full board.

[31] **Ms White:** With regard to compliance with assessment, it is fair to say that ensuring that it is applied consistently across Wales is a challenge. The evidence given to us through audits shows that, in many areas, compliance is very high, but it is still an ongoing challenge to ensure that absolutely every person is assessed within the first 24 hours of their admission. We are seeing improvements, but there is still work to be done in some areas. As we have said previously, some of the audit evidence shows between 87 and 100 per cent compliance. There is still room for improvement in some places. We are monitoring how the boards are performing: through part of our NHS delivery framework, we are looking at the quality of care, and the dignity and respect that patients are shown. So, there is pressure from us to monitor the boards and, in turn, they use the systems that they have in place to monitor their performance. It would be fair to say, however, that we have a little way to go in some places.

[32] **Mr Sissling:** I would just add a comment. We have spoken a lot about internal audit, but the standards are also subject to external observation. The NHS in Wales is subject to the 'Doing Well, Doing Better' series of healthcare standards, which Healthcare Inspectorate Wales monitors and uses as the basis for its judgments about the extent to which the NHS is compliant with good care and good standards. Standard 14 in particular focuses on this area, and so will be subject annually to insight, which is supported by internal audit to give a view on matters of process. There is a degree of triangulation of the standards, and we are encouraged to hear that many of the boards are using external agencies to monitor standards. For example, Abertawe Bro Morgannwg University Local Health Board conducted a major survey earlier this year using volunteers, and had an external, independent review of food, nutrition and catering in relation to patient satisfaction issues, giving the benefits and insight of a different perspective. So, this was not just self-assessment—it was also an external view, using those who have a keen interest in making sure that standards are where we want them to be.

[33] **Andrew R.T. Davies:** Julie, I think that you have a supplementary question on this.

[34] **Julie Morgan:** Looking at this chart, I just noticed that the illustrations do not actually show any water.

[35] **Ms White:** There is a fluid chart as well as a food chart.

[36] **Julie Morgan:** Yes, I was looking at the fluid chart, and it is illustrated by orange juices, teas and coffees, and I just thought that it might be an idea to put water in there, because obviously people might interpret that as not showing the importance of water. There is usually a jug of water at a patient's bedside.

[37] **Ms White:** Indeed. I think that what the creators of this were trying to show was the

different volumes of different sized cups.

[38] **Julie Morgan:** Yes, I understand that.

[39] **Ms White:** I do take your point about the message of the fluid within the cups.

[40] **Julie Morgan:** Thanks; it was just a small point.

[41] **Andrew R.T. Davies:** No problem; it was a very valuable point.

[42] **Mohammad Asghar:** Good morning to all of you. The auditor general's report and the evidence provided by the Commissioner for Older People in Wales have shown that effective leadership at the ward level is a key factor in implementing the requirements of the nutrition care pathway, yet such leadership is not always in evidence. What is being done to ensure that the principles set out in the 'Free to Lead, Free to Care' initiative are being implemented in practice and resulting in better leadership at the ward level?

[43] **Mr Sissling:** It might be helpful if Jean takes a lead on that, and maybe I will make a few comments subsequently.

[44] **Ms White:** The 'Free to Lead, Free to Care' programme was initiated around the role of ward sisters and charge nurses in controlling their environment to make sure that patients were cared for to the highest standard. Part of the arrangement when this was introduced was to set up a support framework for ward sisters and charge nurses, and, within that, we were able to communicate effectively from the senior nursing staff in the organisation down to the ward level—the ward-to-board relationship, if you like. To make sure that staff are complying with the role that has been explained to them through 'Free to Lead, Free to Care', the organisations have a variety of mechanisms—for example, in some areas, they do spot checks on a monthly basis, and the senior staff go and visit the wards to see whether or not the pathway is being implemented in the way that it ought to be. If there is a problem, they then set up local action plans with the ward sister to find out why it is not being complied with. Each of the health boards has an executive lead, but they also have a nutritional and hydration lead within the organisation—usually at deputy or assistant director of nursing level. They work through the networks, doing these spot checks to make sure that the staff on the ward are fulfilling the role that they ought to fulfil. As I say, there are a variety of mechanisms for them to do that.

[45] **Mr Sissling:** May I add one point? The focus, to an extent, should be on nursing leadership, but this is also an area where multiprofessional contributions are necessary. The nurses play a key role, but so do the dieticians, the speech and language therapists, and, of course, the doctors. So, it is good to see the emergence in all health boards of bodies and fora that provide an opportunity for all the professions to come together and provide guidance and leadership across professional areas. We are seeing nutritional steering groups and catering nutrition groups, which also bring the catering professionals into this arena so that we can get a unified view on the best way forward. Of course, it is important to have ward-based nursing leadership, but we would also wish to emphasise the multiprofessional aspects.

[46] **Julie Morgan:** The evidence that we received showed that not all patients get the help that they need when they are taking their meals and that the red-tray system does not always work as it should. What are you doing about this to ensure that everyone gets the help that they need to eat?

[47] **Ms White:** The red-tray system and red tops on water jugs are there as an indicator of people who need assistance at meal times. They are not used consistently across Wales. Some people choose other methods to identify patients who need particular help. The health boards

have given us evidence of a variety of ways of dealing with this. Some areas have introduced a voluntary scheme. For example, the Cardiff and Vale University Local Health Board has been encouraging volunteers to come in to help patients get ready for meal times, and it has introduced a join-in lunch-time club to encourage patients who are able to do so to come together for a meal. Other places have nutritional assistants who come to ward areas to get patients ready for lunch time, for example, by sitting them up and giving them hand wipes and so on. Cwm Taf Local Health Board, for example, gives patients hand wipes to use prior to meal times.

