Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Cyfrifon Cyhoeddus
The Public Accounts Committee

Dydd Mawrth, 4 Hydref 2011
Tuesday, 4 October 2011

Cynnwys
Contents

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

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

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Mohammad Asghar	Ceidwadwyr Cymreig Welsh Conservatives
Mike Hedges	Llafur Labour
Darren Millar	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)
Julie Morgan	Llafur Labour
Gwyn R. Price	Llafur Labour
Jenny Rathbone	Llafur Labour
Aled Roberts	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Leanne Wood	Plaid Cymru The Party of Wales

Eraill yn bresennol
Others in attendance

Ruth Marks	Comisiynydd Pobl Hŷn Cymru Commissioner for Older People in Wales
Rebecca Stafford	Swyddog Polisi, Swyddog Comisiynydd Pobl Hŷn Cymru Policy Officer, Office of the Commissioner for Older People in Wales
Sarah Stone	Dirprwy Gomisiynydd Pobl Hŷn Cymru Deputy Commissioner for Older People in Wales
Dave Thomas	Swyddfa Archwilio Cymru Wales Audit Office
Huw Vaughan Thomas	Archwilydd Cyffredinol Cymru Auditor General for Wales

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

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

Dechreuodd y cyfarfod am 9.01 a.m.
The meeting began at 9.01 a.m.

Ymddiheuriadau a Dirprwyon
Apologies and Substitutions

[1] **Darren Millar:** I welcome everyone to the meeting. I remind you that you may speak in English or Welsh, as the National Assembly for Wales is a bilingual institution. Headsets are available to the public for translation and amplification—channel 0 is for amplification

and channel 1 is for translation. Please switch off your mobile phones, BlackBerrys and pagers, because they can intefere with the broadcasting equipment. If the fire alarm sounds, we should follow the instructions of the ushers, who will lead us to a place of safety. I have not received any apologies and it is good that we almost have a full house—I assume that Jenny is on her way.

9.02 a.m.

Materion sy'n Ymwneud â Llywodraethiant ac Atebolrwydd Archwilydd Cyffredinol Cymru
Issues of Governance and Accountability in Relation to the Auditor General for Wales

[2] **Darren Millar:** We have had some discussions on this, formally and informally, in previous meetings. In order to move things on, I move that

the committee resolves, under Standing Order No. 17.7., to establish a task and finish group of the Public Accounts Committee to consider the issues of governance and accountability in relation to the Auditor General for Wales.

The remit of that task and finish group will be to advise the Assembly on the appointment of auditors to the accounts of the Auditor General; to consider the annual estimate and accounts of the Auditor General; to consider matters relating to governance and accountability of the Auditor General; to consider matters relating to the nomination for appointment of an Auditor General for Wales and to consider other matters remitted to it by the Public Accounts Committee.

The duration of the task and finish group will be for the 2011-2012 Assembly year and it will cease to exist on 20 July 2012.

The membership of the task and finish group will comprise Darren Millar AM, Mike Hedges AM, Aled Roberts AM, and Leanne Wood AM, with Darren Millar elected as Chair.

The proposal is that I will take the Chair on an interim basis, and that we will rotate the Chair at the end of each Assembly term. Are Members content for the task and finish group to be established? I see that you are.

Derbyniwyd y cynnig.
Motion agreed.

9.04 a.m.

Adroddiad ar Arlwyo a Maeth Cleifion mewn Ysbytai gan Swyddfa Archwilio Cymru
Hospital Catering and Patients Nutrition Report from the Wales Audit Office

[3] **Darren Millar:** Members, we have an excellent briefing that has been prepared for us for this session by the Research Service, which contains a number of questions that have been allocated to individual Members. You may stray from that as much as you like.

[4] We received a briefing on this from the Auditor General for Wales and his team a number of weeks ago. I am delighted to welcome to the committee today Ruth Marks, the Commissioner for Older People in Wales, Sarah Stone, the deputy commissioner for older people in Wales, and Rebecca Stafford, policy officer at the Office of the Commissioner for

Older People in Wales. A briefing has been prepared and circulated to Members. Thank you for the interesting paper that you submitted to us. I remind Members that the accounting officer responsible for hospital catering will give evidence to this committee on 8 November, so that we can receive further evidence on this important issue. There was concern when the auditor general produced his report. The older people's commissioner has referenced these sorts of issues in the past on many occasions, but most recently in the 'Dignified Care?' report that was produced in March this year. I will start with questions, unless you have some introductory remarks, Ruth.

[5] **Ms Marks:** Yes, I do. We were offered the opportunity to make brief opening comments, and I will do so if that is convenient. Sarah, Rebecca and I are keen and able to answer any questions that you may have. First, thank you for the opportunity to give evidence to you today. I hope that the information that I provide will support you in developing a robust set of recommendations for the Welsh Government. The commission looks forward to monitoring developments in this important area, going forward.

[6] The United Nations principles for older persons state that older people should have access to adequate food and water, and have access to healthcare to help them maintain or regain their optimum level of physical, mental and emotional wellbeing. Given that people over the age of 60 accounted for 47 per cent of in-patient admissions in 2009-10, and that this figure is likely to increase as the number of older people continues to grow, hospitals in Wales have a clear duty to ensure that the food they provide meets older people's needs, and that the appropriate support is available to provide assistance with eating and drinking—something that I have too often found lacking.

[7] Between January 2008 and December 2009, there were over 228,000 instances where an older person spent five or more days in hospital. As demographics change in Wales and the number of older people increases, this figure is also likely to increase. This means that the effect of poor hospital food and the experience of being in hospital will have an even greater impact. While some of the evidence received during my review into older people's experiences in hospitals relating to dignity and respect suggested that some older people enjoyed hospital food and felt that they had all the help that they needed to eat it, there were significant examples where this was not the case.

[8] Evidence received suggested that there are often failures to cater for dietary needs, for example coeliac disease, lactose intolerance and diabetes, as well as for dietary choices, such as an older vegetarian with dementia being fed meat dishes. The evidence also suggested that inappropriate food was being given to patients with swallowing difficulties; in some cases, guidelines were not being followed. This included one example of a relative who found an older person choking and had to perform lifesaving action in the absence of nursing staff. I am sure that all committee members will agree that that is unacceptable.

