Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Cofnod y Trafodion
The Record of Proceedings

Y Pwyllgor Cyfrifon Cyhoeddus

The Public Accounts Committee

17/10/2016

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Others in attendance

Dr Andrew Goodall	Cyfarwyddwr Cyffredinol/Prif Weithredwr GIG Cymru, Llywodraeth Cymru Director General/NHS Chief Executive, Welsh Government
Anthony Hayward	Cyfarwyddwr Cynorthwyol Cyfleusterau, Bwrdd Iechyd Lleol Cwm Taf Assistant Director of Facilities, Cwm Taf Local Health Board
Rhiannon Jones	Cyfarwyddwr Gweithredol Nyrsio, Bwrdd Iechyd Lleol Addysgu Powys Executive Director of Nursing, Powys Teaching Local

	Health Board
Colin Phillpott	Rheolwr Cyfleusterau, Bwrdd Iechyd Lleol Aneurin Bevan Facilities Manager, Aneurin Bevan Local Health Board
Dave Thomas	Swyddfa Archwilio Cymru Wales Audit Office
Huw Vaughan Thomas	Archwilydd Cyffredinol Cymru Auditor General for Wales
Liz Waters	Nyrs Ymgynghorol, Atal Heintiau, a Chyfarwyddwr Cyswllt Nyrsio, Bwrdd Iechyd Lleol Aneurin Bevan Consultant Nurse, Infection Prevention, and Associate Director of Nursing, Aneurin Bevan Local Health Board
Yr Athro/Professor Jean White	Prif Swyddog Nyrsio, Llywodraeth Cymru Chief Nursing Officer, Welsh Government
Lynda Williams	Cyfarwyddwr Gweithredol Nyrsio, Bwrdd Iechyd Lleol Cwm Taf Executive Director of Nursing, Cwm Taf Local Health Board

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

Claire Griffiths	Dirprwy Glerc Deputy Clerk
Meriel Singleton	Clerc Clerk
Joanest Varney-Jackson	Uwch-gynghorydd Cyfreithiol Senior Legal Adviser

Dechreuodd y cyfarfod am 14:01.
The meeting began at 14:01.

Cyflwyniad, Ymddiheuriadau, Dirprwyon a Datgan Buddiannau
Introductions, Apologies, Substitutions and Declarations of Interest

[1] **Rhun ap Iorwerth**: Prynhawn da. A gaf i eich croesawu chi fel aelodau'r pwyllgor i gyfarfod y Pwyllgor Cyfrifon Cyhoeddus heddiw? Mae clustffonau ar gael, fel yr arfer, ar gyfer cyfieithu ar y pryd ac ar gyfer chwyddo'r sain—cyfieithu ar sianel 1 a chwyddo'r sain ar sianel 0. Mi wnawn ni atgoffa ein tystion o hynny wrth i'r prynhawn fynd yn ei flaen. A gaf i atgoffa Aelodau i ddiffodd y sain ar unrhyw ddyfeisiadau electronig, os gwelwch yn dda, a nodi yn fan hyn os bydd achos i adael yr ystafell mewn achos o argyfwng, mi fydd larwm yn canu ac mi fydd y tywyswyr ar gael i arwain pawb at yr allanfa ddiogel a'r man ymgynnull agosaf?

Rhun ap Iorwerth: Good afternoon. May I welcome you as members of the committee to this meeting of the Public Accounts Committee today? The headsets are available, as usual, for interpretation services and for amplification—interpretation is on channel 1 and amplification is on channel 0. We will remind our witnesses of that as the afternoon proceeds. Could I remind Members to put their electronic devices on mute, please, and note here that if there is a reason to leave the room in an emergency, there will be an alarm and the ushers will be available to lead everyone to the nearest safe exit and assembly point?

[2] Mae ymddiheuriadau heddiw gan Nick Ramsay, y Cadeirydd arferol, ac mae Andrew R.T. Davies yn dirprwyo ar ran Nick Ramsay heddiw. A gaf i groesawu Andrew R.T. Davies i'r pwyllgor? Ar gyfer y cofnod, mi wnaf i'ch atgoffa fy mod i wedi cael fy ethol gan y pwyllgor o dan Reolau Sefydlog 17.22 ac 18.6 fel Cadeirydd dros dro ar gyfer y cyfarfod heddiw. Roedd y bleidlais honno wedi digwydd ar 3 Hydref.

There are apologies today from Nick Ramsay, the usual Chair, and Andrew R.T. Davies is substituting on behalf of Nick Ramsay. Could I welcome Andrew R.T. Davies to the committee? For the record, I will remind everyone that I was elected by the committee under Standing Orders 17.22 and 18.6 as temporary Chair for today's meeting. That vote happened on 3 October.

[3] Fel ym mhob cyfarfod, mae yna, wrth gwrs, gyfle i Aelodau ddatgan buddiannau wrth i'r cyfarfod fynd yn ei flaen a phan mae yna faterion perthnasol yn codi, ond mi

As in every meeting, there is, of course, an opportunity for Members to make declarations of interest as the meeting proceeds and when relevant issues arise, but I will now

wnaf i, yn fan hyn, wahodd unrhyw ddatganiadau o fuddiant personol gan aelodau'r pwyllgor.

invite any declarations of personal interest from committee members.

[4] **Lee Waters**: Chair, I have a declaration. My wife works for Cwm Taf Local Health Board.

[5] **Rhun ap Iorwerth**: Diolch yn fawr iawn i Lee Waters, a dyna'r unig ddatganiad o fuddiant y prynhawn yma.

Rhun ap Iorwerth: Thank you very much to Lee Waters, and that's the only declaration of interest this afternoon.

14:02

Papurau i'w Nodi
Papers to Note

[6] **Rhun ap Iorwerth**: Mi symudwn ni ymlaen at eitem 2, sef y papurau i'w nodi. Yn gyntaf, mae cofnodion y cyfarfod a gafodd ei gynnal ar 3 Hydref. A gaf i ofyn i'r Aelodau: a ydych chi'n cytuno ar y cofnodion hynny? Diolch yn fawr iawn i chi. Mae un papur arall i'w nodi, sef gwybodaeth ychwanegol gan Gomisiwn y Cynulliad, yn dilyn presenoldeb Suzy Davies yn y pwyllgor ar 19 Medi. Mi ysgrifennwyd at y pwyllgor ar 28 Medi yn rhoi rhagor o wybodaeth yn dilyn y sesiwn tystiolaeth hwnnw. Felly, a gaf i ofyn i'r Aelodau nodi'r llythyr hwnnw sydd wedi cyrraedd gan Suzy Davies?

Rhun ap Iorwerth: We'll move on now to item 2, which is the papers to note. First, there are the minutes from the meeting held on 3 October. Could I ask Members: do you agree those minutes? Thank you very much. One further paper to note is the additional information from the Assembly Commission, following the attendance of Suzy Davies at the meeting on 19 September. A letter was written on 28 September, providing further information following the evidence session. So, could I ask Members to note that letter, which has arrived from Suzy Davies?

[7] Mae gen i hefyd bapur, nid i'w nodi—mi wnawn ni'r nodi mewn cyfarfod yn y dyfodol—ond i dynnu eich sylw chi at lythyr gan Gadeirydd y Pwyllgor Deisebau ynglŷn â bwyd yn ysbytai Cymru, sydd yn berthnasol

I also have a paper, not to note—we'll do note it in a further meeting—but to draw your attention to a letter from the Chair of the Petitions Committee about food in Welsh hospitals, which is relevant to the

ar gyfer y trafodaethau a fyddwn ni'n eu cael y prynhawn yma. Ond rwy'n tynnu eich sylw chi at y ffaith bod y llythyr hwnnw wedi cyrraedd gan Gadeirydd y Pwyllgor Deisebau, sef Mike Hedges.

discussions we'll have this afternoon. But I draw your attention to the fact that that letter has arrived from the Chair of the Petitions Committee, namely Mike Hedges.

14:04

Arlwyo a Maeth Cleifion mewn Ysbytai: Byrddau Iechyd
Hospital Catering and Patient Nutrition: Health Boards.

[8] **Rhun ap Iorwerth**: Rŵan, mae hynny'n dod â ni at eitem 3 ar yr agenda heddiw, sef ein hymchwiliad i gynnydd ym maes arlwyo a maeth cleifion mewn ysbytai. Mae yna bump o dystion o'n blaenau ni heddiw ac rwy'n gallu gweld bod yna offer cyfieithu yn cael eu defnyddio'n barod, ond mi wnaf i dynnu'ch sylw chi at y ffaith eu bod nhw yna—sianel 1 ar gyfer cyfieithu a chwyddo'r sain, wedyn, ar sianel 0.

Rhun ap Iorwerth: Now, that brings us to item 3 on the agenda, which is our inquiry into hospital catering and patient nutrition. We have five witnesses before us this afternoon. I can see that the interpretation is being used already, but I'll draw your attention to the fact that it's channel 1 for interpretation, and that amplification is on channel 0.

[9] Rydym ni'n ddiolchgar iawn i'r pump ohonoch chi am ddod atom ni'r prynhawn yma, ac os caf i ofyn i'r pump ohonoch chi nodi eich enw a'ch teitl ar gyfer y cofnod, gan ddechrau efo chi.

I'm very grateful to the five of you for coming this afternoon, and could I ask the five you to note your names and your titles for the record, starting with you.

[10] **Mr Phillpott**: My name is Colin Phillpott. I'm a facilities manager with Aneurin Bevan Local Health Board.

[11] **Ms Waters**: Hello. My name is Liz Waters. I'm a consultant nurse and associate nurse director for Aneurin Bevan health board.

[12] **Ms Jones**: Good afternoon. I'm Rhiannon Jones. I'm the executive director of nursing for Powys Teaching Local Health Board.

[13] **Ms Williams:** I'm Lynda Williams. I'm the director of nursing, midwifery and patient services at Cwm Taf Local Health Board.

[14] **Mr Hayward:** Good afternoon. My name is Anthony Hayward. I'm the assistant director of facilities for Cwm Taf health board.

[15] **Rhun ap Iorwerth:** Diolch yn fawr iawn. Mi fydd yna lu o gwestiynau, rwy'n siŵr, gan aelodau'r pwyllgor y prynhawn yma. Mi wnaf i ddechrau yn gyntaf efo cwestiwn ynglŷn â gwella safon y dogfennau nyrsio ysgrifenedig ac ansawdd asesiadau nyrsio mewn perthynas â maeth cleifion. Mae e wedi'i nodi bod yna arafwch wedi bod wrth safoni dogfennau. A gaf i ofyn pa gamau y mae'r byrddau iechyd wedi eu cymryd yn y maes hwn? Caiff y cyntaf i siarad ddechrau. Rhiannon Jones, mi ddechreuwn ni efo chi.

Rhun ap Iorwerth: Thank you very much. There will be a whole host of questions, I'm sure, from the committee members this afternoon, but I will begin with a question relating to improving the standard of written nursing documentation and the quality of nurse assessments in relation to patient nutrition. It has been noted that there has been a delay in standardising documentation. May I ask what action the health boards are taking in this area? The first to respond may begin. Rhiannon Jones, we will begin with you.

[16] **Ms Jones:** Thank you. I think that from an all-Wales perspective, there certainly has been a delay, but that hasn't meant that individual health boards haven't progressed with the development of local documentation. Certainly from a Powys perspective, we have had a significant piece of work where the documentation has been aligned to the health and care standards, which includes nutritional risk assessments for patients. There are ongoing discussions about the need for a revision to the documentation for nursing, but a recognition that we need an electronic solution, not more paper-based approaches. I know that Jean White will be picking that up later, and there is progress in terms of the NHS Wales Informatics Service taking that forward.

[17] **Rhun ap Iorwerth:** Lynda Williams.

[18] **Ms Williams:** I can endorse that. We met as a group of nurse directors with the chief nursing officer on Friday, and we were very pleased to hear about the appointment to NWIS of an individual to take this forward. We confirmed that that would be part of her work programme, including all of the nurse documentation, but more specifically around the nutrition

assessments. In Cwm Taf, we have a similar approach with regard to a standardised nutrition assessment tool for the whole of the organisation, which follows the nutritional care pathway through, so that nurses are quite clear about the next steps that need to happen for their patient.

[19] **Rhun ap Iorwerth:** Mi wnaf i eich atgoffa chi, yn enwedig efo pump ar y panel, nad oes disgwyl i bob un ohonoch chi wneud cyfraniad ar bob un cwestiwn. A oes yna unrhyw un arall sydd eisiau gwneud sylw cyffredinol ynglŷn ag arafwch y broses hon? Na. Os felly, mi agorwn ni bethau allan. Mae'n ddrwg gen i: a ydych chi am wneud sylw? Na. Felly, Andrew R.T. Davies.

Rhun ap Iorwerth: I will remind you, particularly with five on the panel, that you are not all expected to make a contribution on every question. Does anyone else want to make a general comment on the slowness of this process? No. Therefore, we will open up the discussion. I'm sorry: did you want to make a comment? No. Therefore, Andrew R.T. Davies.

[20] **Andrew R.T. Davies:** Thank you, Chair. Leading on from the first question, if I may: is there a specific reason why standardisation wasn't brought forward by March 2103? Obviously, I hear what you're saying about your individual health groups and that it hasn't stopped you from progressing, but Welsh Government gave a commitment, in response to what the Auditor General for Wales found in 2011, that there would be standardisation and that it would be completed by March 2013. So, is there a specific reason why that date was missed? Now, we are sitting here in 2016, you know. It's not a couple of weeks. We are talking a couple of years.

[21] **Rhun ap Iorwerth:** Rhiannon Jones.

[22] **Ms Jones:** My understanding of the situation is that there has been a gap in terms of a nurse lead within NWIS in terms of taking that piece of work forward. There have been a number of attempts via the all-Wales nurse directors to take that forward. One of the nurse directors, Caroline Oakley, was previously responsible for bringing together health boards, and us moving forward with paper-based documentation. That is a challenge when it's not directed from the centre because each health board undoubtedly thinks that their documentation is of a standard—particularly, I think, when individual health boards have done so much work to rationalise and standardise the documentation in their own health boards. That's a personal view of maybe some of the reasons for delay, but one of the key issues was a gap in nurse leadership at NWIS.

[23] **Rhun ap Iorwerth:** Lynda Williams.

[24] **Ms Williams:** I think Rhiannon is right with regard to standardisation of the nursing documentation, but what we have had agreement over is the screening tool to be used. It is important to know, never mind what the documentation looks like in each of the organisations, that we all use the malnutrition universal screening tool, or the MUST tool, to actually assess the patient, so that we are all assessing against common criteria, which is the important bit, rather than necessarily just the documentation.

[25] **Andrew R.T. Davies:** So, if that position was filled—and our briefing paper does point to the fact that this post has been vacant—then you as health boards could see a far better approach from Welsh Government, a joined-up approach, in standardising it across the health boards. But the absence of having that lead has led to slippage in the delivery time. Is that a fair assessment?

[26] **Ms Williams:** I think that's a fair assessment. There was an individual in post, but the post has been vacant now probably for about 12 months. So, our ability to be able to progress the work, particularly in electronic form, has been sadly very slow in that area.

[27] **Andrew R.T. Davies:** Could I just put two questions, if I may, Chair? The two I'd like to ask are: one around training, because again, the briefing paper does touch on the point about how some staff obviously find it really difficult to get on to the e-training model that you've put in place and—

[28] **Rhun ap Iorwerth:** We'll want to talk about e-training a little bit later on if—

[29] **Andrew R.T. Davies:** It's in this briefing paper.

[30] **Rhun ap Iorwerth:** Yes. We will be talking about it, certainly, but—

[31] **Andrew R.T. Davies:** Okay. Pass.

[32] **Rhun ap Iorwerth:** Okay. Oscar, you wanted to come in.