[48] The health boards are aware that they need to put things in place to assist patients. We have heard mixed messages about allowing relatives in. In a nutshell, the whole concept of protected meal times is to protect the time away from non-urgent medical interventions. However, some people think that 'protected' means that no-one can go anywhere near the patient, but that is not what it is about. In many areas, carers are encouraged to come in at meal times if they want to help their loved ones with a meal. So, there is a variety of mechanisms going on.

[49] The red-tray system is a good example of identifying those who need help. However, it is a challenge in some areas where you may have 10 to 15 people needing help at lunch time but there is only a certain number of staff on the ward. So, they must come up with novel and unique solutions if they have a client base where many people need help at meal times but the staff complement is restricted for the rest of that shift.

[50] **Julie Morgan:** It is absolutely essential that you get this message over that family volunteers can come in to help the relatives, because it is definitely not something that is understood. I have personally experienced difficulties in visiting at a protected time. It is important that there is consistency in the message that we are pleased to see relatives helping with the feeding. How can you do that?

[51] **Ms White:** I meet all of the nurse directors in Wales every month, and we have dedicated conversations about the fundamentals of care, especially around the time when the audit results come out and we drill down to exactly what that means. We, as Government officials, have made it clear that we expect protected meal times to be used in a sensitive way, and that they are not to bar family volunteers and carers. The message from us is consistent about that, and I will continue the conversations with the nurse executive leads on that subject.

[52] **Julie Morgan:** I wonder whether there is something that is put up and clearly states that relatives are welcome, which I have not seen in any hospital.

[53] **Ms White:** No, we do not have that, but it would be a good idea.

[54] **Julie Morgan:** Is that something that you can look at?

[55] **Ms White:** Yes.

[56] **Julie Morgan:** Thank you.

[57] **Andrew R.T. Davies:** I have two supplementary questions, from Mike and then Jenny.

[58] **Mike Hedges:** One standard problem that exists across large organisations is that there are really good policies at the top but, by the time they make their way through to the person who is dealing with them, they are lost in translation; it is like a game of Chinese whispers.

[59] I completely agree with the intention, but does it make its way through to the hospital ward? It is important that there are means by which this information can go through. We are all aware that this is not currently happening; people take 'protected' to mean a time when everyone needs to go out, and that happens in some places. However, you have a key role in ensuring that what you say makes it way down to the nurse practitioner and that it is not lost in translation, via the numerous people whom it goes through in the middle.

10.00 a.m.

[60] **Ms White:** I quite agree with your comment. In a large organisation, it does become like Chinese whispers, which is why we have developed an e-learning tool and guidance on issues, which everyone can view. However, I will continue to pursue this as it is such an important aspect of the booklet.

[61] **Andrew R.T. Davies:** On the point that Julie Morgan made about how relatives should be informed that they are encouraged to come in to assist at meal times, the e-learning tool is obviously a tool for staff involved in the NHS, but relatives often feel vulnerable because they do not push themselves onto the system. However, if the system from the top actively encourages it, there needs to be greater information for the relatives.

[62] **Ms White:** I was remiss in saying that a Wales Audit Office publication came out earlier this year called 'Eating Well in Hospital—What You Should Expect' which is designed for patients and their relatives. It says that you should be allowed to help your loved ones if you wish. These leaflets are being given out throughout hospitals in Wales, and I am happy to circulate copies, although I have brought only two with me.

[63] **Andrew R.T. Davies:** Are these leaflets actively given out?

[64] **Ms White:** Yes. There are also publications designed for board members to make sure that they are asking the right questions, and to make sure that that is happening.

[65] **Leanne Wood:** Are the leaflets given out everywhere as a matter of course to every patient who is admitted?

[66] **Ms White:** I am afraid that I do not know how the distribution is done—all I know is that they are available to hospitals. Perhaps the Wales Audit Office could answer that.

[67] **Mr D. Thomas:** We have made it available on our website for all health boards to take into account in whichever way is appropriate to them. So, we have the leaflets and they are used. It is difficult to say at this stage how comprehensively they have been used. We have also insisted that they take the text of the leaflet and put it into their patient information packs. So, by hook or by crook, we will get there, but at this point in time we have not checked the compliance with that leaflet being circulated.

[68] **Andrew R.T. Davies:** Before I move on to Jenny who has indicated that she has a supplementary question on this, with all due respect to the audit office and that leaflet, I would have thought that the average member of the public would look at an audit office leaflet and would not necessarily pick up the information. The NHS, corporately, may need to have some consumer friendly type of advice so that relatives are informed on entry into hospital about what they are encouraged to participate in.

[69] **Mr Sissling:** Those are useful points, which we will take away. The preparation that we did for this meeting indicated that there are, as you would expect, examples of good practice in this area. In principle, it is encouraged, but as these questions would indicate, it is

not consistent. Through the right channels, we need to make sure that we have the right information available to relatives, friends, carers and volunteers about the opportunity to assist on admission, and that that is provided in a standardised and accessible way, and that we have the right forms of documentation that are easy to read with clear, open and welcoming messages. So, we will take that away and act on that.

[70] **Andrew R.T. Davies:** Thank you very much. There are two other supplementary questions, from Gwyn and Aled, once Jenny has finished.

[71] **Jenny Rathbone:** I just wanted to pick up on the role of care assistants, because David Sissling mentioned a list of people who ought to be involved in collaboration on this important subject, but he did not mention care assistants. When a relative is not available, someone who does not necessarily have nursing duties might have more patience. How are they being incorporated into this team approach?