[9] Ultimately, the nutritional quality of food is irrelevant if the food never reaches the patient's mouth, either because it not suitable or because they have not received the help they need to eat it. Timely assistance with eating and drinking was an issue of concern raised by a significant number of people during our hospital review and in the regular discussions that we have with older people across the country. It is vital that good practice is shared effectively and rolled out more widely where appropriate. Similarly, a co-ordinated approach must be developed to effectively capture the experiences of older patients, their families and carers while they are in hospital and to ensure that their input is considered during planning stages. The Wales Audit Office report notes that hospital food and nutrition have improved over the past few years. We must build on this to ensure that we challenge the low expectations that many older people have of the care they receive in the broader context of health service improvements. Thank you again for the opportunity to make these introductory comments and to give evidence today. All three of us are looking forward to the questions and discussion.

[10] **Darren Millar:** Thank you, Ruth, for those opening remarks. I think that all of us, as Assembly Members, were shocked when we read your report and your paper. Your opening remarks have further highlighted the need for this issue to be addressed in its entirety. I know that your report was presented not only to the Assembly, but to the Government, which gave a response and agreed that action needed to be taken on this issue. However, you also wrote to individual NHS bodies across Wales. What kind of responses like did you receive from those NHS bodies? Were you satisfied with the actions they agreed to take to address some of the shortcomings identified in your report?

[11] **Ms Marks:** The responses from some of the bodies still subject to review are still being assessed because the Commissioner for Older People (Wales) Act 2006 sets out a set of statutory time frames in relation to conducting a review. Therefore, the report issued in March this year required bodies to respond within three months. I am pleased to say that the Welsh Government, the local health boards, Velindre NHS Trust and all the councils responded within that time. We assessed those responses and fed back to all of those bodies that, although we were pleased with the information that had been supplied, I required further information in order to be persuaded and convinced that the recommendations were accepted and that effective action plans would be put into place to make improvements.

[12] The statutory time frame that then kicked in was one month, and, again, I am pleased to say that all the bodies subject to review responded to that in good time. Therefore, a few weeks ago, I corresponded with the Welsh Government, all the health boards, Velindre trust and all the local authorities in Wales to inform them that some of those organisations had provided sufficient information to close the review process at that particular moment, while we retained the opportunity to follow up and monitor in future and to arrange a good practice sharing event in spring next year. However, several of the health boards and the Welsh Government needed to provide further additional information. I issued those bodies with a supplementary notice. We are still within the time frame for that. So, I suppose the best reflection is that I am optimistic, because the discussions that we have had with the Welsh Government and all the health boards have been positive and indicated that these bodies are accepting the recommendations and looking very hard at how they can make them a practical reality to improve patients' experience in hospital. However, we are still within the time frame of receiving that information and assessing it, so the process is not quite over just yet.

[13] **Darren Millar:** I remind Members that the 'Dignified Care?' report went into issues other than hospital catering, but, of course, hospital catering was one of the issues it shone a light on. Before we go to the rest of the questions, I wish to touch on the issue of those responses you are still assessing or waiting to finalise. What proportion of those responses relates to hospital catering? Is that the area that is deficient or is that an issue you are satisfied is being addressed through the action plans that have been produced?

[14] **Ms Marks:** The 'Dignified Care?' report did not make any specific recommendations on hospital catering. One of the reasons for that is that we liaised very closely with the auditor general's team that was conducting the review of hospital catering to ensure that we did not duplicate any of the work of that review. We maintained a close liaison throughout all of our work and all of its work to check how things were progressing and so on. So, the information that is still outstanding from the bodies that are providing information under the supplementary notice requirement is linked to privacy of information, aspects relating to capturing patients' experience and a couple of other matters that we have the details of. If you want, we can go through that detail carefully.

9.15 a.m.

[15] **Darren Millar:** We are looking at hospital catering in particular this morning, but

that information would be useful for committee members to have. Do you believe that the awareness of hospital staff is sufficient with regard to patients' nutritional needs, particularly those of older people? You mentioned three particular categories of individuals who were not being properly catered for in many cases—people with coeliac disease, lactose intolerance and diabetes. What is the awareness of staff like in respect of those particular conditions?

[16] **Ms Marks:** If it is acceptable, Chair, I would like to make an opening comment and then ask whether Sarah or Rebecca, who were closely involved in the review process, have any other information to share with the committee. The opening comment is that the overall awareness of all staff working with and supporting older people in hospital settings requires some further attention. Older people make up significant numbers of hospital in-patients and 'care of the elderly medicine' is now really general medicine and needs to run through the whole of training and continuing professional development and awareness for all staff working in hospital settings. That is my opening comment, but Sarah or Rebecca may have specific points to make on catering and particular needs.

[17] **Ms Stone:** It might be useful to add something that came through in our review, and it is also something that older people speak directly to me about, namely the issue of communication between staff and family around dietary needs. One situation is where someone who should not be given porridge, for example, because of their condition, is actually given it, and the family communicating that that should not happen only for it to happen again the following day. So, it is a question of good communication and taking dietary requirements seriously, whatever they are, and ensuring that those messages get passed on effectively. That is one of the key themes running through this issue.

[18] Another theme, which also runs through the Wales Audit Office report, as it did with ours, is the inconsistency, in that you just do not know whether you are going to get that communication done well or not. So, learning from examples of where it is done well, so that there is consistent good quality and standard, is one of the real challenges here.

[19] **Ms Stafford:** Our recommendation 12 about knowledge and skills links in with our general feeling that there needs to be better awareness of the impact of the ageing process across all staff grades, which would take into account the impact of some of the conditions that older people tend to have.

[20] **Mohammad Asghar:** The Wales Audit Office has given a dismal report regarding nutritional needs. It stated in its report that information is often missing, that too many patients with nutritional problems do not have a care plan in place and that recording food intake for at-risk patients is not always carried out. These are serious allegations of things are not being done properly for our patients. Is current policy on nutritional screening, such as the all-Wales nutritional care pathway and the all-Wales food record chart, being effectively and adequately adhered to? How could they be improved?

[21] **Ms Marks:** The points made about following guidelines and regulations to ensure that patients' nutritional needs are met feeds back to Rebecca's point about knowledge and training for all staff, but it also links in to two other points. The first is in relation to ward leadership and ensuring that people who are in charge of wards not only have all the current and up-to-date training skills and experience, but that they are also empowered to encourage and challenge staff to follow guidelines and look after the best interests of all the patients on the ward. The second point that is important to make is about the fear of complaining, which was a very live issue during our review, as it very much still is. If the patient feels that things are not quite right or family members, carers or friends who are visiting notice something and think, 'Hang on a minute, that isn't right; there's a tray of food there that hasn't been touched'—Sarah was just telling me earlier on about the family situation of someone whom she met yesterday that I would like her to share with you—there is this fear of rocking the

boat and a feeling of 'Oh, don't say anything, just in case something happens to me or it causes problems'. That situation is just ridiculous. That links in to the evidence from 'Dignified Care?' and is also relevant to patients' nutritional needs. If it is all right, Sarah, I think that it would be interesting for the committee to hear about that particular experience.