[33] **Mohammad Asghar:** Thank you very much indeed, Chair, and thank you to the panel. With the Royal College of Nursing having stated that

nutrition was one of the very fundamental parts of care and backed by the 'Trusted to Care' report in May 2014, what actions are the eight health boards taking to ensure that nutrition is being incorporated into the planning and monitoring of patients? All of you.

[34] **Ms Waters:** We've undertaken quite a large piece of work around our assurance processes in nursing and we've just revised our assurance framework, as such. To use Tony Blair's expression, 'Education, education, education', I would lead on that by saying we also need to, 'Monitor, monitor, monitor'. It's about ensuring that you've got structures in place to ensure that anything that's picked up at ward level, through any kind of audit, is fed up through the organisation and back down again. Certainly, the structures that we're putting in in Aneurin Bevan mean that we will have that very close monitoring from board to ward and beyond, where necessary. So, it's that assurance, that structure and the metrics that go along with it, and the quality measures that go along with it, as well, like patient surveys and how they find the food. That information has got to be fed, board to ward, and beyond.

[35] **Ms Jones:** I'd echo what Liz has indicated, but additionally that we have got auditing processes within each of the health boards, as was demonstrated in the Wales Audit Office report. From a Powys perspective, we've got audits that are called 360 degree audits, because they take in the full range of review of the patient experience, but additionally nutrition and the nutritional content of food—the catering service as well as waste. So, that's a full-blown multidisciplinary audit and we use those results to triangulate information about patient feedback as well, and there's a patient feedback that's incorporated into that process.

[36] **Rhianon Passmore:** With regard to the question from Andrew R.T. Davies, you mentioned that the post, for 12 months, had not been filled, is there any reasoning for why that post has not been filled?

[37] **Ms Williams:** I'm afraid I wouldn't be able to answer that question. But it is quite a rare set of skills that the individual would require: to be both a professional nurse and an informaticist is quite a rare set of skills. So, I would imagine that there's probably been a lack of applicants for the post. I do know, from the conversations with NWIS around health and care monitoring that we've talked to them about, that they did take some time to decide what they wanted in that post, to be assured that that post could deliver what was required of it by the NHS.

[38] **Rhianon Passmore:** So, do you perceive there to be a lack of urgency?

[39] **Ms Williams:** I don't perceive there to be a lack of urgency. As I said, it is a very specific skill set that's required and I think that they were right to take the time to make sure that they had the right post to be able to deliver.

[40] **Ms Jones:** I think in terms of following that through, the conversations that we've had with Jean White as CNO, clearly identifying the priorities for that new person coming into post, and one of those priorities being an all-Wales approach to the documentation standards. So, we're seeing that in place, before the individual has even taken up post.

[41] **Rhun ap Iorwerth:** I would like to go on to staff training, now, if that's okay. If you'd like to come back in with the question on e-learning, in particular.

[42] **Andrew R.T. Davies:** If that's possible, thank you, Chair. I'm very keen to explore the ability for staff to train. Obviously, the briefing notes that we've had indicate that staff felt unable to find the time to do that. I'm sorry I'm looking at you, Rhiannon, but you're in the middle, so, if I'm scanning the whole row of people there—.

14:15

[43] That's deeply concerning, that is, because obviously people being able to upgrade their skillsets is surely a vital part of a modern workforce. So, is it a fair assessment to say that there isn't the time made available for staff to get that training and, in particular, to make sure that they then have, because we've heard about sharing of information, the ability to assess that information? Because there's no point taking volumes of information in if you can't assess whether that information is actually what you want to be achieving on your wards.

[44] **Ms Jones:** Shall I answer that first as you were looking at me? I'm not taking it personally.

[45] **Andrew R.T. Davies:** You're the chair. [*Laughter.*]

[46] **Ms Jones:** Okay, thank you. I think it's an important point. The report does highlight the difficulties with e-learning particularly, and that's because

of the availability of computers. What I would draw the committee's attention to is that e-learning is only one approach to learning and education and that classroom approaches are equally important. It's the e-learning that's actually been monitored over the past few years in terms of our compliance. I think Jean White, CNO, has been very clear about the expectations of staff compliance with the training.

[47] I know, from a Powys perspective, we have struggled with that. Some of that is about the compliance that we've got with mandatory and statutory training per se, not just in relation to nutrition. An approach that we've taken to prioritise the importance and have a prioritisation approach to mandatory and statutory training, and I have to say, nutrition and e-learning were not prioritised for Powys in terms of securing improvements to compliance. That doesn't mean that nutrition is not important, but it isn't just about the training compliance, it's about the 'So what?' as a result of that.

[48] If we were triangulating, that we had poor compliance with the e-learning training but, additionally, we were having a lot of complaints about nutrition, auditing was demonstrating that we weren't doing what we should have been doing, and I had low compliance in terms of the assessments of patients within 24 hours of admission, in triangulation, I would say that I would prioritise training more. But, in this instance, for Powys, that isn't the case. I think it's important to look at all the data and what it's telling us about the patient experience.

[49] So, the element of access doesn't just apply to e-learning, it's much wider. I think that the capturing in terms of the experience of our staff, which isn't just about nurses, it's the wider, multidisciplinary team, is that there is availability for other types of learning as well.

[50] **Rhun ap Iorwerth:** But there was an expectation of compliance, of course, with this. What is the Cwm Taf experience of struggling to comply?

[51] **Ms Williams:** We do struggle to comply, as Rhiannon said, because of the availability of computers. We've taken a slightly different tack and we're actually looking at how we can enable our staff to use iPads and Chromebooks—mobile electronic devices—to undertake their e-learning. We're also monitoring what the uptake of e-learning is from their home, because they can actually access the platform from their own home computers as well.

[52] So, we're looking at that as being a range of options. From next month, we'll be able to monitor our compliance directly through the electronic staff record, because the learning platform will actually relate to the ESR record and we'll be able to—as we do for professional development records—monitor that very closely to see if that is an area that they haven't actually picked up on.

[53] We've also increased the nurse inductions. So, at nurse inductions they will have a brief, if you like, taster—although, pardon the pun—session of learning around nutrition. The need to do nutritional assessments will be part of that induction programme. So, we start the education early and then the e-learning would be a top-up on that to try and get everybody to that space. But, a bit like Rhiannon said, that is only just one part of the process, really. We've got a 94 per cent compliance with regard to the nutritional assessments and the use of the MUST tool and the nutritional care pathway. So, I'm quite confident that my staff are doing the actual assessments. And, it is the 'So what?' So what is it telling us? Are we getting it right? Are people well-nourished when they're in our care, which is the most important thing, really?

[54] **Rhun ap Iorwerth**: Perhaps the Aneurin Bevan experience first.

[55] **Ms Waters**: I agree with my colleagues, mandatory training is challenging. For all that we say nutrition is important, which it absolutely is, so is infection control, so is dementia training, so is fire safety—we can go on and on and on. So, we have to be quite innovative in how we deliver the education. Again, my colleagues have put forward some innovative ways of delivering that education. Certainly in Aneurin Bevan, the mandatory training issue has been picked up, and we will be putting on three days in a row of mandatory training throughout the year that staff can access because they find it far easier to access mandatory training when they come off the ward and they're away from the ward for a whole day and they can truly engage in that mandatory training. So, certainly that's the approach we're using in Aneurin Bevan at the moment. There'll be mandatory training days run throughout the year.

[56] **Rhun ap Iorwerth**: Diolch yn fawr. Mae yna gwestiynau— **Rhun ap Iorwerth**: Thank you. There are questions—

[57] **Andrew R.T. Davies**: Can I just check something?

[58] **Rhun ap Iorwerth**: Yes, please.

[59] **Andrew R.T. Davies**: That training—the time that you give the staff to train—has that got to be done in work time or their own time?

[60] **Ms Waters**: Work time.

[61] **Andrew R.T. Davies**: So, it is work time.

[62] **Ms Waters**: Absolutely, yes.

[63] **Andrew R.T. Davies**: Hence that's why we were getting in the briefing note the interruptions that staff were referring to, because obviously they're juggling. So, it's not specific protected training time, it's within the normal working day and they might have 101 other things going on as well.

[64] **Ms Waters**: Yes, absolutely.

[65] **Rhun ap Iorwerth**: Mae yna gwestiynau penodol ynglŷn â hyfforddi gan Mike Hedges hefyd, ond un yn benodol ar *e-learning*—e-ddysgu—gan Rhianon Passmore.

Rhun ap Iorwerth: We have specific questions about training from Mike Hedges, but one specifically on e-learning by Rhianon Passmore.

[66] **Rhianon Passmore**: In regard—. Sorry, I didn't quite catch that.

[67] **Rhun ap Iorwerth**: You have a supplementary on e-learning.

[68] **Rhianon Passmore**: My questions. Okay. Can you talk me through the actual process that the health board in Cwm Taf has adopted around a patient satisfaction score? And obviously that's out of the patient survey element from the meal time audit.

[69] I might have leaped a bit forward there. [*Laughter*.]

[70] **Rhun ap Iorwerth**: Yes, perhaps we—

[71] **Rhianon Passmore**: Do you want me to shelve that?

[72] **Rhun ap Iorwerth**: —can come back to that a little later on. Mike Hedges on other aspects of training.

[73] **Mike Hedges:** Yes. What action is the health board taking to ensure that food and fluid intake are recorded appropriately for all at-risk patients?

[74] **Ms Waters:** Again, this is about audit. Again, I'll be honest and say that the challenge of audit is quite considerable, because it's not just nutrition and hydration that needs to be audited, So, the audit tools that are currently in use in Aneurin Bevan are under review, and we're certainly looking to utilise the quality checks document that has been produced from the chief nursing office. What we want to put within that, though, is some metrics, so we're getting quality measures and we're getting metrics as well. And, again, that needs to be—it's the 'so what?'; it needs to be fed up from ward to board and back down again, and recognise where there are deficits and, actually, and as we picked up with the infection control, making sure the divisions are actually owning their issues, owning their nutritional and hydration issues, and that has been highly successful in bringing C. difficile down in Aneurin Bevan health board, and we certainly expect compliance to go up in terms of nutrition and hydration using that methodology.

[75] **Ms Jones:** I think, as Liz has indicated, there's a full suite of audit documentation that is employed across the health boards, that that takes into account the quality checks tool, which is as a direct result of 'Trusted to Care'. There are specific hydration and nutrition audits that are undertaken; there are spot-check audits that are undertaken by senior nurses and other members of the multi-disciplinary team. So, it's a full range of information, and not just the metrics that are included within the health and care standards monitoring system as well. I think there's a full range of information in terms of providing assurance.

[76] **Rhun ap Iorwerth:** Okay. Thank you. I should note that you don't need to press the buttons; they come on.

[77] **Mike Hedges:** A couple more questions along this: you've got dementia patients, and we're talking to you, and I'm sure you've got absolutely wonderful policies at board level. I also know that a number of you have actually been ward managers in the past. And that's what actually happens, isn't it, that the ward managers are the ones who have responsibility on a day-to-day basis, and you can audit them as much as you like, and you can do all of these things as much as you like, but, if ward managers are not complying, then it ain't happening. That's the thing that concerns me. Now, dementia patients quite often have serious problems with

eating, et cetera. What is being done to support patients in eating and drinking who have difficulty doing it themselves?

[78] **Rhun ap Iorwerth**: Yes, Rhiannon Jones—[*Inaudible.*]

[79] **Ms Jones**: Thank you. It's just because I'm in the middle. [*Laughter.*]

[80] **Rhun ap Iorwerth**: All eyes on you.

[81] **Andrew R.T. Davies**: The two chaps either side are just propping you up.

[82] **Ms Jones**: It's recognising it's all about Powys—no, not at all. [*Laughter.*]

[83] I think they're really important points, and I'd absolutely concur that the role of the ward sister and the charge nurse is critical. They are there with 24/7 responsibility for the quality of patient care. Auditing provides additional assurance, though. For the care of patients with dementia, those patients are identified on admission. We've got something called 'the red tray scheme', so, if people do need assistance, there's a red tray that's given, and that provides a visual that the patient needs additional assistance. Additionally, in terms of care of patients with dementia, we've got the butterfly scheme, which is about a butterfly that is placed above the patient's bed, and that gives additional indication that the patient needs assistance, and, clearly, the nursing team will be aligned to the patients who need assistance during the meal-time experience.

[84] I think the additional element, which actually wouldn't have been captured as part of the Wales Audit Office review, is John's Campaign, which is something that is being adopted across Wales in many of the health boards, and this is where we're particularly focused on patients' relatives being able to come in to hospitals outside of visiting times to assist where necessary. That was picked up as part of the Wales Audit Office report previously, in terms of protected meal times, but John's Campaign now is an additional initiative.

[85] **Mike Hedges**: Have you ever thought of weighing patients? The best indication of whether they are, or are not, getting sufficient nutrients is whether their weight goes up or down. Surely, weighing patients on a weekly basis who have nutritional problems would actually give you an indication.

You keep on talking about—I'm just saying, you keep on talking about the rules and the boards' views. I can talk about ABMU: you can go to two neighbouring wards, one of which will provide absolutely perfect and brilliant support for people who have problems in eating, and the other one will deliver the food and take it away again—same rules, but it's the implementation.

[86] **Rhun ap Iorwerth:** Lynda Williams.

[87] **Ms Williams:** And, I agree with you, that is one of the daily challenges for senior nurses within the organisation and for others: to make sure that we have standardisation, that everybody works to a consistent standard across the organisation. In Cwm Taf, additional to the things that Rhiannon has talked about with regard to protected meal times, we are starting the John's Campaign as well, but we've always encouraged relatives and friends to come in and make eating and meal times a social experience, as opposed to just feeding, because that's what it is for all of us; it is a social experience.

[88] The John's Campaign is where we have relatives actually staying on the ward, a bit like they do with children and young people, and they stay with their relative all of the time, to be with them. One of the other things that we have actually got in place is volunteers, as well, to support the staff in the feeding of patients. The registered nurse will actually go to the food trolley and have the food dished out for that patient, so they ensure that they have what they like and what they feel that they can eat, and in the quantities that they feel are appropriate for the individual.

[89] **Rhun ap Iorwerth:** We're going to talk more about the patient experience and what actually happens in the wards a bit later on, but I'm just keen to keep a focus. Andrew R.T. Davies wanted to come in.

[90] **Andrew R.T. Davies:** Just on that audit point, If I may, Chair, because I did allude to it in an earlier question: it's wonderful taking all that information, but you've got to be able to see if that information is being put to good use, then, when it's been assessed. And, in the papers we've got, you've talked—or the papers talked—about nurses sometimes looking at this information, as well as dieticians—it's not always the dieticians who look at this. Are you confident that the procedures that you have in place to look at the audit information that you're getting back from the ward are robust enough and that you can make the changes where those changes need to be made—where you might find bad practice being undertaken or the quality of

the food isn't meeting the patients' needs?

[91] **Ms Waters:** This is a senior nurse responsibility, and we've been very clear in Aneurin Bevan health board that the senior nurses are there, first and foremost, for the fundamentals of nursing care, be it nutrition, be it infection control, be it dementia. Certainly, the audit results—and they do quite intense audits, I have to say, the senior nurses, and they truly are feeding back to the ward sisters where there are any deficits. So, it's a senior nurse responsibility, as well as a ward manager, to really focus on those audits and to make sure that they follow up on any deficits that are found.

[92] **Rhun ap Iorwerth:** Okay. Mike Hedges, you had another couple of questions that you wanted to ask.

[93] **Mike Hedges:** The only other one I wanted to ask, and I asked it last time, was on weighing, weighing patients.

[94] **Ms Jones:** We do weigh—so, we weigh patients on admission, and it's also part of the MUST assessment, which is the malnutrition universal screening tool. So, weighing is—. And then, depending on the patient's score depends on how often you would then weigh the patient, so that is fundamentally important.