[72] **Mr Sissling:** The fact that they were not mentioned was an omission rather than anything that would indicate that they should not be involved, because they would have an enormously significant role to play in making sure that the system had the right technical components, and, as your question also indicated, that the right attention was given to the personal needs of patients. So, care assistants are an integral part of the team, and the list would probably extend further than those whom I mentioned. I was making the point that we need to make sure that we build on good nursing leadership, but, in a sense, that is a platform in which other professionals and colleagues get involved.

[73] **Ms White:** I should add that they will also be required to follow this e-learning tool so that they are trained to the same level as the qualified staff.

[74] **Gwyn R. Price:** Going back to the leaflets that are being handed out, there is also a fear factor for relatives. They are sometimes scared, on behalf of their relatives, to go forward with it. That message is coming through. So, it is down to the staff to come to the relatives and make them welcome, because these leaflets are all well and good and they are nice to have, but if the staff on that ward do not implement it, the fear factor comes in that they will not go forward with it. That was what I wanted to bring up, Chair.

[75] **Ms White:** As I said, there will be opportunities for us to encompass that in taking this forward. I quite agree that we should be welcoming the engagement of family members or other carers in the care of our sick patients.

[76] **Mr Sissling:** A more general point is that many of the aspects that we are discussing in terms of catering, food and patient nutrition apply to other areas of care. So, for example, on the approach that we are adopting to respond to the report of the Commissioner for Older People in Wales, Ruth Marks, entitled 'Dignity in Care?', which has many common themes, we want to ensure that we address them in respect of the totality of care, rather than just food and other aspects. It is an opportunity for us to ensure that care in all regards in hospitals is appropriate and sensitive to the needs of individual patients.

[77] **Gwyn R. Price:** To follow up, that is all well and good, but if the food does not reach the mouth, the patient suffers. By the time that you have taken an overall look at it, perhaps someone will not have had the food that they should have had.

[78] **Andrew R.T. Davies:** The sentiment has been taken on board, Gwyn.

[79] **Aled Roberts:** May I support what Mike and Julie said? In all sincerity, it is all very well having strategies, but, in reality, it is what happens on the ground that is important. I have to say that I do not think that any of these messages are getting across on the ground.

The noticeboards that are still up in district general hospitals say, 'Visiting times restricted to 3 p.m. to 4 p.m.'. I have come across instances in the last few months where that is still heavily policed, and I have not been aware of any situation in which this information has been handed out to relatives. The care package for the aunt that we have in hospital is that we take food in for her. It is all very well for her, but the lady in the next bed does not have relatives to take food in for her. Our concern is what happens to that lady. I know that you are trying to improve the position, but I do not think that we will be satisfied as a committee by just seeing strategies and glossy leaflets. We want to see change on the ground. What is really frustrating us is that the evidence that we have been getting up to now is that this has been going on for years with little change in practice on the ground.

[80] **Andrew R.T. Davies:** That point is well made. We will move on, because I think that Aled was expressing a point that has been covered by others, and a sentiment that many Members would identify with. I would also make the point that, when you look at these leaflets, you should also think of languages. I represent Cardiff, where there is a big ethnic community, and there is no point in just having English and Welsh leaflets. It is important that you look after the ethnic minority communities, because, often, it is members of the extended family who look after relatives in hospital. We will move on to question 4.

[81] **Gwyn R. Price:** At around the same time as the auditor general's report was published, Consumer Focus Wales drew attention to food hygiene problems at some Welsh hospitals. Has the Welsh Government followed up on those concerns? Are you confident that all the hospitals in Wales are now complying with the necessary food hygiene standards?

[82] **Mr Sissling:** The position is that 58 hospitals have been subject to inspection in line with other facilities that prepare and offer food. They are given hygiene ratings by their local authority in the context of the Food Standards Agency Wales scheme to ensure that there is consistency in the assessment of all places that prepare and offer food. As you are probably aware, these are represented in bands, from 5 being 'very good' through to 0 being 'urgent improvement necessary'. At the moment, we believe that the vast majority of hospitals would be in a satisfactory position, because 86 per cent are rated as either 'good' or 'very good', so they are at the top end of the scale. We have just three hospitals that are at the lower end, getting a score of 1, and they are subject to urgent action to understand the position and to take the necessary remedial action. In summary, 95 per cent have scores of 3, 4 or 5, which are in the 'satisfactory' or 'very satisfactory' categories, and just three hospitals—which is three too many—are subject to further improvement actions. Therefore, since that time, there has been a general path of progress and improvement, and attention being given to all aspects of food hygiene across the NHS.

[83] **Gwyn R. Price:** Is there are a time limit for those three hospitals to get their act together?

[84] **Mr Walker:** The three hospitals include Whitchurch Hospital in Cardiff—the mental health hospital—and we are about to start a £85 million development to replace that hospital. Part of that work has already started on the Llandough site and will be completed in three to four years' time. Obviously, it needs to be improved in the meantime, but there is a major capital development to replace Whitchurch Hospital. The second is H.M. Stanley Hospital, which is in the course of closing and patients have been, or are being, moved to Ysbyty Glan Clwyd and Abergele Hospital. The third is the child and adolescent mental health service in Bridgend, which I think relates to the old unit that has now been closed and is being replaced by a £20 million development on the Princess of Wales Hospital site. That covers the three hospitals that were marked at the low grade. Whitchurch Hospital is the main one on which we need to concentrate in the interim.