[22] **Ms Stone:** Simply, it was about an older person on a ward in a Welsh hospital having a poor experience in a number of ways, including with assistance with eating. She talked to her relatives about it, but then said, 'Don't tell anyone', because she was afraid of what might happen and of reprisals. It does not necessarily matter whether that fear is well founded or not. People have a sense that they should not be complaining, and that is why it is so important to have a good, consistent method of capturing the patient experience, including recent patient experience, that is, the experience of people who have come out of hospital recently, and to find out how it was for them and also capture that from relatives and carers, who will often have an overview of what has gone on.

[23] **Darren Millar:** How widespread are those feelings, that is, of people fearing to make a complaint?

[24] **Ms Marks:** I do not know whether we have any hard evidence with which to provide you, but, anecdotally, I would say that it is very widespread. That is in relation not just to hospital settings and hospital catering, which you are focusing on today, but to the receipt of services that older people can access in all sorts of settings.

[25] **Mohammad Asghar:** My question was about how you can improve all these problems. You have told me the different ways that people are facing these problems, but how will you improve it? That was my question.

[26] **Ms Marks:** I beg your pardon. The way to improve it is to ensure that the recommendations in the Wales Audit Office report are accepted and implemented. I would also recommend the recommendations in 'Dignified Care?' They have been accepted in principle, but we need to see them implemented in practice and then we need to be able to monitor them over the short, medium and long term to see that they are embedded in practice and that people's experiences improve.

[27] **Darren Millar:** I will bring in Aled and then come across to you, Gwyn.

[28] **Aled Roberts:** I found this report frustrating. We are looking at a situation on which the Audit Commission in Wales first reported in 2002, and, although there have been improvements, it is a pretty sad state of affairs. You made reference to the nutritional care pathway. To be a bit parochial, how can we say that nutritional screening has been implemented if, when we look at north Wales, we see that the percentage of patients who are being weighed on admission is 42 per cent? I would have thought that, to ensure that nutritional needs are being met, at the very least, proper screening should be carried out on admission. Have you been able to look at evidence as to what steps management are taking? We have rather large management structures in the NHS, and yet there appears to be a total lack of driving through the recommendations of previous reports as far as management is concerned.

[29] **Ms Marks:** I share your frustrations, Mr Roberts, in terms of previous reports and these reports. We have not scrutinised the management structures, because the unique aspect of 'Dignified Care?' was that it was looking at older people's experiences in hospital settings relating to dignity and respect, but the recommendations that are made as regards the focus on ward leadership, training and awareness for staff and capturing the experiences of patients might begin to make some of the differences and reduce some of the frustrations that you, I and others are no doubt feeling. If there is a chance, Sarah wants to come in here as well.

[30] **Ms Stone:** The report says that the boards receive only limited information on the delivery and performance of catering services. It specifically says that

[31] 'these reports do not include information on important areas such as progress with implementing the all-Wales nutritional care pathway'

[32] and so on. If I can connect that to our own report,'Dignified Care?', we talk about the role of the board as being critical in leading change, because we are talking about change—we are talking about shifting from where we are to consistent high-quality delivery. Involving the board in issues of dignity and respect is key with regard to help with eating, but also, if this is going to change, then the board needs to know about it, lead on it, and have reports on it. If you look at page 51 in the Wales Audit Office report, that is specifically referred to.

[33] **Aled Roberts:** Going back to page 25, it says that:

[34] 'We found evidence that some NHS bodies monitor the compliance'.

[35] Are you able to give us any flavour of what 'some' means? Is it 10 per cent or 70 per cent? Presumably it is the Auditor General for Wales whom we have to address that question to.

[36] **Ms Marks:** I believe so, Mr Roberts.

[37] **Aled Roberts:** Okay.

[38] **Darren Millar:** Jenny, do you want to come in on the leadership issue, and then I will bring Gwyn in?

[39] **Jenny Rathbone:** I am a bit unclear about how rigorously you pursue your recommendations, because you are coming across a little bit as passive bystanders. You say that boards only get limited information on nutrition, but what is stopping you from sending your report to all board members? I am thinking in particular of non-executive board members, because they are the lay people who should be driving this sort of issue—it is not a medical issue. I am unclear as to why you have not followed through with ensuring that all boards are discussing your recommendations and bringing in action plans to implement things of this importance.

[40] **Darren Millar:** To be fair, the older people's commissioner in her opening statement made clear that her recommendations were being followed up with the individual LHBs, and that that process is still ongoing, and the recommendations are being revisited constantly. Of course, the Wales Audit Office report is another matter. I think that that was a bit unfair.

[41] **Jenny Rathbone:** Okay, it is just that Sarah Stone said that board members only get limited information, but it is up to them to ask—

[42] **Darren Millar:** You can certainly ask about nutritional standards and awareness of those among board members; that is a fair question.

[43] **Ms Marks:** Certainly in relation to the older people's commission report 'Dignified Care?' we are not being passive in any way. I would also note that the Welsh Government, the local health boards, Velindre NHS trust and the councils are not being passive in their response and engagement with our statutory process. In relation to the Wales Audit Office report into hospital catering and nutrition, there are some important recommendations that have close links to the findings and the recommendations of 'Dignified Care?', and the

opportunity for boards and for management—picking up Mr Roberts's point as regards management structures—to get an overall sense of the numbers and complexity of older patients staying in hospital, whether that is for a short time or, often, a long time in different ward settings, and the impact in relation to the issue of being weighed on admission. That whole experience, of which food is obviously an important part, is one that we need greater engagement with and greater understanding of. The aspect of my report around capturing patients' experience would be particularly helpful in that regard, I believe.

[44] **Gwyn R. Price:** Do current and proposed policies adequately take into account the nutritional requirements of older people? I can open that up a little more, because you rightly say that, while it is important, it is irrelevant if it does not reach the mouth of the patient. Could you answer on that, please?

9.30 a.m.

[45] **Ms Marks:** The point that I will start off with in relation to that question is that of the need for regular assistance. Many older people in hospital settings need regular assistance. We heard about incidents involving people who had possibly had a stroke and who were, rightly, identified by staff as requiring support—possibly through the red tray system, which has been acknowledged and rolled out across the country. However, when different members of staff come on shift they may not appreciate the range of skills and abilities that a particular patient has. A tray is placed before the patient and, when the trays are collected, that person has not had the chance to touch their food because they need assistance or they have difficulty swallowing and so on. Such situations are unacceptable.