14:30

[95] **Rhun ap Iorwerth:** Is that standardised?

[96] **Ms Jones:** Yes.

[97] **Ms Waters:** One of the challenges, of course, is that, when patients first come in, they're very, very sick and sometimes can't even get out of bed. So, it's about checking with either the patient or the family what they normally weigh, so we at least have that to go on with, and there's also a way of measuring a patient's arm to understand whether they have nutritional problems.

[98] **Rhun ap Iorwerth:** Okay. Briefly, if you could.

[99] **Ms Williams:** Sorry, I was just going to say it wouldn't just be about weighing, it would be about body mass index as well. So, it's about, you know, their height to weight ratio, so that you know what you're—.

[100] **Rhun ap Iorwerth:** Yes. Mohammad Asghar, and I think you've got some questions about the nutritional care pathways.

[101] **Mohammad Asghar:** Yes, I'll ask that question afterwards. Linking into the hospital doing an amazing job for the food and nutrition for the patient, I've seen a first-rate experience with family members. But, the fact is: when the patient is registering for the operation or treatment in the hospital, weeks before they get all the arrangements done for them, what about the nutrition? Are they involved, because there are cultural, religious, there are different age factors involved, and the food is there on a trolley, which is free for all, but some people are not used to that sort of food. Is there any such sort of clause there for you to look at to make sure that every patient is looked after according to his or her needs?

[102] **Ms Jones:** When a patient is admitted to hospital, as part of the initial assessment, you will review what their cultural needs are, what their dietary needs are, and then, if there are special diets required, we will refer to the dietitian or indeed our catering colleagues in terms of ensuring that we provide the food that's most appropriate for the patient.

[103] **Mohammad Asghar:** I've yet to see that there's somewhere with halal food—I don't want to touch it, but that is an area that is not being covered, I think. That has got to be considered. My question now, Chair, actually is related to the panellist—

[104] **Mr Phillpott:** If I may—

[105] **Rhun ap Iorwerth:** On that point, yes, absolutely, please come in.

[106] **Mr Phillpott:** I'm quite confident that we do meet all dietary and cultural needs, halal included.

[107] **Mohammad Asghar:** I'm talking about Royal Gwent hospital—I've been there quite regularly for a few weeks, and there was no such thing I saw anywhere. So, leave it now, because you are not from Royal Gwent.

[108] **Ms Waters:** Yes, we are from Aneurin Bevan health board, and I will certainly look into that aspect.

[109] **Mohammad Asghar:** Okay, thank you very much indeed. My question

actually relates to the nutritional care pathway, and the current compliance with nutrition screening across the health boards' hospitals: what is the condition at the moment? And the second, in the same one, is: what action are the health boards taking to improve and sustain compliance in their hospitals in Wales?

[110] **Ms Jones**: Okay. Thank you. I can confirm that that information is regularly assessed—it's assessed on a monthly basis with a monthly audit to determine compliance. My latest figure for Powys teaching health board is 97 per cent compliance for assessment of the patient within 24 hours of admission, and, additionally, that appropriate action has been taking place based on that assessment.

[111] **Ms Williams**: And that's similar in Cwm Taf. Our monthly compliance rate is running around 93 per cent, and it's reported from the clinical areas up to the board through the quality and safety committee, so the board are advised of what our position is.

[112] **Ms Waters**: And I can confirm that ours is running at 94 per cent.

[113] **Mohammad Asghar**: Wonderful to know, Chair, but the fact is: who is responsible for ensuring that the compliance and nutritional screening is improved and sustained, as you just said?

[114] **Rhun ap Iorwerth**: Liz Waters.

[115] **Ms Waters**: As discussed earlier, we now have an assurance framework. We have a clinical nutrition and hydration committee, so that's where such data will be scrutinised and passed down, most importantly, through divisional quality and patient safety forums. Again, I talked about ownership earlier on—that's an absolutely crucial component in all of this—so, the divisions themselves have their own quality and patient safety forums, and we expect that kind of data to be discussed there.

[116] **Rhun ap Iorwerth**: Rhiannon Jones.

[117] **Ms Jones**: In terms of nutrition and hydration, I would confirm that, as the director of nursing of the Powys teaching health board, I am accountable for the patient experience in terms of nutrition and hydration, which is delegated from the chief executive.

[118] **Rhun ap Iorwerth:** And, speaking of the patient experience, Lee Waters has some questions about the patient's view.

[119] **Lee Waters:** Yes, thank you. I'm interested in a discrepancy, really. Oscar Asghar touched on the question with you, Mr Phillpott, about special requirements. You said you were pretty confident, in the Royal Gwent, that halal was catered for; certainly, a patient's experience here is different to that. The petition that was presented earlier this year to the Petitions Committee was precisely on this case: that special dietary needs were not being met. I've certainly had my constituents raise with me that, in their experience, diabetics are not being catered for by the main service. Their family have to bring in additional food for them. So, how do you account for the official view, which is all is fine, when the views of patients that are coming repeatedly through different avenues are that all is not well in this regard?

[120] **Mr Phillpott:** Well, I don't actually work at the Royal Gwent, but—

[121] **Lee Waters:** It's your health board.

[122] **Mr Phillpott:** It is our health board, yes.

[123] **Lee Waters:** And you are confident that halal meals were served, but that's not the experience that was had by a recent patient, and I can give you several other examples of a disconnect between the health board view and the patient feedback. So, I'm trying to understand the mechanisms for getting patient feedback and how you respond to that.

[124] **Mr Phillpott:** Well, to take your point about diabetics, diabetics should be catered for in the main amended menus that we produce.

[125] **Lee Waters:** But they seem not to be, from some of the feedback I've been getting.

[126] **Ms Waters:** In terms of some of the feedback that we have from our own health board, I've not seen halal issues or cultural issues coming forward, but I can certainly look into that to see where the discrepancy is.

[127] **Lee Waters:** So, what do you do to monitor the patient experience, so that your understanding tallies with the patient experience?

[128] **Ms Waters:** Well, again, we have bimonthly audits. They actually finished in March and we now need to get them back on the agenda again. And we've also got what's called the Hootvox patient experience, which picks up all patient experience issues, not just nutrition, and then that gets fed into our nursing committees. I can't say that we've actually picked this up at all, but I will certainly look into it.

[129] **Lee Waters:** So, why do you think you aren't picking that up, if people are routinely saying there are problems in the system and that special needs are not being met? Why aren't you picking that up?

[130] **Ms Waters:** I don't know. I think we will need to look into that, most definitely, and see why that's falling off our agenda.

[131] **Lee Waters:** Okay.

[132] **Rhun ap Iorwerth:** Lynda Williams.

[133] **Ms Williams:** We have bimonthly patient satisfaction audits that are fed back in through clinical areas and through to our nutrition and catering group. They are currently running at between 90 and 94 per cent in Cwm Taf. We are launching an app for patients to be able to download to assess their satisfaction around food and catering when they get home. That app will come online in November of this year. But, as I said, we've got an overall satisfaction rate of between 90 and 94 per cent, and one of the improvements that we did as a result of that satisfaction survey, because patients were telling us that they didn't have enough access to snacks, so something that we've managed to implement now are ward-based snacks, so food is available when individuals need it, and clearly want it.

[134] **Lee Waters:** But one in three patients said in the last patient surveys that they found the meals unappetising. What are you doing about that?

[135] **Ms Williams:** In Cwm Taf?

[136] **Lee Waters:** Well, across Wales.

[137] **Ms Williams:** Across Wales—you know, I can't comment on what it looks like across Wales—

[138] **Lee Waters:** So, what's the Cwm Taf figure?

[139] **Ms Williams:** —but I do know that, in Cwm Taf, as I said, we have, overall, good satisfaction—excellent satisfaction—from patients.

[140] **Lee Waters:** So, what's the figure for unappetising meals in Cwm Taf?

[141] **Mr Hayward:** I don't know that, actually, but what I do know is that our satisfaction is running at 90 per cent.

[142] **Lee Waters:** Okay. So, you don't think the all-Wales figures are relevant to Cwm Taf.

[143] **Mr Hayward:** Well, I'd like to look at the detail, if that was the case, because I can't answer in the round, to be fair.

[144] **Rhun ap Iorwerth:** Any information that you could pass on to us after today's meeting—

[145] **Ms Williams:** Yes, absolutely. We can let you know what that would be.

[146] **Mr Hayward:** We can certainly look at the detail in relation to Cwm Taf.

[147] **Lee Waters:** I'd like to ask specifically about hydration. The Water Keeps You Well campaign has been promoted as something that should be rolled out and yet, again, the last survey showed that 40 per cent of patients were not routinely being offered drinks at meal times. Why do you think that is?

[148] **Ms Jones:** It's a key question. In terms of answering that, I think there have been a number of discrepancies in terms of the standards that came out about the offering of fluids across the patient day, with a view that they weren't to be offered with the meals, but after the meals. So, I'm not sure whether that's had an impact in terms of the data there. The bottom line is that the standards are quite clear: there are to be seven to eight beverages every day and, certainly in Powys, we're compliant with that.

[149] **Mr Phillpott:** As we are in Gwent.

[150] **Rhun ap Iorwerth:** Okay. Lynda Williams.

[151] **Ms Williams:** The all-Wales campaign actually originated from an idea

that was taken forward in Cwm Taf. We call it the Drink a Drop campaign. We've promoted it throughout our organisation, where each and every individual who comes into contact with that patient—be it a doctor, a porter or nurse—actually offers the patient a drink, so that hydration is everyone's business, really.

[152] **Lee Waters**: So, what can other health boards learn from that, then? Why do you think that it is, across Wales, at 40 per cent, and patients are not being routinely offered that?

[153] **Ms Williams**: I think there is an issue with regard to whether they're being offered it with their meals, or whether it is available for them. Not everyone wants to have a drink with their meal. They might like it between meals. So, some of it will be about personal choice. Rhiannon explained that there is a requirement for us to have seven points at which drinks are available. Certainly, from our health board's perspective, we do manage to hit that in the majority of cases. The area where there is a deficit for us, and we do recognise that, is the evening times, where the jugs are to be replaced by nurses. Often, the water jugs are not a priority—well, I can't say it's not a priority. It's something that does get missed in the round. So, that could be where that 40 per cent comes in. It's the evening drink that is an issue in our organisation.

[154] **Ms Jones**: And that good practice from Cwm Taf is being spread across Wales to all health boards. We piloted the Water Keeps You Well campaign in Powys, and we are now rolling that out across all of our wards and departments.

[155] **Lee Waters**: Okay. Thanks for that.

[156] **Ms Waters**: We participated in the campaign as well.

[157] **Rhun ap Iorwerth**: Okay. Moving on to an associated area, from the food to the meal time experience—Rhianon Passmore.

[158] **Rhianon Passmore**: Diolch. What more needs to be done around protected meal times?

[159] **Rhun ap Iorwerth**: Liz Waters. Shall we start there?

[160] **Ms Waters**: It certainly needs to be much more than a sign outside the

door, saying, 'We have protected meal times.' Again, the auditing process is absolutely crucial here. It's about the quality of that protected meal time. So, yes, it is about signage, which indicates that the ward is protected. But that signage also needs to be very, very clear—and it is—that relatives and family can come and help their loved one during that protected meal time. But we really do need to focus more on the quality—so, for example, if the bed situation is poor. We've got doctors coming on the wards. There are lots of competing priorities, and, certainly, in the work that we'll be doing, moving forward, through the nutrition and hydration group, we'll be looking at the quality of that protected meal time experience.

[161] **Rhianon Passmore:** Before you come in, in terms of the nutrition and hydration group, is that pan-Wales or are you just talking about the local health board?

[162] **Ms Waters:** No, this is our own health board.

[163] **Rhianon Passmore:** In that regard—I don't know who to ask this question to—is there something similar that is pan-Wales on nutrition and hydration? A forum, group, person or lead?

[164] **Ms Jones:** There's a multidisciplinary nutrition group across Wales.

[165] **Rhianon Passmore:** Did you want to come in and answer around protected meal times?

[166] **Ms Jones:** I did. Is that okay? Thank you. Following up on what Liz said, I think, from my perspective, there's got to be a constant focus on it. So, the very fact, as I think you've raised yourself, that there's a policy—that doesn't necessarily mean that, just because you've got a policy, it is implemented. On a number of occasions, I've been very disappointed to have feedback—whether it is through the Wales Audit Office, which it wasn't on this occasion, or Healthcare Inspectorate Wales—that indicates that their experience is that protected meal times haven't been followed to the letter. For example, a doctor may be taking bloods at the time that the meals are being given. Now, there's a perception issue there as well, though, because those bloods may have been critical. So, the very fact that a doctor was taking bloods—there's a perception that that shouldn't have happened. But, actually, it is about non-urgent clinical activity. So, I think sometimes there are some discrepancies in terms of how that's being defined, to be honest. From my perspective, it is about constant attention to this, and how we

monitor that. So, ward sisters' responsibilities for ensuring that's happening—I think they're critical. Liz has mentioned the senior nurses, but I think it goes right through. It isn't just about nursing. It is everybody's responsibility. So, I think that needs to be the constant focus.

[167] **Rhun ap Iorwerth**: Some further questions from Mike Hedges.

[168] **Mike Hedges**: Can I just say that I was very pleased with the answer that Liz Waters gave regarding protected meal times—that relatives were able to come in and help? It's not my experience. I can talk about Abertawe Bro Morgannwg University Local Health Board, but I'm not sure that it's different to any of the other boards. I think that this is where we have the disjoint between what you are saying here and what ward sisters are doing on the ward. I can take you to a ward in Morriston hospital where it says, 'NO-ONE'—in big capital letters—'to come in during protected meal times'. I think that's a problem. You've all got brilliant policies; I have no doubt about the efficacy of your policies. It's making sure those are being implemented. If only every ward had outside what Liz Waters just said, that we have outside, 'In protected meal times, relatives may come in to help with eating.' That would probably be the one thing that would make a huge difference. Perhaps, can I urge you to share that with colleagues and bring it into your own organisations, so that every time anybody goes outside a ward they see that?

14:45

[169] **Ms Waters**: Yes, I agree. We certainly have been reviewing our signage, and we've put some temporary signs up for the moment, but we'll be looking for permanent signage. It's absolutely crucial, moving forward.

[170] **Ms Jones**: I'd probably just follow that up as well, in that, from the highest levels down, that's been cascaded and, you know, there has—I wouldn't say regular correspondence—been correspondence from Jean White, CNO, to indicate the importance of relatives being enabled to join at specific times of the day. I'd like to sit here and say that you would not have that experience in Powys. I know, through our sisters' forums and senior nurse forums, that the message and the assurance that I receive is that the patients' relatives can attend.

[171] **Rhun ap Iorwerth**: I'd like the experience of Cwm Taf specifically in a second, but Lee, I know, wants to come in.

[172] **Lee Waters:** Just to follow up on this idea of families coming in and eating with their relatives, and I can see what you said earlier about the need for it to be a social thing, and for there to be an extra pair of hands. But there's a balance, isn't there, when the families are feeling that they're expected to bring in food? Especially referring back to my point earlier about special dietary requirements, the feedback I'm getting from my constituents is that, often, if they do have special requirements, the family are expected to bring food in for them. That can't be right, can it?

[173] **Mr Phillpott:** No, I don't think that's at all right.

[174] **Lee Waters:** The disconnect reappears.

[175] **Mr Phillpott:** Well, you can pick on me if you like, but I think, basically, we have policies that restrict and advise relatives on exactly what they should be bringing in for their patients. The basics, which you speak of, just simply shouldn't happen.

[176] **Lee Waters:** But it is happening, and that's my point.

[177] **Mr Phillpott:** Well, if you can give me the details, I'd like to look into it.