[85] **Aled Roberts:** A oes ysbyty **Aled Roberts:** Is there a general hospital that

cyffredinol sydd wedi methu â chael seren yn ystod y pum mlynedd diwethaf?

has failed to gain a star over the last five years?

[86] **Mr Sissling:** In terms of the last five years, I could not tell you that particular piece of information. It is something that we would be very happy to look at. We have the current ratings for each of the 58 hospitals, but we do not have the information to hand going back five years. We would be happy to give you that information.

[87] **Andrew R.T. Davies:** Do you not have information with you now about the last five years, or do you not have it in the department?

[88] **Mr Walker:** We do not have it now.

[89] **Andrew R.T. Davies:** Therefore, you could provide a note to the committee on that.

[90] **Mr Sissling:** Yes.

[91] **Andrew R.T. Davies:** That would be helpful.

[92] **Leanne Wood:** I am concerned about what I just heard about Whitchurch Hospital. I have received a number of general complaints about Whitchurch Hospital—not specifically about the food—but if the response to that is the new development in Llandough in three to four years' time, that is too long for people to have to wait. What measures are going to be implemented in the interim?

[93] **Mr Walker:** We need to find out what issues are causing concern for the Food Standards Agency, whether they were related to the building, the structure, the kitchens and so on, or something else. We need to get underneath the information to find out what the problem is at Whitchurch Hospital and work with the LHB to address those issues.

[94] **Mr Sissling:** That is being pursued with urgency: action plans have been prepared, and a re-inspection by the local authority and a re-rating visit will take place later this month. This is being measured in weeks or days, rather than being done in an extended time frame. We want to ensure that matters have been addressed and that it will move from where it is now—that is, a one star, with major improvement needed—to a more satisfactory position. So, it is being addressed with real urgency.

[95] **Julie Morgan:** I have a similar question to Leanne's, because I was very concerned about the Whitchurch Hospital issue. I visited there recently about other issues, but I was not aware of the hygiene issue. Could you let the committee know when you undertake the next inspection or report, so that we know exactly what the position is?

[96] **Mr Walker:** I have a meeting with the health board tomorrow so I can get information from it then.

[97] **Julie Morgan:** We would like to have that information as soon as possible.

[98] **Andrew R.T. Davies:** To clarify what you have said, it has a rating of one star and there will be a re-inspection, which will be undertaken by the end of November. You have a meeting scheduled—will that be the first meeting that you will have had with the health board?

[99] **Mr Walker:** I meet with the health board regularly on a number of issues.

[100] **Andrew R.T. Davies:** Have you met with the health board on this specific issue?

[101] **Mr Walker:** No, but I am meeting the health board tomorrow and Whitchurch Hospital is on the agenda, and it always is, because it is a major capital scheme. It is some way off and we have to do things on the site—not just on catering, but on a number of other issues—to keep it going for the next three to four-year period.

10.15 a.m.

[102] **Andrew R.T. Davies:** So, you will provide us with an update on how things have progressed there.

[103] **Mr Walker:** Yes.

[104] **Andrew R.T. Davies:** Thank you. Jenny, did you indicate that you wanted to come in on this issue?

[105] **Jenny Rathbone:** I think that it has been covered now.

[106] **Andrew R.T. Davies:** Okay, we will move on. Mike, your question please.

[107] **Mike Hedges:** Has progress been made on developing consistent costed models for catering services, and what is being done to increase confidence in and the use of the estates and facilities performance management system?

[108] **Mr Sissling:** I will start and then I will hand over to Andrew to go over some of the detail. I was disappointed to hear about the relative lack of progress in recent years. It is an area that now requires some real impetus, more pace and urgency, to allow us to have the right standardised costing systems across Wales, to ensure that we do not have passive costing systems, but systems that allow us to improve practice and the use of resources. We need to reach a position very quickly where we have a similar approach across Wales. Work is being initiated in that regard and perhaps Andrew can give us some of the details.

[109] **Mr Walker:** Before going into that in a bit more detail, there will always be inconsistency in costs because of the different methods of catering that the health boards use: there is cook-chill, cook-freeze and traditional catering methods and so on. There will always be differences in cost, no matter what system we have. What we need in addition to the costing model are benchmarks for the different types of catering systems, so that we can gauge whether an LHB is above or below the benchmark. So, that is work that we have to do to establish the benchmark targets for the different types of systems. On the model itself, we have the EFPMS data and a financial system. They use very similar datasets. The work we have done to date suggests that the datasets are robust. They need a bit of tweaking round the edges, but we have a model that asks the right questions.

[110] However, the problem is in the quality of the information coming from local health boards to answer the questions. We know of one or maybe two health boards that have extremely sophisticated systems to collect costed information. The best we have seen is the Aneurin Bevan health board, which has a very complex computerised system that can cost in very precise detail. The LHB maintains that it has saved considerable sums of money by implementing this system. We are now working with the Aneurin Bevan health board to find out exactly how it set up that system, what it cost in terms of revenue and capital, whether we can roll that system out to other parts of the NHS in Wales and what benefits it might bring to other parts of Wales—not just in terms of consistency of cost, but whether it will provide savings by getting more accurate information on VAT, for example. The Aneurin Bevan health board has shown that it can save on VAT because its system is so precise in getting the right VAT calculations. So, personally, I would prefer to concentrate on that rather than on

the EFPMS data, because that system is pretty robust in terms of the questions it asks.

[111] **Mike Hedges:** I have a supplementary question. Have you considered having standard meals across Wales—[*Inaudible*.]—so that there is the same food on a Friday, for example? Have you thought about doing this across Wales?