[46] The point that we made in 'Dignified Care?' about the appropriate use of volunteers is one that I would also recommend to the committee for consideration. We know that protected meal times have been widely appreciated by patients, staff and families. However, protected meal times are only any good if someone can eat the food that they have chosen from a menu, which, hopefully, contains appropriate choices. There needs to be assistance during meal times, whether someone needs help to eat or someone to sit with them and encourage them, spending the right amount of time in a considerate manner. Some of the evidence that I read was about someone putting a spoon to someone's mouth and not allowing someone to finish a mouthful of food before being given the next. You can imagine what that is like and how that feels. That certainly does not provide a dignified experience.

[47] **Darren Millar:** Before Leanne asks her question, Julie wants to come in on this point.

[48] **Julie Morgan:** Do you think that it is physically possible for nurses and hospital staff to respond to all of the needs of elderly, frail people? I support very strongly what you have said about volunteers, but, having spent quite a lot of time in hospital, trying to help elderly people to get their meals, I think that it is almost impossible for the staff to cope with people's needs. That is why you have to look for other solutions.

[49] **Ms Marks:** It is a very good and appropriate question. Our inquiry panel featured people with nursing experience. We discussed our findings and proposed recommendations in advance with the Royal College of Nursing, which endorsed the desire for staff to provide the most effective and dignified care that they possibly can, but recognised that the pressure on staff in different circumstances varied.

[50] I would like to come back to one point on ward leadership in that regard. Where possible and where appropriate, volunteers—who can include family members and carers—assisting at meal times is seen as highly appropriate and not stepping on the toes of staff. However, the opportunity for ward managers to have all of the information on their staff

portfolio, the quota of staff and being able to call on additional staff when needed, and so on, was also something that we picked up during the course of our work. Sarah or Rebecca might have something to add to that if you would like a bit more information.

[51] **Ms Stone:** One of the things that our panel talked about was variation, even within the same hospital. Different ward leaders face similar pressures—the pressures that you talked about—and some deliver well, but, in other places, the experience of patients was not nearly as good. So, the level of staff is important, but there is also an issue with regard to how empowered the ward leader is to select their own staff, the way in which they exercise that leadership, the messages they send out and the priorities that are communicated. Certainly, our panel did not think that it was simply a question of staffing; there are other things in the mix. There is real hope there, because, if people are doing it well in some places, it means that we can learn from that and do it well in others, even in difficult financial times.

[52] **Darren Millar:** Mike, do you want to come in on this point?

[53] **Mike Hedges:** I would like to start by saying that this is the first time that I have read—and I am pleased to see it—that it does not matter how nutritionally balanced a meal is if people are not eating it. I wish that that message could get out a lot more. People seem to be interested in the input and less interested in what happens to it afterwards. That was just a comment. For those who know the Swansea area, the *South Wales Evening Post* has been engaged in fairly lengthy discussions with people who have been in hospital about the quality, quantity and type of food served. Some said it was inedible and some had really enjoyed it. One thing that is not mentioned here—although I may have missed it—is the provision of food that people actually want. The kind of food that an 80-year-old and a 20-year-old like can often be substantially different. Many elderly people have not eaten out as often as people do now, and the variety of food that many of us have taken for granted in recent years, such as different ethnic meals and so on, is food that many elderly people have never taken to. Are we making sure that the food in hospitals is what people like? I know that a lot of elderly people will think that if the meal does not consist of meat and two veg, it is not a proper meal.

[54] **Ms Marks:** Those were very interesting points, Mr Hedges, which emphasise the importance of focusing on the individual and the fact that we are all different. If we were offered lunch in a couple of hours' time, we would probably all choose something different. If we were not well, vulnerable and in a hospital bed, having a good selection to consider, often a day in advance—as the Wales Audit Office report states—would be really important. The choice of menu should reflect the diversity of patients who are in the hospital. Again, this emphasises the importance of focusing on individual patients' needs. There is also an issue about raising people's expectations about what good care looks like and that should include a good menu choice for different types of meals. Snacks are another issue that is addressed in the report. However, in terms of the three main meals of the day, having a good selection is imperative.

[55] **Leanne Wood:** Clearly, different people have different needs, so different levels of assistance will be required. You mentioned in your answer to the last question the importance of focusing on the individual. Can you expand on that and let the committee know what good practice looks like?

[56] **Ms Marks:** I will start with a couple of comments, and I will see if Sarah and Rebecca have any other comments to add. I will begin with the importance of being able to focus on the person on admission or on a move to a different ward, and the point that Sarah made earlier about consistency. How can a patient be recognised in one ward as someone who has a set of particular needs and for those to be addressed either by staff or a member of the patient's family, only for those to be ignored on another? One piece of evidence that we received gave an example of someone's mother in her 80s who was encouraged to visit her

husband while he was on one hospital ward, and she gave assistance to him during meal times and during his stay on that particular ward. When he was moved, his wife was apparently not allowed to visit, support and assist during meal times, therefore her husband did not enjoy the same support and meal time experience. That was evidenced in our report and in the Wales Audit Office report.

[57] There are two elements to be considered: communication and an awareness of how important such support would be. If basic information is not shared effectively within a hospital or between hospitals—because those sorts of moves happen as well, and there may even be moves from one LHB to another—and if the staff are lacking a basic awareness of the importance of that in the midst of the many other things that they are juggling and dealing with, combined with the ward manager not being empowered to make sensible decisions and choices, that all adds up to a cocktail of it not being a good experience for the patient. Sarah and Rebecca might have points to add on that.

[58] **Ms Stafford:** In one of those cases, it was an issue of different interpretations of protected mealtimes on wards at the same hospital. One ward manager was happy to let relatives come onto the ward, while other ward managers protected mealtimes in the fullest sense and told relatives that they could not come in. So, there is that inconsistency between hospitals, and within hospitals in some cases.

[59] **Leanne Wood:** If you do not mind me saying so, I have heard a lot of explanations as to what the problem is and a lot about the bad practice. It would be useful if we could hear what good practice looks like.

[60] **Ms Stafford:** One of the examples that we included in the written evidence was the housekeeper role that we saw in one of the hospitals. In the half an hour or so before the meals arrived on the wards, it was someone's dedicated job to get the individual patients who needed assistance sat up with their trays within reach, their hands washed and their dentures fitted and so on. So, when the meals arrived on the ward, they were able to get them out to patients quickly. I think that they reduced the time for getting a meal to a patient from about 20 minutes down to about eight or nine minutes. Everything was ready; meals were not left waiting while someone tried to get people ready. That was the conversion of a healthcare assistant role to a housekeeper role and that dedicated role really seemed to work. However, again, that was an example on one ward; it was not common practice even across that hospital.