[178] **Lee Waters:** Okay. So, you don't think that this is happening in any great scale? You think this is just a nice anecdotal example?

[179] **Ms Waters:** It's certainly not anything that we're aware of, as yet. But I would be quite happy to look into it.

[180] **Lee Waters:** So, there's no policy of encouraging—. I'll happily pass on examples. But as far as you're concerned, there's no policy encouraging families to bring in food.

[181] **Ms Waters:** No, absolutely not.

[182] **Lee Waters:** Okay.

[183] **Ms Jones:** It's the opposite, to be honest, because we've got a clear protocol in terms of what food can be brought in because of environmental health. I can give an example from just last week of a complaint that I was involved in, where relatives were complaining because they were stopped

from bringing food in, which is diametrically opposite to what you're describing. So, I think there's mixed approaches, probably.

[184] **Rhun ap Iorwerth**: Can I ask about the development of your patient satisfaction scoring system, please?

[185] **Mr Hayward**: Yes, sure. It's based on SurveyMonkey, which is—. When a patient leaves the hospital we'll give them a business card, and that business card's got an optical character recognition box on it, which you can scan with your mobile phone. When you scan it with your mobile phone, it takes you to a secure website where you can answer 12 questions based on, 'Did you enjoy the food?', 'What did you think about the food?', 'Can we improve the food?'—any general comments, and a free text as well. We're doing that for our restaurants and we're also doing it for our coffee shops as well.

[186] **Rhun ap Iorwerth**: How many respond to that? How do you—?

[187] **Mr Hayward**: It's being launched in November.

[188] **Ms Williams**: The app is being launched in November, but we already do the patient satisfaction surveys bimonthly while they're in hospital. As I said earlier, we then try and tailor the comments that we have to try and make the improvements that are required.

[189] **Mr Hayward**: What we try and do is capture a wider audience, because when you try and speak to people in beds it's often difficult because, you know, their care is the priority, not the surveys. Whereas, when they go home, they can do it at their leisure. So, that's why we try and do it then.

[190] **Rhun ap Iorwerth**: And, clearly, in doing something like that you think that there's a gap that needs plugging. I think that some of the questions that Lee Waters has been asking—you know, somehow, there's a disconnect between what people are thinking and, perhaps, that information getting through to you. Is that what you're trying to do here?

[191] **Mr Hayward**: Rather than suggest there's a gap, I would rather suggest that there's an improvement that could be made.

[192] **Rhun ar Iorwerth**: Okay. Rhiannon Jones.

[193] **Ms Jones**: I think that's really important, because the surveys that we undertake at the moment are when patients are in hospital, and sometimes, they'll give a different view when they're in hospital, for reasons that I can understand, than, perhaps they would give once they're at home and they're feeling better in themselves. Actually, when they reflect on their experience, they might give us a very different view. So, I think the very fact that we're looking at something outside of the in-patient setting is really important. That's probably a gap from a Powys perspective: we don't gain views when patients have been discharged. So, I think that's really important.

[194] **Rhun ap Iorwerth**: Which is quite important, actually.

[195] **Ms Jones**: Absolutely. It might link in with what you said, Mr Waters, in terms of people's views once they're outside. I don't know, but it's something, I think, to pick up on.

[196] **Neil Hamilton**: How do you conduct these surveys? Is it a random sample of patients? Presumably, you haven't got the staff to interview everybody along these lines.

[197] **Ms Jones**: It's a sample of patients in Powys.

[198] **Mr Hayward**: Certainly in Cwm Taf it's the same.

[199] **Mr Phillpott**: It's the same—[*Inaudible*.]

[200] **Rhun ap Iorwerth**: Is there an admission that the sample isn't big enough and that you're trying to cast the net wider?

[201] **Mr Hayward**: I think we're trying to just open another opportunity and another medium for them to actually provide the information back.

[202] **Ms Williams**: I was going to say that that sample will be across all clinical areas. Obviously, we provide services for mental health patients, we provide services in community hospitals, in maternity services. So, that sample survey will be across the clinical areas.

[203] **Mr Phillpott**: I think we need to pick up on what they're doing in Cwm Taf and piggyback on what they're doing, because it seems a good system.

[204] **Ms Jones**: I just wanted to follow through in terms of Mr Hamilton's

question there in terms of the random sample. What's important is that it's independent. It's people going into the ward and selecting patients, so it's not necessarily the nurses on the ward who are selecting, because you could select positively, couldn't you? So, when it's independent people, it can be any patients who they approach. Just for assurance.

[205] **Ms Waters:** Yes. And that's what's particularly good about the CNO's quality check tool: it's peer reviewing, which gives you a much more objective view of what's going on on a ward.

[206] **Rhun ap Iorwerth:** Mi fyddwn i'n dymuno symud ymlaen yn eithaf buan at faes pwysig iawn, sef gwastraff bwyd a chostau arlwyo. Mi ddown ni at gwestiwn gennych chi, Neil Hamilton, mewn eiliad, ond un pwynt bach olaf neu gwestiwn olaf gan Lee Waters fan hyn.

Rhun ap Iorwerth: I would like to move on quite quickly to an important area, which is food waste and catering costs. We'll come to a question from you, Neil Hamilton, in a second, but one final point or question from Lee Waters.

[207] **Lee Waters:** Diolch, Rhun. Just very briefly, to pick up on something Mr Phillpott said about the spreading of good practice. The auditor's updated note in September pointed out that, up until 2013, the all-Wales menu framework was reported to Welsh Government twice a year, but since then, that's stopped and is now being dealt with within health boards. So, I wonder what mechanisms now exist for the pan-Wales sharing of good practice or raising of issues and whether or not you think things have changed since that all-Wales twice-annual reporting has stopped.

[208] **Mr Phillpott:** The all-Wales menu framework group meets several times a year—three times a year—and there are work streams that emanate from that group. You talked about training earlier and we were focusing on, perhaps, clinical training, but for non-clinical staff—ward hostesses and ward-based caterers—this is a work in progress here, which is a nutritional skills for life learner workbook. That's just one example of the things we're trying to do to develop consistency and standardisation throughout Wales. So, it isn't just the menus and the input there, we do work on other streams.

[209] **Lee Waters:** So, is that not right, then, that this group—? The report suggested it stopped reporting twice yearly to the Welsh Government in 2013. You're saying that's happening. Is it?

[210] **Mr Phillpott:** I'm not sure—

[211] **Ms Waters:** They may have stopped reporting, but the group is still in existence.

[212] **Lee Waters:** Right, but it doesn't report.

[213] **Mr Phillpott:** I'm not sure. Judith John is the chair of the group. She's a dietician. I'm not sure whether—

[214] **Rhun ap Iorwerth:** Perhaps we can seek more clarification on that.

[215] Ymlaen at wastraff bwyd a chostau. Neil Hamilton.

Moving on, therefore, to food waste and costs. Neil Hamilton.

[216] **Neil Hamilton:** I'm interested in the extent to which health boards are confident that the food wastage statistics that are being collected are accurate. The background to this is that, in 2011, the auditor general reported that there were significant variations around Wales, and then, in 2012, a new model was introduced for costing patient and non-patient catering services. And although the wastage figures have improved significantly since then, inconsistencies in the way things are measured, or indeed, the possibility of measurement at all between health boards, still means that we can't necessarily rely fully on the statistics that are collected. Can I use Powys as an example, not just because you're sitting in the middle? The average cost of a patient meal throughout Wales is apparently £3.31, but in Powys the figures appear to be nearly double that. We're concerned that that figure may be an overestimate because the responsibility for catering budgets is not centralised within the facilities management team, and therefore the way you cost food procurement generally is not differentiated from the cost of providing meals for patients. So, we can't really tell, even when you calculate the wastage figures, to what extent they can be related to the other costs that are obtained overall.

[217] **Ms Jones:** Shall I answer that one?

[218] **Rhun ap Iorwerth:** Yes.

[219] **Ms Jones:** Thank you. Yes, the report does indicate that it's probably £6 per patient per day, which, as you indicate, would be almost double what it is elsewhere, but there was a note of caution against that because of the

challenges of not a centralised approach to the costing. Previously, it was a north-and-south approach, and they were different. What I can confirm today is that the restructuring has taken place in terms of facilities, and we've now got that back-office function for facilities in terms of now calculating that on a Powys-wide basis. I can't tell you today what the costs are that are associated with that because that new structure has literally just come into being, but a caution in terms of that figure.

[220] **Neil Hamilton**: So, you're confident now that the intended benefits of this will be realised. How soon do you think we'll be able to get some indication?

[221] **Ms Jones**: I think, speaking to the head of facilities, certainly within the next three months you would hope to have a better position around that.

[222] **Neil Hamilton**: I see. Okay.

[223] **Ms Jones**: And we can share that with the committee, if that's—

[224] **Neil Hamilton**: Obviously, I didn't mean to single you out—

[225] **Ms Jones**: No, that's fine.

[226] **Neil Hamilton**: [*Continues.*]—for the specific questioning on that point, although I don't know whether the extent to which the other health boards had similar organisational and management problems for the way in which their costs are calculated.

[227] **Ms Jones**: Shall I just—

[228] **Rhun ap Iorwerth**: Just before you finish, I think it is fair, by the way, to single out Powys because of the discrepancy in the figure. Rhiannon Jones.

[229] **Ms Jones**: I didn't feel it was unfair and I was probably expecting it. So, that was fine. Thank you. I just wanted to add in there that perhaps, certainly from a Powys perspective, our head of facilities still raises concern about maybe some discrepancy in the way that waste is being calculated on an all-Wales basis. So, I think that that's something that we do need to pick up.

[230] **Rhun ap Iorwerth**: If I understand correctly, even though there was the discrepancy—and presumably Powys would have wanted to sort out what was

going on, and there has been a restructuring—you still don't know exactly what the figure is for Powys.

[231] **Ms Jones:** We will know that—

[232] **Rhun ap Iorwerth:** But you still don't know now what the figure is for Powys, even though—

[233] **Ms Jones:** Well, we're reporting the figures. We continue to report in the way that we've reported for years on that waste, but we recognise that when we compare Powys to the all-Wales basis there's a confidence that that's an overestimation. Additionally, there's concern from a Powys perspective about how all health boards and trusts in Wales calculate waste.

[234] **Rhun ap Iorwerth:** Shall we get the Cwm Taf experience first?

[235] **Mr Hayward:** Yes, I'm happy to pick that up. In Cwm Taf, as assistant director of facilities, we actually have those costs contained within facilities; so, there are no discrepancies. Our food production is through a central production unit; so, waste is minimised that way. It's at 2.1 per cent. Then, obviously, you've got a different set of waste, where you've got the plated waste, which is recorded at the ward level, because we've got very low plated waste as well. Because, in the process, we actually regenerate based on the patient's choice two hours before the meal time. So, as I said, we get low waste.

[236] **Neil Hamilton:** So, your 2.1 per cent figure relates to unserved meals, does it?

[237] **Mr Hayward:** It's overall, that is. It's overall, and then that's split down.

[238] **Neil Hamilton:** Right. What do you see as the main causes of waste from unserved patient meals? I notice from the figures that that varies between 2 per cent and 10 per cent across NHS bodies in Wales, and that overall cost is about £1 million, which could obviously be better spent elsewhere. Why is it that meals go back completely uneaten or unserved?

[239] **Mr Phillpott:** I think there are a variety of reasons. I think ordering near to consumption is something we could do to improve it. In YYF—Ysbyty Ystrad Fawr—we're going to do a trial, starting next month, of same-day ordering so that patients will order their lunch and their supper in the

morning. We hope that way we'll have accurate figures.

15:00

[240] It'll also reflect the appetite of the patient on the day with their clinical condition. It'll minimise, I think, the number of ghost patients—where patients have moved out of the ward. So, hopefully, we'll be able to tell you in not too much time whether that was successful.

[241] **Neil Hamilton**: Where patients are either elsewhere in the hospital at the time meals are served or, maybe they're asleep, or whatever, what happens then to ensure that they do get proper sustenance during the day, outside of normal mealtimes?

[242] **Mr Phillpott**: We go back to them a little later on, when the patient is ready to receive the meal. We also supplement that with snacks, so the patients have got access to food 24 hours a day, really.

[243] **Rhun ap Iorwerth**: Mr Hayward wanted to come in on that last point.

[244] **Mr Hayward**: Certainly, in Cwm Taf—[*Inaudible.*]—introducing an à la carte-style menu, so, rather than giving a patient a full breakfast, a full lunch and a full tea and then sandwiches at the evening meal—in reality, nobody wants to eat that much all day—we gave them the option of a lighter lunch or a lighter tea, which then reduces the waste levels and they also maintain their nutritional values.

[245] **Rhun ap Iorwerth**: Before you continue, I think Andrew R.T. Davies wanted to come in, just on a supplementary.

[246] **Andrew R.T. Davies**: Just on that point, you were saying that a same-day ordering service—. I notice from the papers that you're one of the few health boards that has a computerised system of ordering i.e. tablets on the wards. You're more the exception—I think Cwm Taf, as well, have it, if I've read this paper correctly—but you're one of only three that are doing that, and there's a business case at the moment before the Government as to whether they want to roll it out across the NHS. Is it having those tablets on the ward that offers you the flexibility to have same-day ordering and that greater flexibility in the system?

[247] **Mr Phillpott**: It's not so much that tablets will promote the same-day

ordering, we could do that with paper menus, but—

[248] **Andrew R.T. Davies**: But it simplifies it, though, surely, having it on tablets.

[249] **Mr Phillpott**: Certainly. We want to roll it out right across the board. We've had it for 12 months in YAB—in Ysbyty Aneurin Bevan—and that's been quite successful. The beauty of it is you are asking the patient what they want at the time of ordering and you can show them a photograph of the meal, you can provide nutritional information and, basically, the information then goes down to the kitchen and it collates all your totals for production. But, the only thing with that at the moment in YAB is it's done the day before; it's done the afternoon before. We feel we want to move that to the same day.

[250] **Andrew R.T. Davies**: So, that's a procedural thing, though, being done the day before. It's not a technology thing, is it?

[251] **Mr Phillpott**: No, it's not.

[252] **Andrew R.T. Davies**: But, actually having that technology within your health board has a huge advantage in the way that you are able to deal with patient requests, food waste and getting a better product to the patient in the first place.

[253] **Mr Phillpott**: Yes—to all three.

[254] **Andrew R.T. Davies**: So that's a win-win all the way round.

[255] **Mr Phillpott**: Certainly.

[256] **Rhun ap Iorwerth**: Hold your last questions for a second, Neil Hamilton, here's a question from Lee Waters.

[257] **Lee Waters**: Just a quick follow-up to something you said about when a patient misses a meal—that they are offered another meal. Because the auditor's report shows that from the all-Wales survey only 12 per cent of patients were offered a replacement when they missed a meal.

[258] **Mr Phillpott**: Well, I can only speak for Gwent, but it is the case, yes; we would look to replace the meal at the next convenient time. It depends on

the circumstances. It might be a sandwich; it might be a snack.

[259] **Lee Waters**: I wonder why we keep getting these discrepancies. I'm wondering whether we can ask the auditor, because, clearly, the experience in Gwent does not tally with the evidence that we've been reported, and I'm puzzled by this consistent picture.

[260] **Mr H. Thomas**: We have the consistent picture from the all-Wales nutrition standards. It is as the patients are recording. I think the test is always how that is then measured against the experience of individual hospitals.

[261] **Rhun ap Iorwerth**: Neil Hamilton.

[262] **Neil Hamilton**: In 2011, NHS bodies were subsidising non-patient catering services quite extensively. It amounted overall to about £4 million. That's been reduced substantially to just over £1 million in 2014-15. So, I'm wondering to what extent you are able to tell us that you know whether you are subsidising non-patient catering out of the catering budget overall. In 2011, most authorities didn't actually know they were doing this, and I wonder whether the information systems are now in place to enable you to be able to measure this, and hence to give us the confidence to say that this isn't happening any longer, or is negligible.