[112] **Mr Walker:** No.

[113] **Mr Sissling:** Some work is currently being progressed in response to the all-Wales nutrition and catering standards to look at more standardised menus to ensure that we have a degree of consistency, use the benefits of good practice within Wales and have a degree of standardisation. At the moment, that has not extended to the point of having an all-Wales menu, but we are certainly looking for more consistency and less divergence in menus, predominantly to ensure that they hit the mark in terms of nutrition and patient satisfaction.

[114] **Andrew R.T. Davies:** We are having a problem with the sound, with the microphones not coming on, so we will adjourn for a short time to sort this out.

Gohiriwyd y cyfarfod rhwng 10.19 a.m. a 10.24 a.m.
The meeting adjourned between 10.19 a.m. and 10.24 a.m.

[115] **Andrew R.T. Davies:** I invite Oscar to ask question 6.

[116] **Mohammad Asghar:** The auditor general's report highlights big differences in the amount of money hospitals spent on food and beverages for patients, despite standard contracts being in place to procure these consumables. Why is there such a large variation in these provision costs across hospitals? What can be done to minimise this variation?

[117] **Mr Walker:** I think that the answer is similar to that to the last question: there is always procurement of certain provisions where that happens. There is always going to be some use of local suppliers. So, there will be differences, but that probably does not account for such wide differences. It comes back to the previous point, that this is largely due to the information that the local health boards have, which supplies us with the costing information that goes into the various reports. In certain cases, it is not as accurate as it could be. That is where we need to concentrate our efforts. We need appropriate benchmarks for provisions for non-patient catering costs, wastage and so on that we can gauge LHBs against, rather than having a range of different costs and parameters. Otherwise, we will not be able to work out what is good and what is bad. So, benchmarking and getting better information from local health boards is the way forward to address many of these issues. We may have to invest in computerised systems to obtain that information.

[118] **Mohammad Asghar:** Further to your answer, I have some more questions. Why have more health boards not introduced a daily food allowance? Does the Welsh Government have any plans to set such an allowance? If so, at what level? Has any progress been made in establishing a national database of standard, nutritionally assessed meals and menus to reduce duplication to ensure patients get the same quality meals irrespective of which hospital they are in throughout Wales?

[119] **Mr Sissling:** I will offer a response to the first question. The position, at the moment, as Andrew described it, is not an entirely satisfactory one. Even if we accept that there is variation in the model of preparing food, in patient groups and needs, in the number of distributions, and in logistical difficulties, the range of costs, from £6 to £17.50, is too great. It must be a function of unsatisfactory submission of data. Therefore, that needs to be resolved, and that is being resolved. We have set up groups to address that as a matter of urgency, because there are significant opportunities to use money wisely and to make sure

that we are using our precious resources in the best possible way.

[120] As to whether we should introduce a standardised daily allowance for consumables, in principle, I think that we should explore that. However, we need to do that when we have a better understanding of the costs. I spent an afternoon with Cardiff and Vale University Local Health Board, looking at its systems last week. It is using a figure of £4, which is probably in the middle of the pack. We should know whether that is the right figure, or whether it should be around that figure, once we have completed the detailed costing work that is now in progress. In principle, it would be helpful to establish a base on which there could be consistency. We could then look at common efficient procurement and common efficient use of resources. There may need to be some variation to account for particular patient groups or issues, but it should not be of the range that currently exists.

[121] **Jenny Rathbone:** What you are telling us, then, is that you have absolutely no idea whether the Royal Glamorgan Hospital's meals cost three times what Velindre Hospital's cost.

[122] **Mr Sissling:** What I am saying is that we are looking at a range that is difficult to justify by virtue of the different models of preparation of food and the different distribution systems. We have established a technical group to look at this, because the appropriate financial expertise is required to allow us to work through these particular issues. Within the next month or two we need to be in a position where we have a much better fix on the actual costs. Clearly, there is variation in how some costs are being attributed to this particular area.

10.30 a.m.

[123] **Jenny Rathbone:** This information has been in the public domain for some time, so how come you do not already know whether there is no validity to the auditor general's analysis? Action is needed now. We cannot just hang around for another year and wait for the auditor general's next report. You are telling us that there is absolutely no validity to this range of cost.

[124] **Mr Sissling:** I am saying that it raises questions that, at the moment, we cannot answer. We are pursuing that with real urgency. Andrew mentioned that Aneurin Bevan LHB has a costing system that we think is best practice. So, by December, we want to have reached a point where we can, if needs be, roll that out and standardise that across the NHS in Wales. As a matter of urgency, we have established a technical group, which met just last week, to allow us to understand the technical financial aspects so that we can produce the right approach in terms of accounting for this particular area. We are focusing on this as a matter of priority. The time frame for this is not a year—in a matter of a few weeks we want to reach a point where we have conclusions and we can adopt and generalise best practice. I would agree that that particular part of the report raises some significant questions. However, the response has been to mobilise action to ensure that we, in swift order, introduce satisfactory practice across the NHS.

[125] **Jenny Rathbone:** What is the cost per meal in Aneurin Bevan LHB? What method is it using?

[126] **Mr Sissling:** I think that the consumable cost is £3.50 per meal. That would obviously be a benchmark in terms of how it operates its systems. I am sure that we can locate the figure.

[127] **Jenny Rathbone:** Okay. Three pounds fifty is a good figure to hang on to, but is a bit difficult to equate that with the auditor general's figures, which are based on the cost per patient day. Perhaps that is the figure that I am seeking in order to get some idea—

[128] **Mr Walker:** You are illustrating part of the problem. There are so many different ways of measuring different hospitals, because they all do things differently. It is about getting consistency. It is not as easy as it may seem, because of the variation in supply, production, and in the way food is served at ward level. There are many different practices going on.