[61] **Leanne Wood:** Things are going the other way on wards, are they not? Due to financial pressures, staff numbers have been reduced in some cases. Do you have any experience of the impact of financial reductions on the quality and quantity of care provided? Do you think that it is going to get worse?

[62] **Ms Marks:** At the moment, we do not have any evidence of the impact of the financial situation on care on the wards. We are monitoring this across the whole of the public service and we are in discussions with the Welsh Government about how it is monitoring its impact on the lives of older people. However, no, we do not have any specific evidence on that at the moment.

[63] **Leanne Wood:** You said that good practice would mean one dedicated person on a ward taking care of all of this. Some facilities may already have that, some do not. Given the financial squeeze, it seems unlikely that new people will be appointed to those roles. Can you suggest any other good practice that does not involve additional staff?

[64] **Ms Marks:** One example would be the appropriate and effective use of volunteers. We found evidence of schemes for ward volunteers known as Robins in north Wales and

south-east Wales. Some of those volunteers have received training and some schemes have arrangements in hospitals and LHBs in relation to assistance with feeding, and some do not. Again, that takes us back to the inconsistency that we have found on many occasions, not just in relation to guidelines or communication, but in relation to volunteer schemes. Sarah, do you want to add something on this?

[65] **Ms Stone:** Yes, I think that the example given related to the redeployment of staff, not additional staff. That is a really important issue. In the process that we are in with the health boards, Welsh Government and local authorities, in which we have been receiving action plans in response to our report, what we have not been hearing is, 'We can't afford to address this agenda'. No-one has said that they cannot afford to do it. I think that the feeling is that we cannot afford not to do it. Behind that, there may be a lot of concerns about the reality of money and all the rest of it, but in the explicit responses that we have been given there has been no reference to the fact that resources are too limited to do this. So, I have a reasonable sense of optimism that people mean that. I think that we have a fair wind and a sense that this is the agenda of now—trying to treat patients much better, as people in fact. We need to watch this process very carefully, but I think that there is a will to try to improve.

[66] **Darren Millar:** A couple of other people want to come in on this now. Leanne, do you want to come back on that very briefly?

[67] **Leanne Wood:** I just want to make the point that, if that is the case, a lack of money should never be seen as an excuse on this from now on.

[68] **Ms Marks:** Absolutely. I also wish to acknowledge the fact that the Welsh Government has determined that dignity and respect in hospital settings is to be a tier 1 priority; that is something that we welcome very much indeed.

9.45 a.m.

[69] **Gwyn R. Price:** To go back to the lady who could help her husband while he was on one ward, but who was not allowed to do so on another ward, what is your conclusion on all that? Did someone override the decision and say, 'Well, this is the commonsense approach' and was there any conclusion to that? If there is no outcome, one ward will be playing against another in the same hospital; consistency does not seem to be coming through in that instance.

[70] **Ms Marks:** Absolutely. To reinforce the description that Rebecca gave, as an additional response to that point, it is about the empowerment that different ward managers feel or experience to be able to say that common sense will prevail, as opposed to merely complying with a rigid analysis of guidelines or regulations around protected mealtimes. Again, I do not know if Rebecca has anything to add on that.

[71] **Ms Stafford:** No.

[72] **Gwyn R. Price:** Was there an outcome to it or are those same ward managers still allowed to manage their wards in their own way, irrespective of the overall policy of that hospital?

[73] **Ms Marks:** The 'Dignified Care?' recommendation was that ward leaders should be empowered to be able to make those decisions. In relation to that particular case, it was part of evidence that was gathered during the process. So, in relation to that particular patient—that particular gentleman and his wife—we will have gathered that evidence as part of that. So, in relation to that circumstance, I do not have the information to give you at the moment with regard to what that outcome was. We might be able to track that through our evidence gathering if you wanted us to, but I do not have that information available.

[74] **Darren Millar:** I think that the wider point is the more important one, about the inconsistency in approach, even within a single hospital.

[75] **Jenny Rathbone:** Chair, I disagree; it is very important to know how these things are followed through, otherwise why are we gathering this information? There are complaints procedures in each hospital. If you found that particular piece of evidence of inconsistency between one ward and another, what was then done with that evidence? Simply recording it is interesting, but it is not going to change the situation.

[76] **Ms Marks:** My powers enable me to issue a report with recommendations, which I have done, and to follow through in relation to responses from the Welsh Government and the health boards as regards whether they accept those recommendations and whether they are going to implement them, and that is the process that we are currently in.

[77] **Jenny Rathbone:** So, that hospital knows that it is the one being talked about in this instance, in this particular case with the 82-year-old?

[78] **Ms Marks:** No, it does not.

[79] **Jenny Rathbone:** You have cited it in your report, so does the hospital in question know about it?

[80] **Ms Marks:** I will go to Rebecca.

[81] **Darren Millar:** Do you want to respond very briefly? I have other people who want to come in here, Jenny, and I was going to come to you in a few moments.

[82] **Ms Stafford:** The evidence that we gathered relates to instances during the two-year period before the call for evidence was issued, and it was gathered with assurances of confidentiality. If there were any live issues in the evidence—if there were ongoing issues—our team in the office went back to the people to see if any further assistance could be offered or advice given around issues like complaints. However, in some cases, we had complete stories that tracked through from the experiences, and those experiences had concluded, if you like. Often, the evidence did not give us the name of the hospital; sometimes it did not give us an area of Wales. It may have been an anonymous e-mail. Any evidence that was given to us from hospital visits was given under the guarantee that it would be kept anonymous and nothing would be tracked back to the hospital that could identify individuals.

[83] **Darren Millar:** Do you want to come back very briefly on that, Jenny?

[84] **Jenny Rathbone:** I am just concerned whether fact-checking is going on. One person's perception is important, but the facts may be at variance with the perception, and if there is no fact-checking with the hospital concerned, how do we measure the accuracy?

[85] **Darren Millar:** The issue, as I understand it, Jenny, is that no-one has disputed the findings of the report, and every single health board and the Welsh Government have accepted the recommendations. So, no-one is disputing the quality of the evidence that has been gleaned by the older people's commissioner.

[86] **Jenny Rathbone:** They are not in a position to dispute it because they do not know which hospital is being referred to.

[87] **Darren Millar:** To be fair, no-one is disputing the evidence that has come in and everybody has accepted the recommendations. The committee has heard two very powerful

messages this morning. I accept that it would be impossible to track each individual case that has been reported to the older people's commissioner, particularly if information is coming in on an anonymous basis.