[263] **Mr Hayward**: Can I pick up on that from a Cwm Taf point of view? After the audit report identified that, one of the main things we did was we split the cost centres, which was the financial reporting system, and we split patient catering away from commercial catering. We actually set up a commercial catering cost centre. Last year, we made a surplus of £86,000 on our commercial catering. So, we set up a chain of coffee shops, and our restaurants, and we're managing those on a profit and loss basis. This year we're forecast to make £111,000 surplus. So, they're set up completely differently. One's a service base and one's a business base.

[264] **Neil Hamilton**: Very good.

[265] **Mr Phillpott**: Can I say that, in Aneurin Bevan, we'll probably break even this year. The larger sites will generate income streams, whereas the smaller sites, the smaller hospitals, might be working at a loss, at a slight deficit. But I think if you take the health board view on its own, together we would be breaking even.

[266] In terms of subsidies, we've got a new director now, and he's very keen to maximise our commercial side with a view that—. For example, we're introducing chip and PIN in our restaurants next month. It's envisaged that that should increase income by 10 per cent, maybe 12 per cent. His view is that this money could be ploughed back into some initiatives for patient catering. So, our view is to try and subsidise patient catering development with income streams.

[267] **Neil Hamilton**: I'd just like to go back to the point arising from what Andrew's just said about the use of tablets as well. We've heard what Aneurin Bevan health board is doing. Are other health boards following your example?

[268] **Ms Jones**: I was going to say earlier, but we moved on with questions—we have completed a business case. It's about £30,000 of investment and that's going forward for a decision through our capital allocation.

[269] **Mr Hayward**: We're actually in the process of building a business case for our system, but we haven't got one for a paper-based system, where we do take meal requests two hours before a meal time.

[270] **Neil Hamilton**: So, what's the timescale, then, for moving in this direction?

[271] **Mr Hayward**: We're aiming to get the business case before our financial director by the end of the financial year.

[272] **Mr Phillpott**: I'd say that Abertawe Bro Morgannwg management members have come up, and also Cardiff and Vale. Both have been quite impressed and went away thinking that they were going to roll it out as well. So, I think everybody's keen to do it.

[273] **Andrew R.T. Davies**: Could I just seek a point of clarification? In the papers we've got, it does say that there's an all-Wales business case being put forward:

[274] 'The Welsh Government has indicated that the business case and its viability as an option will be discussed by the NHS Wales National Informatics Board in November.'

[275] I find new boards all over the place when I come to meetings like this. So, you're in isolation in your health boards putting business cases together, then there's another business case that's going to this national board. You've already got the technology. There just seem to be a lot of hares running here. From a layperson's point of view, can you help me make sense of how, actually, you will get to the position that Aneurin Bevan are in, where you will have a computerised system where you can take the information straight off the ward, and offer the patient a choice with pictures and all the rest of it? It just seems a logical way to progress, to be honest with you.

[276] **Mr Hayward**: I was of the understanding that the board you're talking about, which is run by the NHS Wales Informatics Service, and was supported by shared services, didn't come up with a report. So, each individual health board has taken their own view on board, I think, basically.

[277] **Andrew R.T. Davies**: So, what I read out was incorrect, then.

[278] **Mr Hayward**: Well, that's my understanding. I think that was identified in the Wales Audit Office report.

[279] **Rhun ap Iorwerth**: We're running out of time. A quick one from Lee Waters.

[280] **Lee Waters**: Just a quick one to Mr Hayward on the question of food waste. Andrew Goodall's provided us with a note on how different health boards are dealing with waste, and there's a mixed picture. It does seem that most health boards are still relying on maceration of waste. Some are using anaerobic digestion. Your health board in particular jumped out at me—in Royal Glamorgan, where the waste goes to black bags.

[281] **Mr Hayward**: No, that was at the time of the report. At the moment, we've got a strategic partnership with Merthyr council, so they take the waste from the north part of the health board, and from the south part of the health board we're dealing with a private company that takes it to—it doesn't go to landfill anymore, it goes to anaerobic digestion.

[282] **Lee Waters**: Right. That's out of date, then.

[283] **Mr Hayward**: It was originally going to black bags, but it doesn't now.

[284] **Lee Waters**: Okay. But you're still using macerators as a primary means

of disposing of waste, are you?

[285] **Mr Hayward:** No, it's going in its constituents parts. We don't macerate it. It just goes as a lump, and it goes off to anaerobic digesters.

[286] **Lee Waters:** Okay. Excellent, thank you.

[287] **Rhun ap Iorwerth:** Oscar.

[288] **Mohammad Asghar:** I've got a very short one. Thank you, Chair. Reading this report, I come to the conclusion that some of the health boards are doing a wonderful job, and some of the health boards aren't—on page 33, if you look at that, but Neil mentioned it—on non-patient catering, with the percentage of the costs recovered. So, in other areas also you're not the same. Why don't you share best practice amongst yourselves so that, in all the areas, you take the best from there, and the best from there and share with each other? Are there any barriers between you?

[289] **Ms Jones:** I think that best practice is shared. It's shared through the all-Wales group, but, additionally, there needs to be recognition of the differences between the health boards as well. So, the issues in terms of the costs from a Powys perspective is—. You indicated the significance of the impact of the bigger acute sites, but we've got 10 small community hospitals, so where we're providing staff meals, that's quite challenging for us when there are only small numbers of staff meals required and the subsidy then is a different matter for Powys than it would be for other health boards. So, it's just recognising there are differences, even though good practice is shared.

[290] **Rhun ap Iorwerth:** Any more comments on that?

[291] Os caf i ofyn, gan fod yr amser bron iawn ar ben, un cwestiwn yn gyffredinol i'r tri bwrdd sy'n cael eu cynrychioli yma heddiw: i ba raddau mae materion yn ymwneud â maeth a phrofiad cleifion o fwyd yn yr ysbyty yn cael sylw digonol ar lefel bwrdd yn y byrddau iechyd, ac o le mae'r arweinyddiaeth yn dod i sicrhau bod yna wellhad yn digwydd yn y maes

If I could ask, given that the time is running out, one question generally to the three boards represented here today: to what extent are issues to do with patient nutrition and their experience of food in hospitals having enough attention at a board level in the health boards, and where is the leadership coming from to ensure that there is improvement in

yma? Mi wnaf i ddechrau gyda Liz this area? I'll start with Liz Waters. Waters.

[292] **Ms Waters:** Again, it's that board-to-ward reporting, isn't it? We've produced an annual report, which will be presented to the quality and patient safety committee in November, and I've no doubt that our non-independent members will be challenging in terms of what we're reporting. It'll be the first time that we've presented an annual report, but it's a good start.

[293] **Rhun ap Iorwerth:** Okay. Rhiannon Jones.

[294] **Ms Jones:** Thank you. I think that, from a hydration and nutrition perspective, there is a high priority within the health board. As I've indicated previously, I am the delegated executive with responsibility. What we've had is reporting to our patient experience, quality and safety committee, which is a sub-committee of the board, and information is fed from that committee to the board. What we haven't had, but what we've put in place as a result of the Wales Audit Office report through our action plan, is recognition that specific information in relation to the performance around nutrition and hydration against a range of metrics hasn't been reported to the board previously. As part of our plan, we will be taking, as a minimum, an annual report to the board. So, that will be happening. But, to reinforce, reporting does go through a sub-committee of the board currently.

[295] **Ms Williams:** And it's the same in Cwm Taf university health board. We have a multidisciplinary nutrition and catering group, which has representation from facilities, from dietetics and from nursing. And that reports through the quality and safety committee up to the board, and we regularly take reports from quality and safety up to the board through our integrated governance committee that we have, particularly around the fundamentals of care audit, which happens on an annual basis, but also we will be looking to do an annual report. A bit like Rhiannon said, as the director of nursing, midwifery and patient services, I am the designated lead for patient nutrition and hydration, and it is important to show leadership throughout the organisation with regard to both aspects of that, so much so that I actually followed a lasagne from our central processing unit down to ward level and spoke to the patients as they ate it, last year, to see what they—

[296] **Neil Hamilton:** You didn't eat it yourself?

[297] **Ms Williams:** I did eat it myself, actually, in the canteen afterwards. But I talked to the patients about what their experience was and talking to them about the fact that I'd actually seen their food that day being produced, and was able to assure them of what the standards were. So, it's those sorts of things that need to be publicly available, really, to show ownership and leadership within the organisations.

[298] **Rhun ap Iorwerth:** I'm not sure where that leaves us in relation to what we were talking about earlier about giving patients peace and quiet to eat their meals. The last word: Mike Hedges.

[299] **Mike Hedges:** A very simple question: do any of your boards have a non-executive director with responsibility for catering?

15:15

[300] **Ms Jones:** Certainly in Powys, we haven't got that at the moment, no.

[301] **Ms Williams:** And neither have we in Cwm Taf.

[302] **Ms Waters:** And neither has Aneurin Bevan.

[303] **Rhun ap Iorwerth:** Diolch yn fawr iawn. Rwy'n meddwl bod eich atebion olaf chi yn eithaf arwyddocaol i'r cwestiwn gan Mike Hedges, ond hefyd y ffaith bod adroddiadau yn cael eu paratoi i'r byrddau rŵan am y tro cyntaf. Mi fydd yna syndod nad ydy hynny wedi digwydd o'r blaen, ond croeso hefyd, rwy'n siŵr, eu bod nhw yn digwydd rŵan.

Rhun ap Iorwerth: Thank you very much. I think your final answers are quite significant to the question from Mike Hedges, but also the fact that reports are being prepared for the boards now for the first time. It will be surprising that that hasn't happened before, but very welcome that they're happening now, of course.

[304] Mae'r cloc wedi ein curo ni. A gaf i ddiolch yn fawr iawn i'n tystion ni am ddod i siarad â ni heddiw—Colin Phillpott, Liz Waters, Rhiannon Jones, Lynda Williams ac Anthony Hayward? Mi fydd y clerc yn anfon drafft i chi o'r trawsgrifiad i chi gael

The clock has beaten us. Could I thank the witnesses for coming to speak to us today—Colin Phillpott, Liz Waters, Rhiannon Jones, Lynda Williams and Anthony Hayward? The clerk will send a draft transcript for you to check it for any errors, rather

gwirio hwnnw am unrhyw gamgymeriadau, yn hytrach na newid cynnwys yr hyn rydych chi wedi'i ddweud. Ond, unwaith eto, diolch yn fawr iawn i chi am fod yn agored efo ni heddiw. Mi fydd y pwyllgor rŵan yn cymryd toriad tan 3.25 p.m. Diolch yn fawr iawn i chi.

than to change the content of what you've said. But, once again, thank you very much for being so open with us today. The committee will take a short break until 3.25 p.m. Thank you very much.

Gohiriwyd y cyfarfod rhwng 15:15 a 15:25
The meeting adjourned between 15:15 and 15:25.

Arlwyo a Maeth Cleifion mewn Ysbytai: Llywodraeth Cymru
Hospital Catering and Patient Nutrition: Welsh Government

[305] **Rhun ap Iorwerth**: Prynhawn da. Mae hi'n 3.25 p.m. erbyn hyn, felly rydym yn symud ymlaen i eitem 4 ar yr agenda heddiw, sef sesiwn dystiolaeth arall fel rhan o'n hymchwiliad i gynnydd ym maes arlwyo a maeth cleifion. Rwy'n atgoffa ein gwesteion ni'r prynhawn yma bod y cyfarfod yn ddwyieithog efo chyfieithiad ar sianel 1 a chwyddo'r sain ar sianel 0.

Rhun ap Iorwerth: Good afternoon. It is now 3.25 p.m. by now, so we will move on to item 4 on the agenda today, which is another evidence session as part of our inquiry into progress in the area of hospital catering and patient nutrition. I remind our witnesses this morning that this is a bilingual meeting and that we have the interpretation on channel 1 and amplification on channel 0.

[306] Y peth pwysig i'w wneud yn gyntaf, wrth gwrs, ydy gwahodd ein tystion i ddweud eu henwau a'u teitlau ar gyfer y cofnod.

The important thing to do to begin with, of course, is to invite our witnesses to give us their names and titles for the record.

[307] **Dr Goodall**: *Prynhawn da*, good afternoon, I'm Andrew Goodall. I'm the director general for health and social services and the NHS Wales chief executive.

[308] **Professor White**: Good afternoon, everybody. I'm Jean White and I'm the chief nursing officer at Welsh Government.

[309] **Rhun ap Iorwerth**: Rydym yn

Rhun ap Iorwerth: We welcome you

eich croesawu chi yn fawr atom ni, y Pwyllgor Cyfrifon Cyhoeddus, y prynhawn yma. Cyn agor y cwestiynau allan i'r Aelodau, mi wnaf i ddechrau efo cwestiwn ynglŷn â'r arafwch sydd wedi bod i ddatblygu dogfennaeth nyrsio safonol i Gymru gyfan yn y maes maeth a bwyd. Pam yr arafwch? Pam yr oedi?

very much to the Public Accounts Committee meeting this afternoon. Before opening up the questions to Members, I will begin with a question in relation to the delay that there has been in developing standardised all-Wales nursing documentation in the area of catering and nutrition. So, why has this delay taken place?

[310] **Professor White:** I think it's useful to take a stepped approach to this. So, the health boards and trusts within Wales have responsibility for nurse documentation, as we have for all patient care. So, the all-Wales work that we have initiated and has taken a pause, shall we say, is really to bring some governance and some opportunity for an electronic approach rather than a paper-based approach. So, it's not to say that we haven't had work to do with nurse documentation, which is at board level, but there has been a pause in some of the work at a national level. This was being led by the nurse informaticist at NWIS and, unfortunately, through personal circumstances for that individual, they were off sick for a long period of time and it is only recently, since they retired, that a replacement person has been found. So, you will have been aware that we've shared with you the areas of work that that individual—the new individual, who starts at the end of the month—will pick up. So, we'd already set the work in motion and then had this pause, shall we say, due to personal circumstances with the project lead.

[311] **Dr Goodall:** Chair, I would also add that it's important to make sure that, although we're focusing on nutrition specifically, we are aligning that to the range of functions and responsibilities that are carried out by nurses. Certainly, any introduction of an electronic system needs to be enabling the patient care rather than adding an additional burden. I think it would be easy to look at the range of areas that nurses are having to complete across Wales in all sorts of different settings, but really importantly, we're going to be looking to withdrawing some of those to make sure that we don't withdraw the wrong types of levels.

[312] I think we've got an opportunity to focus on this on a country-wide basis. It can feel a little fragmented when it's being dealt with by individual organisations, but certainly as part of the support ultimately for even electronic patient records, this is an area of progress that we would want to be taking forward for the future. Again, very specific circumstances have got

in the way, but that is now being handled within NWIS, as our support structure and information services, and overseen by Jean in Welsh Government.

[313] **Rhun ap Iorwerth:** Mike Hedges.

[314] **Mike Hedges:** Is there now a clear timetable?

[315] **Professor White:** Yes, there is. So, the new nurse informaticist starts at the end of this month. As you saw in the documentation that we prepared, there are already established streams of work that we had identified with the previous individual. So, once the new informaticist starts, we will refresh the timetable from that opportunity for starting. There will be individual work streams with their own timelines within it.

15:30

[316] As I say, this is not just about nutrition and hydration; this covers quite a wide range of areas. So, there will be offshoots of it that will not necessarily relate to this area, particularly in terms of escalation where you have a patient who is deteriorating. We're looking to embed some good practice within moving to an electronic system that might help us drive improvements in that area. So, some of this will be testing out new technologies; some of it will have to be piloted first. So, we're expecting that some of it will have quite a short time frame. Others, probably, will be quite long as we go through a testing phase with it.