[129] **Andrew R.T. Davies:** I will draw this part to a close, because I am mindful that time is against us. I apologise for the adjournment, which meant that we lost five minutes, but we are only half way through the questions that we would like to ask. If you feel that you could offer the Member and the committee any additional insight on that point, perhaps you could drop the committee a note. I draw the chief executive's attention, as he said that the time frame is not a year, to the fact that this report refers back to March 2011. With your work stream, it will almost be a year by the time things get actioned. So, you can understand why the committee is somewhat hesitant in looking at time frames, thinking that time is moving on. Aled has the next question.

[130] **Aled Roberts:** Mae gwaith yr archwilydd cyffredinol yn dangos, ar gyfartaledd, bod tua 15 y cant o'r bwyd sy'n cael ei baratoi yn cael ei wastraffu yng Nghymru. Mae'n sôn am broblemau gorgynchyrchu ac o ran diffyg cyfathrebu rhwng staff y ward a staff arlwyo. Mae hefyd yn amcangyfrif bod y gwastraff hwnnw wedi costio £1.5 miliwn yn ystod 2009-10. Mae sôn am rhai wardiau lle nad oes bwyd yn cael ei wastraffu, ond mae rhai esiamplau lle mae 62 y cant o'r bwyd yn cael ei wastraffu. Beth yn union ydych yn ei wneud ynglŷn â'r gwastraff hwn a beth fydd yn digwydd os byddwch yn arbed yr £1.5 miliwn hwnnw? A fydd yr arian yn cael ei roi yn ôl i'r gyllideb arlwyo o fewn y gwasanaeth iechyd?

Aled Roberts: The work of the auditor general shows that, on average, around 15 per cent of the food that is prepared is being wasted in Wales. He talks about problems of overproduction and of a lack of communication between ward staff and catering staff. He also estimates that this wastage cost £1.5 million during 2009-10. He mentions some wards where no food is wasted and some examples of where 62 per cent of food is wasted. What exactly are you doing about this wastage and what will happen if you save that £1.5 million? Will the money go back into the health service catering budget?

[131] **Mr Sissling:** I will start and I am sure that Andrew will want to make some comments. This issue of reducing waste is clearly an important issue for us to understand in more detail. Work has already started in that regard. We are working on that internally within Wales, and we are also looking to draw on best practice from other jurisdictions such as Scotland, Northern Ireland and other parts of the public sector to understand how we can better improve the management of the flow of food to reduce waste.

[132] In terms of the process, all health boards are now monitoring food waste to a very high level of detail. That is being monitored on a national basis. Hospitals are looking at the reasons for waste and putting improvement plans in place to allow very rapid responses to any causes of waste. All health boards are looking to introduce or have in place appropriate computerised systems to allow that to happen. All are introducing systems with collective responsibility, bringing catering staff and ward-based staff into fora to allow this to be addressed. We are beginning to see signs of improvement. One of the questions is whether we should set a target for waste, and we believe that it would be appropriate to do so. In the first place, we believe that it would be appropriate to set a target in the order of 10 per cent, but we would want to improve on that, while also accepting that zero waste is impractical. However, we would like to get down from 10 per cent to 5 per cent in due course.

[133] **Aled Roberts:** A yw gwastraff bwyd

Aled Roberts: Is food waste collected

yn cael ei gasglu ar wahân ym mhob ysbyty? separately in every hospital?

[134] **Mr Walker:** Yes, it is.

[135] **Aled Roberts:** Pe byddech yn arbed £1.5 miliwn, a fydd hynny'n cael ei roi mewn i'r gwasanaeth arlwyo? **Aled Roberts:** If you were to save £1.5 million, would that be put into the catering service?

[136] **Mr Sissling:** I would assume that that would be the case to an extent. It would be a matter for local health boards to look at in terms of the various opportunities and options that they have for the reinvestment of that kind of funding. However, the opportunity to improve the catering and nutritional service should feature quite significantly in there, if only to create the right motivation incentives for the staff who are at the heart of creating that kind of improvement.

[137] **Jenny Rathbone:** We are being told that non-patient catering services are being subsidised to the tune of £2.5 million, but your earlier remarks make it unclear as to whether that is really the case. However, it apparently equates to 92p per patient per day. What is your view about the appropriateness of subsidising catering for staff and/or visitors when we eventually find out what the true costs are?

[138] **Mr Sissling:** The actual position is that there are some subsidies, having asked one or two health boards to look in detail at it. We would wish to avoid that, and we would be very eager for health boards to take action to remove the need for cross-subsidy in respect of staffing arrangements, non-patients and visitors.

[139] **Jenny Rathbone:** What relationship, if any, is there between subsidy and healthy eating aspirations?

[140] **Mr Sissling:** Sorry, could you—

[141] **Jenny Rathbone:** When patients come into hospital, we want to encourage them to eat food that will make them better. In the same way, staff and visitors might be encouraged to eat food that is good for them, rather than to eat rubbish.

[142] **Mr Sissling:** I see. That would be very much the case; we would want all of the food for patients, visitors and staff to have the right nutritional qualities. I am not aware that that issue is particularly relevant to the issue of subsidy.

[143] **Mohammad Asghar:** The cost of waste is a bit of a scandal in some hospitals. Have you ever thought of providing vegetarian food as well as non-vegetarian food? Vegetarian food can be consumable for a much longer period—you can even use it the day after—but non-vegetarian food probably has to be thrown away sooner because of its meat content, and so on. Have you ever thought of saving money in hospitals by reusing food, especially vegetarian meals?