[88] **Julie Morgan:** The only way that you will get this evidence is by having confidentiality. We must accept that that is the basis of getting this evidence, and then it is up to us, and the agencies and boards involved, to ensure that standards improve. The reports place an onus on us, as politicians, to take things forward. The only way that you can get this evidence is by using confidentiality.

[89] **Darren Millar:** Ruth, you indicated earlier that many people are afraid of being identified as making a complaint, because of the consequences that they fear, rightly or wrongly, as a result of making that complaint. Therefore, anonymity is even more important with regard to getting the messages out from individual patients about their experiences. The bigger issue is how people record their experiences. How are these to be captured in the future? Ruth, you have made some clear recommendations about that in your report, which we will come to in a moment. I am conscious of the time and that other Members want to come in here. I will come back to you in a second, Jenny, because I know that you have other questions that you want to ask, but Aled wanted to come in.

[90] **Aled Roberts:** Yes. Although I understand the confidentiality issue, I think that Jenny does have a point. We have already heard that individual boards vary in the degree to which they have become interested in this subject, but without them knowing that they have specific problems, or that there are criticisms of individual institutions or variations between wards, I do not understand how they are going to tackle the issue on a hospital-by-hospital basis.

[91] Mae gennyf fodryb sydd wedi bod yn Ysbyty Maelor Wrecsam ers chwe wythnos. Nid wyf yn cyd-weld â Leanne. Yr wyf wedi ei gweld yn yr ysbyty, ac nid diffyg arian yw'r broblem bob tro, ond y gwastraff bwyd sy'n mynd yn ôl o'r ward bob dydd. Nid yw hyd yn oed yn fater o bobl yn cael problemau wrth fwydo eu hunain. Mae'n ymwneud â safon y bwyd a'r ffaith ei bod, yn aml iawn, yn anodd i unrhyw un ei fwyta. Mae fy modryb yn 85 oed ac mae wedi dweud wrthyf ei bod yn fodlon iawn â safon y gofal a roddir gan y nyrsys ac ati ar y ward. Fodd bynnag, y teulu, i ryw raddau, sy'n gorfod mynd â bwyd iddi. Mae hynny'n iawn i bobl a chanddynt deulu, ond yr hyn sy'n fy mhoeni yw bod yn rhaid i lawer o deuluoedd yn y gogledd deithio am filltiroedd, ac mae'n bosibl mai dim ond unwaith neu ddwywaith yr wythnos y byddant yn ymweld. Beth sy'n digwydd i'r bobl hynny pan na allant fwyta'r hyn sy'n cael ei roi o'u blaenau?

I have an aunt who has been in Wrexham Maelor Hospital for six weeks. I do not agree with Leanne. I have visited her in hospital, and the problem is not always lack of funding, it is the wasted food sent back from the ward daily. It is not even a matter of people having problems feeding themselves. It is to do with the standard of the food and the fact that, very often, it would be difficult for anyone to eat it. My aunt is 85 years old and she has told me that she is very happy with the standard of care given by the nurses and so on on the ward. However, it is the family, to some extent, that has to take food in for her. That is fine for people whose family is able to do that, but what concerns me is that some families in north Wales have to travel for miles, and they may only be visiting once or twice a week. What happens to those people when it is not possible for them to eat what is in front of them?

[92] **Ms Marks:** The points that you have picked up in relation to the Wales Audit Office report about the waste and standard of food link back to some questions and discussions that we had earlier with regard to the options and choices that are available, and focusing on that individual person. The point that you also made with regard to whether someone has a family member or friend to visit, whether it is to assist at mealtimes or just to visit and spend some

time with a relative or friend, endorses the relevance of appropriate use of volunteers to provide additional support and company to the patient while they are in hospital.

[93] **Aled Roberts:** Yr oeddech yn sôn am gynllun gwirfoddoli Robins yn y gogledd. Nid wyf yn ymwybodol o'r cynllun. Pa mor eang yw'r defnydd o gynlluniau o'r fath?

Aled Roberts: You mentioned the Robins volunteering scheme in north Wales. I am not aware of the scheme. How broad is the use of such schemes?

[94] **Ms Marks:** As far as I understand, the Robins volunteering scheme started in north Wales. Rebecca or Sarah may have more detailed information for you. It has been rolled out to other health boards as part of good practice sharing and so on. I do not know whether we have details in the report about the Robins scheme.

[95] **Ms Stafford:** There is reference in the report to the evaluation of these schemes and how well they work. I do not know how widespread it is in north Wales but I know that it is quite successful there and that the board is looking again at taking that forward and expanding it across other hospitals and wards. We could certainly try to get in touch with our contacts up there to ask whether they can provide some more information.

[96] **Darren Millar:** I know that the Robins scheme operates in Ysbyty Glan Clwyd, the local hospital serving my constituency, and it is very successful and well received.

[97] **Ms Marks:** I just want to reinforce the point about the sharing of good practice. That is one example of a practice that we heard about in north Wales and which we saw in north and south Wales. One of the recommendations that has been received by local health boards, the Welsh Government and partners, including the NHS Confederation and the Royal College of Nursing and so on, is to share the opportunity to build on learning exchanges, as the Wales Audit Office and other networks have, to ensure good practice, particularly good practice that demonstrates good value for money as well as focusing on patients' needs. We are keen to include that in our monitoring and follow-up work to ensure that people are not reinventing the wheel and that we are not missing a trick by not capturing something that is working effectively and could easily be rolled out, provided that people have the basic information and frameworks with which to do it.

[98] **Darren Millar:** Auditor general, you wanted to provide some information that might be useful to the committee regarding evidence.

[99] **Mr H. Thomas:** I just want to remind the committee of three things. First, when we produced our report, it was actually the third in a week. The Older People's Commissioner for Wales produced a report on the Monday, followed on the Tuesday by a report from the Public Service Ombudsman for Wales, which again reflected on experiences within hospitals, and then ours came out later in the week. They were not co-ordinated, but they offered a considerable body of evidence.

[100] Secondly, our report is built up from individual reports that were done within local health boards. So, it has not drilled down, at a macro level, but has been built up. That is important, because it has meant that, if there were challenges to what was being said, there was an opportunity to challenge that locally.

[101] Ruth touched on my third point, which is that we have had feedback with regard to learning experiences with hospitals and staff engagement. There has, again, been no challenge to the basic stories, we are told. I accept that, in every case, there will always be another side to the story regarding a particular experience that someone has had in hospital.

[102] **Darren Millar:** Thank you for those comments. Aled, do you want to come back

briefly, before I bring in Jenny?