[317] **Mike Hedges:** So, will there be a plan that we could see—a sort of PERT chart, or something like that—that shows the stages at which things are occurring? And will be made available to us?

[318] **Professor White:** Yes, as soon as the nurse informaticist has come in, we will have to draw up a project plan for her to work on. So, what you have here is the plan that was with the previous lead. So, it would have to be refreshed, and I'm very happy to share that with the committee.

[319] **Dr Goodall:** Chair, if you could allow us to just allow the individual to settle in through November, and we can perhaps respond to you after that, so that we've tied it together within their job specification.

[320] **Mike Hedges:** Well, I think the auditor general started this back in

2011, so a couple of months is not going to make a great deal of difference.

[321] One final question. This new nurse informaticist; what will they be working on as well as what we're talking about here? Are they going to be working solely on the Wales nursing documentation, or will they be doing other things?

[322] **Professor White:** They will be employed within NWIS as the nurse lead, so, they will be giving professional advice into other work streams within NWIS. So, yes, they will have a much wider remit than this. And, to bear in mind, we're not expecting this individual to deliver all of these things; they're going to act as the co-ordinator. Most of the work will be done in association with the health boards and trusts across Wales. That's how it was set up originally. So, we're looking to involve quite a number of the people who are going to be affected by this.

[323] **Mike Hedges:** If a lot of this work is going to be done by the health boards and others, why couldn't that have been done when there wasn't an informaticist there?

[324] **Professor White:** Because of its link to some of the IT infrastructure, we felt it was really important to have a lead from the organisation that understood how it fitted with the wider strategy. So, whereas you've heard from previous members who have come before you this afternoon about local innovation within a health board, we wanted to look on an all-Wales basis to make sure that we were sharing good practice. So, we felt it was really important to have a central linkage into the IT infrastructure for Wales, and best led by that person.

[325] **Rhun ap Iorwerth:** Lee Waters.

[326] **Lee Waters:** One of my concerns, reading the whole material here, is: where does the drive and the leadership come from within the system to progress this agenda? The auditor general identified this as a problem in 2011. At the very earliest, we're going to get a solution by the end of 2018, possibly later. That's glacial progress, and it doesn't seem to me entirely satisfactory to blame the fact that one person hasn't been in a post to account for that—you know, at least seven years from identifying a problem to fixing it. It seems to me there is a deeper problem here with leadership and drive for pushing this within the system.

[327] **Professor White**: I go back to my earlier comment that the health boards and trusts have a responsibility to ensure that they have documentation. So, this is a way of us bringing some governance and opportunity for movement from paper to electronic. So, it's not as if nothing has happened in that time; each of the health boards already has a paper-based system that they have to do, because it's a legal requirement—all care has to be documented. We were looking to try to bring some consistency across Wales, and there were some opportunities there, too, to look at new and innovative ways of doing it. So, it would be unfair to say nothing has happened since 2011.

[328] **Dr Goodall**: I think, also, Chair, we're trying to ensure that it does tie in to areas where we have taken our national overview, like the updated healthcare standards, for example, so there is a chance for national frameworks. It is an area, as you look across the NHS generally, where there aren't just consistent systems available; you've often found individual organisations developing their own local products, choosing to make investments. We just think that the approach in Wales should be more countrywide oversight at this stage and to make sure that we can follow through on these recommendations.

[329] **Rhun ap Iorwerth**: And we certainly realise, as a committee, that food and nutrition is just one element of the wider remit of the NHS, but we were told earlier today that reports specifically on nutrition had been prepared for boards for the first time, when, for the past five years, we have had a very specific focus on the shortcomings of systems throughout Wales. That kind of delay seems odd.

[330] **Dr Goodall**: I would say there's been a lot of focus within boards on the overall healthcare standards, of which nutrition fits with one part of that. So, we can see the overview that's been taken across these professional responsibilities being facilitated in quality and safety committee meetings, for example. I think it's right to ensure that as these reports and recommendations have an area of focus nationally, we do need to drive to make sure that boards can set it in a local context. I hope, during the course of our evidence, we can show some of the evidence of that happening in some of the individual organisations in Wales, as well as our national oversight.

[331] **Rhun ap Iorwerth**: Okay. Neil Hamilton.

[332] **Neil Hamilton:** The experience of the NHS in England has been nothing short of catastrophic in terms of centralisation of patient records and so on. So, I'm well aware of the problems that any monolithic organisation of the scale of the national health service has in trying to bring all this together, given the history of the way in which disparate systems have been developed at local levels. But I'm quite surprised that the absence of one person, albeit the lead informatics person within the NHS in Wales, could have led to a complete halt effectively in the development of a new system. Just following on from the point that Lee made, was there no deputy or group of people collectively who could have substituted for the person who's been absent in this time?

[333] **Professor White:** No, there was no deputy. Just one nurse informaticist is employed in NWIS. We weren't able to source another person with the skillset required to do that who was working within the organisation. I think it would be fair to say that there have been many calls on NWIS. The requirements are quite huge to be honest. We are living in a digital age and seeking digital solutions for practically everything. It is a tall order.

[334] **Rhun ap Iorwerth:** With hindsight do you think it may have been a good idea to put something else in place?

[335] **Dr Goodall:** I think certainly looking to improve the missing documentation is a core part of business. To give some general reassurances beyond just the sort of nutritional and the catering side of areas, we are making progress on a range of different fronts about how practitioners are able to use IT systems to enable what happens right through from GPs with their own systems to the current development of the all-Wales social care and community care information system. So, I think it does sometimes come to a choice of priorities when we're investing in these very big areas. We're rolling out in emergency departments at this stage. But, certainly, we need to promote the nursing documentation side alongside the healthcare standards. I think there could have been a chance for a different discussion, but there are some limited resources and limited expertise that's available in this arena.

[336] **Rhun ap Iorwerth:** Rhianon Passmore.

[337] **Rhianon Passmore:** So, there is some acknowledgement with hindsight that things could have potentially been different. I can infer that from what you were saying. In terms of transitional arrangements, as you move from a

paper-based system to a more electronic-based system, with reference to the local-based projects, this is a 'national' project, how can we as a committee be reassured that the monitoring of nutrition in particular is going to be taken a step forward during this infancy period, as we move from paper to electronic systems?

[338] **Dr Goodall:** Well, perhaps if I start and, Jean, you come in. I think we have to emphasise the approach here being moving people from a traditional world of where facility staff only would perhaps in the background worry about these issues and focus almost on the kitchen function aspects to where nutrition and hydration as well are fundamental parts of the care pathway and the professional approach on there. That is a change that has happened. So, increasingly and, hopefully, through some of the evidence you've seen here today, you will have seen that we've moved it to three sets of professional groups talking through together to make sure there's a focus on the individual patient. But it is also monitored on a local premise and we do hold people to account for progress as well, Jean.

[339] **Professor White:** You will have heard from the previous witnesses that it is an interplay of responsibilities between the nurses on the ward to make sure that patients receive their food and things to drink, the dieticians to give expert advice and then the catering staff. The approach that has been taken so far is that these groups have been working somewhat separately from one another, and going forward we see that the power of three, if you like, getting these people to bring their work closer together, is really an important step. You'll have heard examples of same-day ordering as a good example of either a paper-based or electronic system where you're able to capture the patient's needs closer to the time they actually consume it. You ask how we can be sure about not losing something in the transition, well, the example you heard of some of them having paper based systems, that will be made electronic. This should be a seamless thing, if you get the process right. I think there's always a danger of thinking that IT is the solution, if you haven't got the process right. So, I think that, once they've got the ideas of what they should be doing, turning it then into an electronic process should be fairly straightforward. But the biggest conversation is to make sure that you're doing the right thing to start off with. I do think that bringing the people together and bringing these all-Wales groups together to share good practice is a really important step forward. They'll be doing that fairly soon.

[340] **Rhun ap Iorwerth:** I don't know if you'd like to go on to some

questions that you had on training and another electronic development.

[341] **Rhianon Passmore:** Yes, okay then. We've mentioned that, in 2015, auditors found that, on some wards, food and fluid intake for patients identified at risk was not always recorded. Based on the information from NHS organisations provided, compliance with the e-learning packages, which are fundamental, as you understand, ranged from 25 per cent to 80 per cent in 2015. Now, as this is one of the key monitoring mechanisms of how well we're doing, how concerned are you—yourselves, and Welsh Government—about the relatively low levels of compliance with the e-learning packages? If there is a concern—and it sounds like there is a concern, from my perspective—how fit for purpose is that e-learning package, if that's one of the key monitoring tools that we're using to rely on, if patients who are at risk are not being given the basic nutrition and fluid?

[342] **Rhun ap Iorwerth:** Jean.

[343] **Professor White:** Yes, I do agree that it is concerning that some staff may not have had what we felt was mandatory training. We listened to what the service was saying to us about why that was. Partly, it's to do with ease of access. So, I see my role and the Government role to try to get systems in place to make it easy for people to do the right thing. So, there was a difficulty in staff accessing the electronic package itself, so, we arranged for it to be placed on a platform—Moodle 3.0, I think they call it—which means you can access it both in hospital and at home. Some people didn't have e-mail addresses, so we arranged for them to have e-mail addresses or group accounts. So, what we've been trying to do is make it easy for people to do the right thing. But I do think it's probably fair to say that there is some challenge about attendance for all mandatory and statutory training when the service is under pressure. So, having people released to do it, and the willingness then to spend their own time doing it, remains a challenge that this committee will have heard previously when I've been here, because this is a long-standing problem, to be honest.

[344] **Rhianon Passmore:** So, if it's a long-standing problem, what are we doing, and what are you doing specifically, to be able to challenge (a) the platform—the tool in which we can access that training—and also, really, if that training is fit for purpose, bearing in mind the outcome if it's not effectively undertaken?

[345] **Professor White:** The feedback we've had is that the training is fit for

purpose. It is more around the access and the ability of staff to access it. So, we've been focusing on making it easy to do. In terms of compliance, one of the step changes that is happening this autumn is that, when somebody has completed the training, there will be an automatic report into the electronic staff record. So, when they come to have their annual review, their manager can say, 'I see you haven't done this. I require you to do it', or 'Why haven't you been able to do it? What's the problem?' So, there's something about this next step change that, again, will make the managers do the right thing, which is to say to the staff, 'I think it's appropriate for you to do it', or 'I think you've probably got the skill set, and we will perhaps prioritise somebody else to do something else and I want you to do this.' It all depends on what the senior manager will say that the person needs to do their job. So, I think this is an important facility for managers to make sure that things are happening.

[346] **Dr Goodall:** I think the electronic staff record simply allows us to ingrain it, rather than have something as standalone reporting. So, it just becomes part of core business. I think that's an important shift at the end of this month that is occurring. I think, equally, there is a responsibility within health boards in respect of mandatory training, irrespective of the workload and the busyness of the environment, to make sure that people do have the time and the flexibility to be able to comply and to have time to actually complete training as necessary as well. We will need to keep an eye on that, too.

[347] **Professor White:** May I just add something, Chair, if that's all right? We have formal medical and surgical wards across Wales. We've been looking at the nursing establishment—in other words, how many nurses and nursing assistants are employed on the ward. I introduced some principles in 2012, and the health boards are now increasing their establishments to meet those principles, and that does cover an amount of time to do mandatory and statutory training. So, in some of the workforce planning approaches that Government has been working with the health boards over—it does pay attention to that. So, as I say, our attention has been trying to make people easily be able to do the right thing in this area. But it is a concern, to be honest.

15:45

[348] **Rhun ap Iorwerth:** It's these words 'mandatory' and 'compliance', isn't it? I mean, if it's a matter of compliance, it's a matter of compliance. Is it

important enough to be a matter of compliance?

[349] **Dr Goodall:** It is a matter of compliance. What we've at least unlocked are, however, people describing problems with some of the existing systems. And, as I said earlier, I think the change to the electronic staff record is quite an important change.

[350] **Rhun ap Iorwerth:** I apologise to Oscar for not calling you earlier. Do you still have a question?

[351] **Mohammad Asghar:** Yes, please, thank you very much Chair, and thank you to you both. Ruth Marks, the former Older People's Commissioner for Wales, said that National Assembly for Wales's Public Accounts Committee report on hospital catering and patient nutrition said, and these are her words:

[352] 'Having nutritional and appealing food is an essential part of getting better'.

[353] Quote closed. Given this, what action is the Welsh Government planning to improve nutrition services in hospitals across Wales? Just to Andrew, now.

[354] **Professor White:** So, from the evidence that was previously given from the Wales Audit Office on looking at menus, which we have reported on here previously, there is an all-Wales approach now to looking at menu development, both in nutritional terms, as well as in, 'Does it look appetising? Does it look palatable?' This group meets two to three times a year and it has chefs, as well as representatives from all the health boards, to look to see whether or not the food is of the right quality and standard. I understand from that group that they are adding nine extra dishes to the all-Wales list this year, and that health boards are between 95 and 100 per cent compliant with using only those things that are on this all-Wales menu platform. So, although the patient survey that had been done in 2013 and 2015 shows that some patients are saying, 'Okay, the food doesn't look that attractive', when you drill down into some of the other comments they are saying, three quarters of them were saying they were quite satisfied with the food, and only about 10 per cent were saying the food was poor or unacceptable. So, there are some things to go at, I would say, that the menu group are very aware of. They get local feedback, as well as feeding into the national group to see what they can do with the all-Wales menu framework

itself. I think the involvement of all of the health boards with the chefs, the dieticians, the catering staff, in looking at where they get the material from—local procurement, that sort of thing—and then looking at the nature of the menus that sit on the framework, is an important driver for us in the quality and palatability of the food that is being presented.

[355] **Rhun ap Iorwerth:** Okay. That brings us on to the patient experience and the food that they get, and the screening of what they require. Lee Waters.

[356] **Lee Waters:** It seems to me one way of dealing with this would be to serve the food that's served in hospitals in your own canteen. Have you considered that?

[357] **Professor White:** I personally haven't, no. I don't think there are any plans that I've heard of, of offering different types of meals. I think you heard Lynda Williams from Cwm Taf actually describe the lasagne journey from production, and she herself then had it in the canteen. So, I think quite a lot of the food that is presented to the patients is presented in the canteens as well. So, I don't think there's any—.

[358] **Lee Waters**: No, I mean in the Welsh Government canteens. Because you're telling us that, since the Auditor General's report, things have moved along, that new things are being offered, and in fact these figures that patients don't like what's put in front of them aren't accurate. So, a way of doing real-time true progress tracking would be to serve it in the Welsh Government canteen, so the Ministers and senior officials could track it in real time. Would you consider that?

[359] **Professor White:** I didn't think I said that it wasn't accurate. I'm just saying that there's some evidence to suggest that not all patients find the food disagreeable.

[360] **Lee Waters:** Well, a third of patients felt the meal was not appetising.

[361] **Professor White:** But, out of that, three quarters did say that they were satisfied with what they'd got. So, there are some nuances within patient—

[362] **Lee Waters:** Indeed. And my sincere question to you is: if that is the case, a good way of cracking it would be to serve that within the Welsh Government canteen. Would you consider doing that?

[363] **Professor White:** I don't know the logistics of that. I—

[364] **Dr Goodall:** I can reinforce from a health board perspective that those sorts of taste tests are done at the board level, and they are led on a local basis within those organisations and there are mechanisms in place for patients. That's not just an oversight issue from Welsh Government, that's from my previous experience of having been a health board chief executive. I recall my previous nurse director, for example, always going and ensuring that, actually, the quality, from her perspective, was being maintained actually at the ward level for patients' experiences.

[365] **Lee Waters:** Do you like powdered egg?