[144] **Mr Sissling:** Within the context of the nutrition and catering standards, we are looking at a range of different options on menus, including vegetarian meals and other areas where there are particular needs. We would want to apply the same rigour to costing and to understanding the benefits of different menu types. The driving force is to ensure that we have food that has the right nutritional quality and is attractive to patients. We need to ensure that we do not compromise on that to any extent in terms of the financial challenges that we face. We are looking to create an outcome that hits all the different marks.

[145] **Mohammad Asghar:** Patients go to hospital for treatment not for hotel services. I

understand that they do not go there for the food, but food is important to get people cured properly and to make them feel at home and comfortable. If comfort is not provided by the food, it is definitely not helpful.

[146] **Andrew R.T. Davies:** The sentiment is taken and the point well made, Oscar.

[147] **Leanne Wood:** The report concludes that a more comprehensive and co-ordinated approach is needed to seek the views of patients and families, and for those views to be used in the planning of catering services. What is the Welsh Government and NHS bodies doing to improve the way in which patients' views are obtained? Would it be better to develop an all-Wales approach rather than to rely on a range of different mechanisms employed by various individual health boards and trusts?

[148] **Ms White:** Currently, health boards address this is by conducting patient and food satisfaction surveys on a local basis, which then inform decisions within individual organisations. The only national surveys currently conducted are fundamentals of care auditing processes and Healthcare Inspectorate Wales spot checks. I know that the Older People's Commissioner for Wales was keen on the idea that we try to have more of a national approach in gathering the patient's voice, and this is a piece of work that we are going to take forward as part of our approach to looking at the patient experience. So, at the moment, the arrangements are local satisfaction surveys and then some national audit that informs decisions locally and gives us some idea of what is going on. However, more work could be done on gathering the patient's voice, and we are taking that forward this year.

[149] **Leanne Wood:** Are those food satisfaction surveys done with every patient, as matter of course, or are they done with a sample?

[150] **Ms White:** From what I understand, most health boards conduct a survey of some description, but they are all quite different. The evidence that I have had is that all of them have the means in place to gather the patient's voice. The evidence that has been given to me is that most will ask patients about their experience of hospital meals. It is difficult to generalise, because some patients are restricted when it comes to food—particularly in intensive care units, not all patients will necessarily be asked about meals. Where it is appropriate, I understand that they are asking for views.

[151] **Leanne Wood:** You mentioned the older people's commissioner and her views on this. She told us that some older people are afraid to raise concerns about food because of fears of reprisals. You have talked about a leaflet from the Wales Audit Office, but what other ways would you use to inform NHS patients or their relatives about what they can expect in relation to food, and what to do if they are not satisfied?

[152] **Ms White:** The health boards have been working on putting out patient information leaflets. The examples from the Wales Audit Office inform those patient leaflets. There is not a consistent approach across Wales, but I understand that they put out information leaflets of that type. Could you repeat the second part of the question?

10.45 a.m.

[153] **Leanne Wood:** What can people do if they are not satisfied? How are patients informed of the process?

[154] **Ms White:** This year we have put in place the NHS redress arrangements, and throughout the hospitals there are posters and leaflets that tell people how to make a complaint if they are not happy. The NHS redress reforms of earlier this year are very explicit about how people should raise concerns, if they have them.

[155] **Leanne Wood:** So, you have information leaflets and posters. Are staff trained to explain to people, because some people are unable to read information on a poster?

[156] **Ms White:** Again, I am afraid that it tends to be a local issue; it is not national training that is undertaken. Certainly, when new policies are introduced, the health boards provide local training to explain the new policies, but it is not something that we would necessarily mandate centrally from Government.

[157] **Julie Morgan:** We have already covered some of this, but my question is about how you bring together all these different, disconnected initiatives and make a coherent strategy. I do not know if you have anything to add to what you have already said about this.

[158] **Mr Sissling:** One thing that we have done recently is try to bring all the different areas together into one framework—and there are many things that contribute to success in this area of hospital catering and nutrition. This framework operates, to an extent, through a website, which is available to all staff. It brings together issues related to healthcare standards, the all-Wales nutrition care pathway, the all-Wales catering nutrition standards, fluid provision, guidance on healthy food and drink choice for staff and visitors, the health-promoting hospital, and the estates and facilities performance management system. We are trying to bring all this together because we believe that all the good endeavours and initiatives in their own right have an impact, but it is only when we have an opportunity to combine them that we begin to see the added value. We are also working at a general level with health boards to make sure that the nature of the task and the opportunity is clear. For example, at the next chief executives meeting in a few weeks' time we will be talking about this particular issue, and it will be an opportunity for me to emphasise that this is a critical part of the delivery agenda. It needs to be treated as a priority by chief executives, and they must give it their particular, personal attention. I will be seeking formal reassurances from them that progress will be made over coming months, because this report and this issue clearly merits that degree of corporate attention. So, the answer to the question is that, yes, we are bringing it all together into a framework, and through processes we are beginning to bring the right focus and leadership attention to this, building on all the good practice that is evidenced in the report, to take us up to another level.

[159] **Julie Morgan:** How are you going to measure whether that has been achieved?