[103] **Aled Roberts:** A yw'r adroddiadau unigol yn cael eu cyhoeddi? Nid wyf erioed wedi gweld adroddiad ar fy ysbyty lleol sy'n dweud beth yw'r gwendidau o fewn yr ysbyty. Yr ydym yn gweld hynny o ran cynghorau lleol, ond nid wyf yn ymwybodol ein bod yn cael y fath wybodaeth ar lefel leol.

Aled Roberts: Are the individual reports published? I have never seen a report stating what the weaknesses are in my local hospital. We see that with regard to local councils, but I am not aware that we have that sort of information on a local level.

[104] **Mr D. Thomas:** All our local reports are on our website. So, the information that you seek can be found there—on a hospital and ward level.

[105] **Jenny Rathbone:** On the issue of how we share good practice, particularly the housekeeper model of working that you mention on page 54 of your report, which hospital were you referring to?

[106] **Ms Stafford:** We would have to go back to the records of the visits to check that.

[107] **Jenny Rathbone:** I can understand that one may need to be cautious with regard to issues of poor practice, but, in the case of good practice, I cannot understand why you are not mentioning the hospital concerned, because that would enable other hospitals to contact it to identify how it achieved that good practice. We must share good practice in order to move forward.

[108] **Ms Marks:** I agree with your comments. The important thing to remember is that, in relation to the publication of the report back in March, I was determined to have a balanced picture, to demonstrate good practice—I will come back to your points in just a second—as well as highlighting areas where significant improvements needed to be made. The process that we are still involved with is in relation to the recommendations and responses from all the different bodies that were subject to review.

10.00 a.m.

[109] The opportunity with the bodies, individually and collectively through other partners such as the NHS Confederation, to share good practice effectively—once this legal review process is over—is something that we will be taking forward. I can assure the committee that all the bodies that have been subject to the review have been positive about that and are looking at sharing information, through existing systems such as the National Leadership and Innovation Agency for Healthcare and through other ways. We will be playing our part in that. It is not solely our role, but we will certainly be playing a part in that.

[110] **Jenny Rathbone:** I want to pick up on the porridge incident mentioned by your colleague Sarah Stone. I am keen to know how much you are able to tell us about how that came about. What you want to know is whether porridge was marked down on that patient's sheet as something that was counter to their welfare. If so, clearly, there was a failure to follow procedures. Or was it the case that this was not known? In order to understand it, we need to know a little bit more about it and what happened subsequently. Do you receive this information historically, a year after this person—

[111] **Darren Millar:** Jenny, to be fair, a response was given before about the failure within that hospital to communicate the fact that porridge was an inappropriate breakfast to give to that particular patient. That was communicated at the time by the patient's family to members of staff on the ward, and the same problem was repeated the following day. It was down to a lack of communication. I think that we need to get to some of the wider issues in

the report rather than drilling down into individual cases.

[112] **Jenny Rathbone:** Okay, although the specifics can be helpful. The way in which hospitals or any institution improves is by learning from complaints. If hospitals are not aware of these complaints, how can they possibly learn from them? I am interested in finding out how much flexibility exists on each ward to use common sense in the way they manage a ward. For example, we have heard about the situation in a hospital where, on ward 1, a lady was allowed to feed her husband and, on ward 2, someone else was not allowed to do the same. Is there a problem with empowering the matron or the ward manager to look at patients' individual needs?

[113] **Ms Marks:** Yes, there is inconsistency, and that is why we formed the recommendation in relation to ward leadership and the recommendation on overall staff training and awareness. There is inconsistency.

[114] **Jenny Rathbone:** I appreciate that the leadership may vary, but what about the terms of reference of the ward manager?

[115] **Ms Marks:** I think that that would flow from the empowerment and training of the person in charge of the ward at any particular time. The application of common sense to their reading and delivery of the guidelines and regulations they are working to will flow from that.

[116] **Jenny Rathbone:** Okay. I would like to ask you about communal dining areas. Most acute hospitals do not have communal dining areas any longer. What do you think the impact of not being able to eat with other people might be on people's rehabilitation and recovery? Eating with others can be a very good psychological boost and can encourage eating.

[117] **Ms Marks:** Absolutely. I do not have any specific information about communal dining rooms. I will check with Sarah and Rebecca in a moment, but, with regard to evidence gathered in the course of the review, the use of day rooms and supporting patients to get out of bed and sit in a chair next to the bed or leave the ward entirely to go to a day room were issues in which we found inconsistency. The evidence was that these are things that people benefit from. If they were mobile or were able to be assisted to get to a different space for certain parts of the day it was certainly seen as advantageous to the patients, their families and the staff. I do not have any specific information about communal dining rooms, but I will just check with Sarah and Rebecca.

[118] **Ms Stafford:** I believe that the panel saw some examples of one or two hospitals—generally, they were the smaller hospitals—where staff did encourage people to eat together at a table in a day room. I think the panel's observation was that, in some cases, it was a mixed success because people quite rightly had a choice, and some did not want to leave their bed to eat; they wanted to stay there. However, some places were trying to offer that choice and provide a larger table on the ward at which people could be brought together. Therefore, there are some examples of ward leaders trying to take that approach to mealtimes and make them more of a communal event.

[119] **Jenny Rathbone:** Looking overall at protected mealtime policies, how much account is taken of patients' wishes when enforcing these mealtimes? Some people will not want their relatives present if having them there interferes with their meal, but others would want them there, so, how is the matter appropriately managed in the best cases?

[120] **Ms Marks:** Again, I will ask Sarah and Rebecca if they have any detailed comment on that, because I do not.

[121] **Ms Stafford:** Most of the evidence that we received tended to be from relatives

expressing frustration with the protected mealtimes, rather than from patients. Again, that could be down to the circumstances. Quite a number of pieces of evidence were from relatives after their loved ones had passed away. So, we did not always get the perspective of the patient on whether they wanted more assistance and whether protected mealtimes were the issue. In some cases, the issue of assistance was brought up by relatives more often than patients.

[122] **Jenny Rathbone:** So, how do you address the possibility that ward managers were appropriately excluding relatives because it was felt that they were disrupting the patients' ability to eat?

[123] **Ms Stone:** What is important about protected mealtimes is the purpose for which they were suggested, which is to minimise disruption so that clinical procedures, ward rounds and so on can happen. It is difficult to be completely prescriptive about things like this. That is where the leadership and judgment on the ward comes into play. I am not sure that there is a simple answer to what you are suggesting. I think that a good ward leader or manager would be looking at the spirit of protected mealtimes and why they are there, ensuring that that is what is being implemented rather than being doctrinaire about a particular policy. Every great idea has intended consequences. That is why you need people with good judgment on the ground to look at what the end result is supposed to be.