[366] **Professor White:** Depends what it's in.

[367] **Lee Waters:** I'm told on social media that, in Glangwili hospital in Carmarthen powdered egg is served.

[368] **Dr Goodall:** Right.

[369] **Lee Waters:** So, back to the question I put to you, Mrs White, you said that you weren't sure about the logistics. Well, I'm not being glib here—

[370] **Rhun ap Iorwerth:** You're making a very interesting point. I think there is an issue of logistics, that's quite right, there. If we can broaden it out from what happens in the Welsh Government canteen—.

[371] **Lee Waters:** It's a serious point, because the evidence we've been given by the auditor general consistently shows there's a problem, the witnesses we heard before you, it didn't seem to be happening in their health boards, it was fine, and the evidence you're suggesting to us is that, actually, it's not as bad as we've been told, and things have moved on and there's progress. And I'm saying to you there's a disconnect between the data we've been given and the evidence we've been presented with. This is a massive operation, I fully sympathise with the logistics involved, and I suggest, finally, to you again—it's a serious suggestion—one way to track this would be that the food served under the all-Wales pathway is also served in the canteens of the health boards and also of the Welsh Government so that you can see what patients—. If it's good enough for patients, surely it's good enough for everybody else. Would you consider—? Could you look into the

logistics of that?

[372] **Professor White:** I think it might be beyond my ability as a chief nurse to fix it, but, certainly—

[373] **Lee Waters:** Well, the chief executive of the NHS can look into the logistics of making that possible.

[374] **Dr Goodall:** Chair, we can look at the sentiments of it, which is why I reinforced about the taste test being an important aspect of what happens at this stage. But, irrespective of the functional issues of the way in which health boards run their own respective organisations and the catering approach in there, I take the sentiments of what you're saying and we'll look at that for you.

[375] **Lee Waters:** Thank you.

[376] **Rhun ap Iorwerth:** Okay. Further questions on this matter. Oscar.

[377] **Mohammad Asghar:** Yes. On the food and beverage service in the national health service and whether the Welsh Government monitor the extent to which NHS bodies are sticking to its all-Wales menu framework, and does Welsh Government have any early evidence to suggest that the Water Keeps You Well campaign is making a difference to patients' care across Wales?

[378] **Professor White:** We understand the feedback has been—from the all-Wales group—that compliance with the menu framework is between 95 and 100 per cent. So, it suggests to me that most of the hospitals are fully compliant most of the time.

[379] In terms of the Water Keeps You Well campaign, this was introduced on the back of 'Trusted to Care', which was a review of the care of older people into the hospitals in south Wales. We introduced a national campaign earlier this year, which, essentially, encourages people, whether it's relatives or members of staff, that, every time they go to a patient who is allowed to drink orally, to offer them a drink. Anecdotally, when I go around talking to the patients on the wards, it certainly has made a difference. I spent 30-odd hours this summer visiting wards across Wales looking at this. The signage was clearly there and a lot of people have been very actively engaged in it. There's also a suggestion of encouraging relatives, if they want to bring

anything into hospital for the patients, or for the patients themselves bringing it in, they can bring in squash to make the water more palatable—not everybody likes to drink water. So, there's that sort of thing as well.

[380] We, on the back of 'Trusted to Care', also introduced a spot-check methodology, which focused on some very key areas and hydration was one of those. The health boards now have a quality toolkit, which they can use to do audits around this, and, when we did spot checks, commissioned by the Government, looking at this, hydration was not seen as a major issue from that process. However, it's one of those things you can never ever take your eye off; it is absolutely fundamental. Nutrition and hydration are one of those things that, to be frank, is almost as important as the medication that people receive. It is that essential. So, there is a constant drive to make sure that the health boards are doing that, and the campaign is but one way to capture people's imagination about what they might do.

[381] The Water Keeps You Well campaign also has one particular change agent element to it, which is unusual, which is about getting patients to make a commitment to drink. Whereas it's all very well having professionals come and say, 'Have you had a sip? Would you like a sip? Have you had a drink?', there is something about engaging with patients to say, 'We'd like you to agree to drink this amount in a period of time.' So, that is being looked at and evaluated as a methodology. When the campaign was being developed, we engaged with the Bangor University change management team to look at the methodology and the thinking behind it, because it's all very well having posters on walls, but if you have a particular change methodology underpinning it, we're hoping that will make the difference, and that will be evaluated.

[382] **Mohammad Asghar:** Thank you very much. Another thing is: the Welsh Government uses the patient survey findings to inform its discussions with NHS bodies on scope to improve catering and nutrition services across Wales. My question is to you, Jean: You have a wonderful, we fully acknowledge it, NHS catering system, but where there are some people with different ethnicities, religions or beliefs, like halal and kosher meat, and all these different reasons, the food is not served according to their needs. Most of the cases—. I recently have been in hospital—not myself, my wife—for weeks, and we took our own food, which the patient likes. So, is there any provision that you can look at to improve this way that people can bring food? The patient loves to have food with their loved ones sitting with them and eating together. Those who bring food eat less, but they give a patient more,

because they know there's nothing in the hospital.

[383] **Professor White:** You are making a very important point about patient choice and, particularly, if an individual has particular, challenging dietary needs, it is essential that the hospital provides that food for them. We don't stop people bringing food in, per se, however, there are certain things that you have to be very careful of. So, you wouldn't want to bring in food that would go off in a warm environment, because you could actually make the person ill. So, there is a health and safety element to some of this. What we've always said around things like protected mealtimes is it's down to the ward sister and charge nurse to agree with the family about how to manage this sort of thing. So, I wrote out a couple of years back, reinforcing the arrangements around protected mealtimes, which are to engage with the family and if their loved one needs to have support or would like to have a shared eating and drinking experience at mealtimes, then that should be enabled wherever possible. Now, obviously, on the ground, in certain areas, it's quite challenging to do that. Not all wards have dining rooms and some of it is actually in the clinical area, so it is a little challenging, which is why it has to be the ward sister or charge nurse that makes that determination. But if there are some suggestions for improvement, then I'd be very happy to look at those to drive that.

[384] **Rhun ap Iorwerth:** Oscar also raises the important point of lack of availability, from his experience, of food that was required because of a particular religion. We've heard today discrepancies between patient experience, the anecdotes, and what health boards, for example, are saying actually happens on the ground. How do you monitor what is actually happening as compared with what health boards are saying when they say, 'Yes, everything's fine; there's no problem'?

[385] **Professor White:** We rely on lots of sets of eyes, to be honest. So, you've heard mention of an annual audit. Well, annual audits only give you a snapshot in time. So, what instead we also require feedback from is—the community health councils go in. They talk to patients, they talk to their relatives. HIW does inspections and there will be elements of that that will come up through the inspection reporting. So, there are a number of ways that we pick up data. It is a combination of audit at points in time and then people being part of a CHC or HIW inspection.

16:00

[386] Most of the feedback will go to the health boards, not to us within Government. That, I think, is appropriate, because what you want is on-the-ground action if there is an issue. So, if your wife—and I do hope she's better now—if you found that things were not happening there and then, what we expect people to do is raise concerns and have their concern dealt with right at that moment. It's no good waiting a year for me to find out, and for Government to try to do anything.

[387] So, there is very much an emphasis now from Government on patient feedback. We set out a service user framework, under which the health boards and trusts are all required now to look at different ways of gathering patient feedback, whether it's real time, whether it's audit, whether it's patient stories, and you will have heard in your previous evidence different ways people are doing that with apps, with paper questionnaires—three minutes of your time, two minutes of your time. So, they've all got lots of different ways of gathering the information. Is it perfect? No, of course not. Is there more to be done? I would say yes, there is. Because there are quite a number of interactions across the services, not just in the hospital bed, and you need to be quite creative about how you get to people. There is also a challenge: if you ask somebody sitting in the bed, 'So, how was the meal today?' will they honestly say what they think? They might want to go home and reflect on it and give some feedback.

[388] So, it's important for us to have real-time information, an ability to raise concerns and have those concerns addressed, and then different ways of feeding back about what my experience was like. So, there is often a difference in terms of seeing what the levels of satisfaction with the service are, and then drilling down into elements of the experience, which is where I think sometimes we have these conflicting stories, because it depends what you're asking, when you're asking it and how you're asking it. You can play all sorts of games with statistics, but the general feel we get is that people are mostly satisfied, but there are elements there that they want improvement on.

[389] **Rhun ap Iorwerth:** I think Lee Waters might want to pursue this a bit.

[390] **Lee Waters:** Just a related point: you said that it's right that the leadership on this lay at the health board level. We have the regulations for which board members are responsible for which subjects on the local health

board. It doesn't seem entirely clear who's responsible for catering and patient nutrition. In fact, when we asked the health boards earlier, they said nobody at a health board level was responsible. They talked a lot about the importance of ward-to-board accountability, but few of them reported routinely on this at board level. So, I wonder what reflections you have about that: if that's where you want to put the responsibility, what can we do to improve on the current level of the current abilities?

[391] **Dr Goodall:** I've always seen the patient experience side being very strongly held by nurse directors and their function, both where I've worked in organisations before and currently. But the facilities management aspects will tend to be within the responsibility of chief operating officers, and that's why I think it's important—in the same way we've emphasised here, working across those operational services with the professional team—that that's done within the health board environment itself. But certainly, I think as we translate these approaches into improvement for the future, I think it's the patient experience aspect that probably drives the concerns of this committee at this stage, and I see that firmly on the professional side, but with proper operational support from those overseeing and running these facilities services.

[392] **Lee Waters:** Would it be useful for the Welsh Government to be explicit about how often it expected this to be reported at board level, and which director took the lead?

[393] **Dr Goodall:** I think we can be explicit on that. We also have to make sure that health boards are dealing with all of their other priorities, so I wouldn't see this as suddenly a monthly area, other than on an exception basis. This was a really significant area of concern, but certainly as part of our annual reporting mechanism, the way in which the patient surveys come through, we don't see that as just a one-off annual process. If there's a need for clarity, we can make that clearer, I think, for the individual health boards at this time. But I think a regular contact on it to make sure there's progress, but not necessarily a monthly kind of occurrence—

[394] **Lee Waters:** Okay, but that's not currently happening, is it? So, what might you do to make sure that it happens regularly?

[395] **Dr Goodall:** I know that the oversight of this on the patient experience side is held within more detailed quality and safety committee meetings, but we can make sure, firstly, that we cover it on the governance side. What

we're doing with all material reports—whether it's from PAC or Wales Audit Office or external regulators—is making sure that they become visible at NHS board level in Wales, but equally in terms of the reviews that we do with individual organisations at their mid-year and end-of-year reviews, so we can look to make sure that people understand they have to account for it there also.

[396] **Rhun ap Iorwerth**: Just to clarify, you said two or three times there, 'We can do this'. Is that a 'Yes, this is something we could do, and we are in the process of doing it', or have you any specific steps that you are already putting in place to change the relationship between the board and how it's happening?

[397] **Dr Goodall**: Having overseen at health board level, I would expect the patient experience reports to come through very strongly through the quality and safety mechanism, and that's where I would have wanted to have located those previously, and for it to be taken on an exception basis to the board. In terms of more national oversight of what we do here, and given the ongoing importance of these issues, yes we can call that these are drawn in to some of the supporting documentation and discussions around our mid-year and end-of-year reviews with the organisations across Wales, and we will commit to do so.

[398] **Rhun ap Iorwerth**: So you are planning to do that, and that would be a change to previous years.

[399] **Dr Goodall**: We'll commit to do so. The importance of these national reports and the compliance and recommendations—. We've been drawing them increasingly through the NHS board mechanisms over the course of the last 12 to 18 months in particular.

[400] **Rhun ap Iorwerth**: And where would we find reference to any announcements that you've made in relation to this?

[401] **Dr Goodall**: Chair, I'm sure there'll be a number of areas that you want to highlight on the back of this report, not least the nursing documentation side, and I think we'd be happy to contain it in the same correspondence to you.

[402] **Rhun ap Iorwerth**: Okay, thank you. Shall we move on to costs? Neil Hamilton.

[403] **Neil Hamilton:** It's six years, now, since the auditor general highlighted the benefits of introducing computerised catering information systems, since when some limited progress has been made, with three NHS bodies using the Menumark system and the remainder apparently waiting for a decision to be taken on an all-Wales system—and, in order to get there, we have to get a business case put together and some assessment of its viability. Is the delay in doing this related to the same problem we were talking about earlier on, namely the head of informatics not being available?

[404] **Dr Goodall:** No, that's a separate issue, there. So, that's not to do at all with the nursing documentation discussion that we had earlier. There has been a need to ensure that all health boards would sign up to a national IT system here, and we've been emphasising increasingly the use of national IT systems through our overall approach around digital services within Wales. This particular product also needs to make sure that, as well as just simply being a system to be used, it's a system that actually gains the benefits that are expected as well, at the same time. Certainly, I think on some of the provisional cases put forward, perhaps the value for money and benefits were less explicit than they could have been at this stage. It's also about balancing the costs of introducing a system like this in terms of other requests on the capital budget for Wales.

[405] In and of itself, it's £3.5 million to actually roll this out across all of the health boards and Velindre trust. It's a material amount of money. We have choices about how we spend capital: should it be on this system, should it be on equipment at ward level, should it be on implementing a community care information system, or on three linear accelerators for cancer services? So we do have to make some judgments here. However, having said that, I'm now chairing the national informatics board, and I have asked for the case to come through so that this is properly reviewed, and it is going to our November board meeting. I'm looking at the capital implications of that, and I do want to make sure that it can achieve the benefits. My view was that, amongst a whole series of issues, it was intended to help to drive down the wastage issues. Alongside other actions, we've been able to do that as well, and it may well be that the information system is the final piece to allow a further push again, but I can certainly report back after our board meeting, which is taking place in November, and confirm the outcome of that to the committee, because I know you'll have an ongoing interest.

[406] **Neil Hamilton:** Yes. So, there won't actually be a decision taken in

November, presumably.

[407] **Dr Goodall:** No, the intention is that we're receiving the business case and we will look to make a decision, but I'd like to make sure we take it on its proper benefits and the outcomes that we expect, given the materiality of that particular case. I would hope that that is resolved one way or the other, but the hope will be obviously that it'll be resolved positively in order to allow implementation across the whole Welsh system. But I would like to still see the benefits come through strongly.

[408] **Neil Hamilton:** Well, the waste figures show that there are significant savings that could be made, even though no system is going to be 100 per cent perfect, and that a cost of £3.5 million on your capital budget would produce, potentially, quite a significant revenue return on the figures that we've seen so far, which are themselves incomplete.

[409] **Dr Goodall:** And I would like it not just to be seen, for that reason, as just an addition to the system; I think it is to make sure that we can actually drive those revenue benefits. I'm pleased, at least over the time of all of the reviews that have taken place, that we've managed to have a concerted focus to get down from what was 16 per cent to 6 per cent. I actually hope, alongside any discussion on systems anyway that, hopefully, shortly, we can put out advice to the Cabinet Secretary to say that we think that the target needs to be revisited. People are operating well within the extant 10 per cent target; personally, we feel professionally that that should at least be dropped down to 5 per cent in the interim, but we need that to be endorsed by the Cabinet Secretary. If we could make more progress through a range of actions, including the computerised system, we would be very prepared, of course, to reduce that target further, because there are some cost savings within that envelope.

[410] **Neil Hamilton:** As part of this evaluation exercise, you will presumably be looking at the effectiveness of the local IT systems, which are currently in existence, to see whether it's worth taking the risk of centralising, and all the problems that we know can be caused by moving to a bigger but more centralised system.

[411] **Dr Goodall:** There are benefits of national approaches and systems, and we're rolling out on a number of other consistent areas across Wales, in areas such as radiology and pathology services. But you're absolutely right, you need to have a very tight local implementation to make sure it works,

and, yes, we are bringing in the expertise out in the service to give us that final call.