[160] **Mr Sissling:** We will use some of the things that we have spoken about already, in terms of the various means by which we audit performance in this area and take advantage of inspection, where appropriate. We might enhance that and involve Health Inspectorate Wales and community health councils in a particular area. We are keen to make sure that we show, over a three-month, six-month, 12-month time frame, that there is demonstrable evidence of progress. We want to make much more use of patient satisfaction surveys, so that, again, we have the voice of the patient loud and clear as we begin to appraise progress. Our position is that it is a priority to focus on delivery. Take, for example, the approach that we adopted with the 'Dignified Care?' report—that is now one of our top-level priorities for performance, alongside waiting lists, accident and emergency performance and financial performance. It is one of the key areas that we are focusing on within a delivery framework that describes the support, but also the issues that flow from poor performance.

[161] **Jenny Rathbone:** In the absence of reliable figures on catering costs, according to your estimate, how have you been able to advise health boards about whether they should be installing cook-chill and cook-freeze methods? If you do not have reliable data, how are you able to say that they are better than the conventional methods? I am sure that there are commercial companies that say that they are better, but that will not necessarily be the case.

[162] **Mr Walker:** There is no definitive correct or cheap way of providing food to the health service. These systems emerge over time to suit local practices and circumstances. If we were to say now that every LHB should use only cook-freeze, that would not necessarily provide the benefits or improvements in the service that you are looking for or improve cost. There is no precise or correct way of doing it; that is why there are so many different systems out there. If one system was perfect, we would use it, but it is not as simple as that.

[163] **Jenny Rathbone:** We do not appear to know, at the moment, whether it is a good idea or not.

[164] **Mr Walker:** We do know that there is not one system that fits all.

[165] **Mr Sissling:** A further response is that, in time, we will have an indicator. Within the next two or three months, we will have the necessary analysis of the costs, using a standardised approach based on best practice. That will form a foundation on which we can move ahead with more confidence.

[166] **Andrew R.T. Davies:** Thank you for that answer. It seems as if considerable pieces of work will come together in the next two to three months, and the committee might be mindful of finding out the conclusions of those pieces of work.

[167] **Aled Roberts:** Un o'r themâu sydd wedi dod allan y bore yma yw'r anghysondeb rhwng byrddau iechyd o ran y wybodaeth sydd o'u blaenau. Trof yn ôl at y wybodaeth sy'n cael ei hystyried gan fyrddau iechyd lleol. Mae argymhelliad 10 yn yr adroddiad yn sôn am y ffaith bod pob bwrdd yn awr yn derbyn gwybodaeth ynglŷn ag arlwyo a maeth ar gyfer cleifion yn flynyddol, ond mae'r archwilydd cyffredinol yn dweud bod gwahaniaeth ym manylder yr wybodaeth sydd yn cael ei derbyn. Mae'n sôn am rai byrddau iechyd nad ydynt yn ystyried sut mae'r bwrdd yn datblygu llwybr gofal maeth Cymru gyfan, y cymhorthdal sydd yn cael ei dalu o ran staff ac ymwelwyr na'r bwyd sy'n cael ei wastraffu. Nid oedd gan rai byrddau iechyd syniad faint o fwyd oedd yn cael ei wastraffu. A ydych wedi argymell bod pob bwrdd iechyd lleol yn ystyried yr un wybodaeth yn flynyddol?

Aled Roberts: One theme that has come out this morning is the inconsistency between health boards as regards the information that they have before them. I return to the issue of the information that is considered by local health boards. Recommendation 10 in the report mentions the fact that every board now receives annual information on catering and patient nutrition. However, the auditor general states that there is a difference in the level of detail received. He says that some health boards do not consider how the board develops the all-Wales nutritional care pathway, the subsidy that is paid in terms of and visitors or food waste. Some boards had no idea how much food was being wasted. Have you recommended to every local health board that it considers the same information annually?

[168] **Mr Sissling:** This is one of the areas in which we can see the value of the auditor general's report. It has stimulated consideration in every board and across boards of the kind of reporting arrangements that they need in place. So, all NHS bodies now produce an annual report that provides the necessary information that the board will require to form judgments and to exercise its governance and stewardship responsibilities. That is a mixture of some of the issues that come through the estates and facilities performance management system, aspects of nutritional screening and how nutritionally at risk patients are cared for. We have not concluded that work yet; it is a work in progress. We will be in a position reasonably soon to have that standardised approach across all of Wales.

[169] **Aled Roberts:** Do they all report at the same time, or do different boards consider their annual reports at different times of the year?

[170] **Mr Sissling:** I do not know, but I can provide that information. I would be surprised if it was exactly the same time of year, but I suspect that the reports that they get to inform them are probably in the same broad time zone of the first or second quarter of the year, because it is at that point that they will get the information from the PMS later in the year.

[171] **Aled Roberts:** So, would your expectation be that, if all boards receive that information during the first quarter, the standardised approach will be adopted during the first quarter of next year?

[172] **Mr Sissling:** Yes, absolutely.

[173] **Andrew R.T. Davies:** Would Members care to raise any other points or are Members content with the questioning? I see that you are. I thank you all for attending today and, in particular, for making yourselves available so early in the morning for us. That extra half an hour proved beneficial and Members were able to question you fully on the evidence that they had received. A transcript will be sent to you of today's proceedings; please check it for accuracy and, if you have any concerns, raise them with the clerk. Once again, thank you for the evidence that you have provided. We look forward to you making progress in this important field of the health service.

[174] That concludes our meeting today, unless there any other points or any business that Members care to raise. I see that there are not. Therefore, I will draw Members' attention to the next meeting, which will be held on 22 November, two weeks from today. Thank you all for your attendance.

Daeth y cyfarfod i ben am 10.55 a.m.
The meeting ended at 10.55 a.m.