[124] **Darren Millar:** We need to move on; the clock is against us.

[125] **Gwyn R. Price:** What are the advantages and disadvantages of the red tray system?

[126] **Ms Marks:** The advantage is that it indicates to all staff that a particular patient might need some form of assistance during meal times. The disadvantage, as we have heard from patients, family members and staff, is that it might be seen as an obvious label and therefore something that stigmatises certain patients on the ward. That would be my summary, Mr Price. Again, I will check with Rebecca and Sarah whether they have any further detailed comments for you.

[127] **Ms Stafford:** We heard from some members of staff that they found it stigmatising. In one instance, we heard of staff using an alternative method, such as a sign by the bed or something placed near the patient to indicate, more subtly, that he or she needed assistance. Again, it was a bit of a mixed picture. Some people thought it was a good thing to have, while others thought it singled people out on wards.

[128] **Gwyn R. Price:** It demonstrates that nursing staff have often introduced some initiatives themselves. I am aware that when the doctors and consultants come around, they can see straight away that the nutritional needs of the person in that bed are being taken care of. I was wondering if there was a recommendation that pointed to that as a good idea.

[129] **Ms Marks:** It picks up the point that Ms Rathbone made earlier about the importance of sharing of good practice. Where good initiatives that provide alternatives have been developed, and people feel them to be advantageous, the desire would be to share them more widely. That is, if the experience on a ward is that red trays are seen as not being too helpful, and there are other means, people will think, 'Let's share the other ways that we've found that are working'.

[130] **Darren Millar:** Mike, did you want to come in on this?

[131] **Mike Hedges:** It seems to come down to ward management. If you have a good ward manager who knows about the patients who are there, red trays will be superfluous, because they would know which patients need help and would allocate people accordingly. It seems to

come down to good management or otherwise. You seem to be bringing in systems to deal with the fact that, sometimes, management is not adequate.

[132] **Ms Marks:** I understand the point that you are making. The red-tray system is widely used; there are alternatives and there are positives and negatives to it. The points about all staff being trained and ward managers being empowered are incredibly important.

[133] **Julie Morgan:** I was going to ask about specific dietary requirements. We have covered some of this already, but there are cultural or ethnic reasons for having particular types of food, too. Can you tell us whether that aspect is covered? Did you find sensitivity about that type of food being needed?

[134] **Ms Marks:** Again, I will refer to Sarah or Rebecca, if that is okay, Julie. However, I would like to comment that, with the 'Dignified Care?' review, we undertook some additional research in relation to diversity needs and the experiences of black and minority ethnic patients across Wales and found that there was a level of awareness but that more could and should be done. That would be my starting point.

[135] **Ms Stafford:** We did not receive a huge amount of evidence on this and it was noted in the appendix to our report that more research was needed into that aspect specifically. However, our collection of evidence and visits did not highlight any substantial evidence on this point.

[136] **Julie Morgan:** So, you do not have any—

[137] **Ms Marks:** Nothing major to offer at this particular time, no.

[138] **Julie Morgan:** Right, but is it something that you think should be looked into?

[139] **Ms Marks:** In our opinion, yes.

[140] **Julie Morgan:** It seems important for them to—

[141] **Ms Marks:** Absolutely, especially in relation to the nature of your discussions today focusing on hospital catering.

[142] **Darren Millar:** Oscar, you wanted to come in on this issue, and then we will move on.

[143] **Mohammad Asghar:** To follow up Julie's point, which is important, I am pleased to say that I think that, at the Royal Gwent, they have a special system in which they get in halal meat and halal foods regularly for their ethnic minority patients, which is best practice. Not only does it help the patients to improve their health, but the families are grateful for this. I think that they are doing a good job in Newport.

[144] **Darren Millar:** Thank you for those comments.

[145] **Mike Hedges:** How are the views of patients with regard to the standard of care currently collected? How can the experience of older patients, their families and carers be used to help improve the level of care?

[146] **Ms Marks:** This links directly to my recommendation for introducing a robust and consistent method to capture patients' experience of hospital while they are there and after they have left. It links in neatly with the Wales Audit Office point on patients being involved in the planning of meals and any changes in service. Sarah might have a point to add here, Mr

Hedges.

[147] **Ms Stone:** It is difficult to tell what the balance is between good experience and poor experience in terms of nutrition and more widely in relation to dignity and respect. So, from the commissioner's perspective, we used the evidence that we could gather, visited hospitals and so forth and triangulated that information. However, going forward, we need a much more consistent way of measuring the experience of patients and, certainly, the Wales Audit Office report talks about that. In our report, we talk about having a way of capturing the patient experience that allows comparison over time and also between areas. That is a real challenge for the providers of the service, but it is incredibly important to get that right.

10.15 a.m.

[148] **Darren Millar:** Thank you for that. If there are no further questions then I just ask you, Ruth: is there anything in particular that you would like to draw our attention to as regards the evidence that you have been able to help us with this morning? We have covered a lot of territory on the issues of communication in hospitals, menu choice, and identifying specific nutritional needs or support that might be required. Are there any other areas where you would like to give us some more information, just in closing this part of the meeting?

[149] **Ms Marks:** I would first reassure the committee that, in relation to any areas of detail that we did not have available to us this morning, we have made notes and will ensure that we supply that detail, either directly or through the committee clerk. In relation to reassurance, if it is needed, about doing something about situations where something has been identified as going wrong, there were a couple of occasions during the course of the 'Dignified Care?' review where we identified things in situ that were wrong and took action. That was responded to positively in the settings, and we have monitored thereafter and made sure that things that were a cause of great concern in a couple of settings would not continue. The problems that we found in those particular settings have been solved. That is an important point of reassurance that I want to make to the committee.

[150] Secondly, the importance of capturing patients' experience, both in hospital and after a hospital stay, is absolutely vital. That links closely with the Wales Audit Office recommendation on the need to provide timely and appropriate assistance to patients during mealtimes, whether through staff, family members or volunteers. Finally, I would make a point about staff training and ward leadership. Those would be the three points that I would want to leave the committee with.

[151] **Darren Millar:** Thank you Ruth, Rebecca and Sarah for your evidence today. I look forward to receiving the further information that you want to send on to us.

10.17 a.m.

Cynnig Gweithdrefnol
Procedural Motion

[152] **Darren Millar:** Before we move on to the next item, I move that

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

[153] I see that the committee is in agreement.

Derbyniwyd y cynnig.

Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 10.17 a.m.
The public part of the meeting ended at 10.17 a.m.