[412] **Neil Hamilton**: And the other aspect of that kind of analysis will also be what will be the impact of not introducing a new IT system and to what extent the existing system could be improved or better monitored and have greater feedback or communication between different systems.

[413] **Dr Goodall**: Indeed, and I hope the case can be made. I think, as long as we can look at the criteria, and, if you like, a return on that investment, given the sense of materiality of it, hopefully we can just have a positive outcome from that. I'll report back after November.

[414] **Rhun ap Iorwerth**: Can I just pause for a second?

[415] **Neil Hamilton**: Yes, sure.

[416] **Rhun ap Iorwerth**: Lee.

[417] **Lee Waters**: It's been quite a long tale, hasn't it? Just looking at the auditor general's report, it was in 2012 that the NHS Wales Informatics Service and shared services were asked to come up with an outline business case. They prepared one in 2013. There were then delays with it being shared within NHS Wales. By the time it was considered, the figures were out of date, and now, in 2016, you're eventually making a decision. That is then subject to the all-Wales capital programme, which, as you've just implied, is under heavy pressure from other demands. You said at the outset that you thought that NWIS was under a lot of pressure, a lot of competing demands, and that it had limited capacity. So, what are you doing to address that capacity, and shaking up NWIS, but why on earth should it take so long to reach a decision on a business case?

[418] **Dr Goodall**: I think, again, I go back to what was its intended outcome. And it's been possible to make progress on the wastage, if you like, despite the system there. I think that, alongside investing in a material system like this, if we haven't got the benefits coming through clearly, we have to place it alongside many other choices that we're making. We always spend the all-Wales capital programme on the NHS side every year at this stage. I certainly need to know that the case actually is able to be defended at this stage, and some of the early work that was done didn't do that. From a NWIS perspective, they have a much broader set of responsibilities. They oversee

our GP systems in Wales. They're overseeing the implementation with local organisations about their radiology implementation, and I think we need to ensure, for them to keep making progress at this stage, that they do have an infrastructure in place that allows them to do so. And we are reviewing that, because, of course, our digital approach is quite fundamental to the way we enable service change and patient care for the future at this stage. But there will always be choices within any annual work programme.

[419] **Lee Waters:** Of course there will, but it does sound like they're struggling.

[420] **Dr Goodall:** I think there's a lot of expectations because people want to have change happen very speedily, and some of our roll-outs require a very expert team to be involved in every individual health board area as they support this, rather than spread and distribute it all in parallel at this stage.

[421] **Lee Waters:** But the trouble is, as your note to us makes clear, in the meantime, individual health boards are holding back on making their own arrangements because they're waiting for a decision that has taken four years to come to.

[422] **Dr Goodall:** Indeed. But it will come to a close now, and hopefully—

[423] **Lee Waters:** Well, you say 'close', but it's then dependent on a capital decision. So, what's the date that you hope that a solution will be in place?

[424] **Dr Goodall:** I hope that we'll have made a decision around the national informatics board in November. That means that we can actually make some progress against it, because the business case is already written within the capital allocation mechanism. That's simply making sure that we have the funds available, and if it was rolling out in 2017-18, for example, it becomes part of advice up to the Cabinet Secretary.

[425] **Lee Waters:** So, that's when you expect it to be rolled out, is it, 2018?

[426] **Dr Goodall:** It won't be rolled out during 2016-17, if we get the go-ahead in November. What it can do is be considered as part of the 2017-18 capital programme.

[427] **Lee Waters:** So, just briefly, Chair, assuming the go-ahead gets given next month, when do you expect this to be live?

[428] **Dr Goodall:** I would expect that if the go-ahead was given on it, we should be able to be implementing it through 2017-18.

[429] **Lee Waters:** And by the end of 2018, it should be in place everywhere.

[430] **Dr Goodall:** It should be in place. It's not got the same implications as rolling out a patient administration system, for example. It is a consistent backroom function that we can actually put in place. So, I see that as an easier implementation than some of our other technology.

[431] **Rhun ap Iorwerth:** Right, okay. Just out of interest, if capital expenditure has been one of the barriers, have any attempts been made to make a bid for some funding for such a programme through invest-to-save, for example?

16:15

[432] **Dr Goodall:** I think that's partly where the case comes from. The NHS has actually been able to make pretty good use of some of the invest-to-save processes. I think, perhaps, danger of this is that it almost emerged with more of a traditional, 'We need one of those and, therefore, let's have the centralised system'. I know it was a clear recommendation. I do think that there's an invest-to-save mechanism on here, when you look at some of the underlying principles, and I think that it should (a) help with usage, but actually it should help with some of the streamlining of how the functions work in the individual hospitals and sites as well. So, I personally feel that that would be a possible avenue for us to use. But I'll still be looking, through advice to the Minister, to see whether we can at least be making some provisional or notional allocations around the system, knowing that it's coming through the informatics board.

[433] **Rhun ap Iorwerth:** Okay. Back to Neil Hamilton.

[434] **Neil Hamilton:** Although the figure's not entirely reliable, as far as the auditor general can establish, the cost of food wastage among served meals has been reduced from £4 million to £1 million and the target is £1 million. Now that things have improved, are you going to introduce more challenging targets to keep the pressure on?

[435] **Dr Goodall:** Yes, I think we need to. I'm genuinely pleased that we've

been able to address the actual financial outcome because that's about making resources available back for patient care. And I think that is a material shift, even though we know that there's more to go to. But, absolutely, if we can account for the current level of wastage in what's reported within the report—. I've already indicated that we would look to drop the wastage levels and I think that that should be aligned, actually, with a refreshed target as well.

[436] **Neil Hamilton**: If you've got better tracking systems, you should be able to make a lot of further progress.

[437] **Dr Goodall**: I agree.

[438] **Rhun ap Iorwerth**: Okay. Oscar.

[439] **Mohammad Asghar**: Thank you very much, Chair. Andrew, I think, in my first term, in exactly the same room, one of your officials said, in his words, that, 'In the NHS, we spend 20 per cent of our budget inappropriately.' That was said in this room. Things have happened since then and I'm sure things have improved—you might have read it. So, I'm not saying that we're wasting money in the NHS, but I think that one third of our national budget goes to the NHS. It's a great ask and, as Jean said earlier, it's like walking up a hill to save the money. On what area are you focusing on to cut the budget and give the best possible NHS service in Wales?

[440] **Dr Goodall**: Look, in this specific area, any opportunity to make a saving for patients, where it doesn't affect the outcome of their care, is about support mechanisms and going at issues like wastage. We should of course be ensuring that we continue to make progress. So, in this very discrete area, with all of the attention that we've had on it, I think we've still been able to demonstrate some good progress. I think it is important to make sure that we focus on outcomes for patients. One of the key issues there is always trying to ensure as much as possible that patients can be cared for in an appropriate environment. I think part of that comes with looking at the underlying reasons for why people come into hospitals in the first place. I think we have a responsibility to, as much as possible, demonstrate that there are alternative services available and around so that people are being cared for as close to home as possible. I think we need to continue to focus on that.

[441] Ultimately in the catering and nutrition arena, we still provide a very

high-volume response for the number of patients who actually come through. You know, every year in our hospitals, we have 0.75 million admissions who are being served. So, it still remains an approach at an industrial level that is going on. But I still believe that it's possible to revive personalised care, hence why, over the recent years, we've been introducing a much greater focus on the patient reflection, patient feedback and patient experience. We do need to ensure that, despite the complexity and volume of our system, it does provide something that feels more personal to people's needs as well.

[442] **Rhun ap Iorwerth:** Okay. For the final three questions—Rhianon Passmore.

[443] **Rhianon Passmore:** Thank you. There's been some quite intense questioning today, and I'm sure you would agree with that. In terms of how you're obtaining assurances from NHS bodies that are addressing the auditor general's recommendations, and those of the previous committee, how would you outline how you're obtaining that assurance?

[444] **Dr Goodall:** Do you want to pick up professionally first, Jean, and I'll pick up the organisations?

[445] **Professor White:** As I said earlier, having food and fluid is really, really important. So, there are tiers to assurance. At health board level, it starts at the ward—a ward sister or charge nurse must be assured that patients receive the food and fluid. The senior nurses need to spot-check to make sure that the processes are followed and so on and up the tree, which you've already heard this afternoon. For us, to make sure that things are happening, we rely on many eyes: community councils, Healthcare Inspectorate Wales, that sort of thing.

[446] One of the things that I didn't mention was our move to look at some of the essential care metrics in our NHS delivery and outcomes framework, because in the past we've, if you like, focused a lot on process. So, it's very easy to say, 'Has this jug of water been changed three times today, yet has the person had enough to drink?' So, making sure that we move from process, which is around the things that you do that are easy to measure, to actually looking at patient outcomes, in terms of food and nutrition, is quite an interesting step for us to do. Most places focus on quasi-measures of outcome and they're mostly process. So, there is work at the moment that will come in for the next financial year, which is looking at attention put on

patient outcomes. So, whether we look at urinary output or levels of thirst, or blood chemistry, or whatever it happens to be, we're looking to see impact on the patient and the outcomes of their care. So, we will have a complete set of process as well as outcome measures, and that's the important next step for us to take. But it is quite challenging to pick the right outcome, because you can you can end up doing lots of interventions to people, which is also a bad thing. So, there's quite a healthy debate at the moment about how we're going to measure patient outcomes in this respect.

[447] **Dr Goodall**: Chair, I've also said about how we can use the contact points for the service in a different way going forward. We've been trying to use our NHS board to have oversight of these types of issues. We've had previous Public Accounts Committee and Wales Audit Office reports that we're drawing through there. But there are also some discreet issues to go at. I now chair a value and efficiency board, absolutely to be able to draw in the opportunities to be more efficient in our system—to do that through a patient lens in a different way. And it also gives, again, I think, a good opportunity to include areas like this where we know, for example, we can go at wastage in a different way. So, we do have mechanisms and contact points in with the service. But the operational day-to-day performance of the NHS still remains with the individual boards, so I think we still have to have an ongoing expectation for them to respond.

[448] **Rhianon Passmore**: And in regard to that ongoing expectation, we talked about accountabilities within that board, and you've mentioned several shifts moving forward. Do you feel satisfied, then, that the NHS bodies are making satisfactory progress in improving hospital catering and nutrition? Do you feel that there needs to be more emphasis? How would you encapsulate where we are at the moment in this journey?

[449] **Dr Goodall**: Well, I would use the report that's been given from WAO to say that there has been progress over recent years on a number of different areas. We have been able to demonstrate the completion of some of the actions in place, even though I know we've put attention quite rightly today on areas that are still outstanding. So, I'd want to acknowledge that, but it's to ensure that we're not complacent in those issues because, clearly, there are areas we need to continue to improve on at this stage.

[450] **Rhianon Passmore**; And how would you outline those areas that you need to improve on?

[451] **Dr Goodall**: I think there are some distinct issues—we've talked about our national approach on some areas: for example, if it's not for individual health boards to determine what they want a local catering system to look like, that we step into that space and make sure it happens through a national lens, for example. I think it is absolutely our oversight and responsibility to make sure that there is consistency about the way in which we report patient outcomes and experience. And I think, again, through a variety of mechanisms we've been able to do it, and I think we have done some different things in Wales. We've taken a countrywide approach to the development of the all-Wales menu framework. There aren't many areas across the UK that have been able to discharge something in a very similar way, and the fact that we've got 95 to 100 per cent compliance on that is a real improvement, I think, over the last couple of years. But, because of the volume of patients we treat, you can't take any of that for granted, and it's absolutely important not to be complacent.

[452] **Rhianon Passmore**: Okay, thank you.

[453] **Rhun ap Iorwerth**: What has changed since 2011? Because a lot of what you have said could have been said in 2011, when some of the original criticisms were raised. And I accept that the existence now of the value and efficiency board is something that's different. What are the other examples of what has changed that could give people faith that Welsh Government is able to drive through change?

[454] **Dr Goodall**: Jean may want to come in, but I've been involved in managing operational services over 25 years in the NHS, and catering services would have been seen to be something that facility staff do. Of course, they are involved in provision and they are expected to do that with some excellence. I think the change that has come is about setting that delivery of service in the context of the professional expectations for the service. And I think that joining up of professional care alongside those operational functions, for me, has probably been the most significant change over that period of time.

[455] **Professor White**: I think, for me, seeing the nutritional care pathway come in and be fully owned by front-line staff is one of the things I'm most reassured about. The fact that there are clear steps that everybody must follow. So, patients must be assessed, they must be weighed, they must be referred if there's any concern. There must be due attention paid to nutrition and hydration and the fact that we're able to look at it and monitor it, I think,

is really important—the whole ethos of valuing the importance of it—because without food and proper hydration, our patients will come to harm. For me, the emphasis and the importance of that is one of the things that I think is much more to the fore than it was in the past, to be honest.

[456] **Rhun ap Iorwerth**: Wel, diolch yn fawr iawn i chi. Rydym wedi bod drwy'r rhan fwyaf o'r hyn yr oeddem wedi bwriadu ei drafod. A oes yna gwestiynau ychwanegol y mae unrhyw aelodau o'r pwyllgor yn dymuno eu gofyn?

Rhun ap Iorwerth: Well, thank you very much. We have covered most of what we wanted to discuss. Are there any additional questions that any members of the committee would like to raise?

[457] **Mohammad Asghar**: Thank you very much indeed, Chair, and thank you to you both. I wanted to put a proposal to Andrew here now: if you provided ambulance staff with packed meals in their vehicles, rather than them going to the staff canteens and a great time being wasted or spent, that could change ambulance timing. If we just provided them with a meal—only the ambulance staff—a packed lunch, I mean, or dinner, or whatever it is, to stay in the vehicle, that would improve your timing for the ambulances.

[458] **Dr Goodall**: Could I add another hour, Chair, on to your questions there? [*Laughter*.]

[459] **Rhun ap Iorwerth**: It was a little bit off topic.

[460] **Mohammad Asghar**: Andrew, it's only a proposal.

[461] **Rhun ap Iorwerth**: Diolch yn fawr iawn. A gaf i ddiolch yn fawr iawn i'n tystion ni, Jean White a Dr Andrew Goodall, am ddod i roi tystiolaeth heddiw? Wrth gwrs, mi fydd y clerc yn anfon drafft i chi o'r trawsgrifiad er mwyn i chi allu ei wirio. Ond, diolch yn fawr iawn i'r ddau ohonoch chi.

Rhun ap Iorwerth: Thank you very much. May I thank our witnesses, Jean White and Dr Andrew Goodall, very much for coming to give evidence today? Of course, the clerk will send a draft of the transcript for you to be able to check it. But, thank you very much to both of you.

16:26

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o Weddill y Cyfarfod ac o'r Cyfarfod ar 31 Hydref
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Remainder of the Meeting and the Meeting on 31 October

Cynnig:

bod y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod, ac o'r cyfarfod ar 31 Hydref 2016, yn unol â Rheol Sefydlog 17.42(vi).

Motion:

that the committee resolves to exclude the public from the remainder of the meeting, and the meeting on 31 October 2016, in accordance with Standing Order 17.42(vi).

Cynigiwyd y cynnig.
Motion moved.

[462] **Rhun ap Iorwerth:** Rŵan, rwyf yn cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer y busnes a ganlyn, sef eitem 6 heddiw a'r cyfarfod ar ddiwrnod olaf Hydref, os nad oes gwrthwynebiad. Diolch yn fawr iawn i chi.

Rhun ap Iorwerth: Now, I move under Standing Order 17.42 to resolve to exclude the public from the meeting for the following business, namely item 6 today and the meeting on the last day of October, unless there's any objection. Thank you very much.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 16:27.
The public part of the meeting ended at 16:27.