The Governance of Nutritional Care in Hospital Settings: A Pathway to Sustainable Development?

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THESIS

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ABSTRACT

As part of the economic activity of the state, the concept of the 'Public Plate' is synonymous with sustainable public food procurement, where sustainable development outcomes of democracy and social justice are brought about through the provision of healthy nutritious food and localised supply chains, within a moral economy guided by an ethic of care. The economic activities of the state are also concerned with how public services are designed, delivered and accounted for, as governance. This research explores these issues through a study of the governance of nutritional care in hospital settings, the national context of Wales providing the focus for sustainable development outcomes. By examining the historical development of sustainability and healthcare governance in Wales and adopting a critical realist perspective, the research departs from the focus of existing studies on 'what' needs to be done, and aims to understand 'how' change has been brought about. The research finds that emerging structures for nutritional care in hospitals have been planned, designed and adapted over time, through leadership, learning and collaboration. Equity provides a guide for action, linking individual patients' needs and outcomes, whilst values of dignity and respect guide activities of caring. Quality, patient experience and safety provide evidence of outcomes from those care processes as effectiveness. Effectiveness therefore becomes the driver of efficiency and efficiency drives lowest cost, resulting in best value outcomes. Variations in outcomes in practice lead to the proposition that the mechanism enabling and constraining change is that of capabilities, as an integrative concept linking structural empowerment with both cognitive and behavioural conditions. The challenges to governance are identified within best value as the need to reduce, rather than constrain costs, of particular concern in publicly funded healthcare systems where the demand for care, already in excess of supply, is expected to increase.

Table of Contents

PREFACE

My hospital food research journey began as a small group project during my MSc studies. I already had a personal interest in food and health, from a social policy perspective, but the particular focus on hospital food came about from personal experience. For three weeks during the first semester of my MSc my time was split between lectures in the University and hospital wards in two hospitals in Wales. As a result of a serious spinal injury, my teenage son was admitted to hospital for surgery. Most of his hospital stay was on high dependency wards, occupied by elderly and seriously ill patients. I was fortunate in that staff welcomed my presence for most of the day, but I did observe some of the now well reported shortcomings in relation to nutritional care, as well as the wide variation in the quality of the food served to patients. The opportunity to carry out a research project on hospital food was therefore not to be missed. As a short coursework project however, the study was merely an appetizer!

The PhD journey was approached as a problem solving project. I wanted to know why, when I had observed what appeared to me to be good practice, it was not being replicated elsewhere. The organisational route opened up a whole library of academic work on organisational studies that left me, at times, wondering what I had taken on. Over time I also began to wonder what exactly this often used, but poorly defined, concept of sustainable public procurement actually was, and alighted on the idea that instead of looking at 'what' was happening, I needed to look at 'how' things were being done. The research naturally evolved into one of governance, and as the mysteries of epistemology and ontology unfolded, so did my understanding of the research topic. At the end of the day, had I been aware that the answer would lie in the 3 'E's of effectiveness, efficiency and economy, I doubt I would have left the starting blocks. Although overwhelming at times, there is a huge sense of achievement in arriving at the stage where I feel that I have fulfilled the research aims and answered the research questions.

ACKNOWLEDGEMENTS

LIST OF FIGURES

INTRODUCTION

The primary aim of this research is to understand how change is being brought about in the governance of nutritional care in hospital settings and how this relates to the contextually contingent principles of sustainable development.

Green political theorists view the state as the primary actor in the sustainability transition, by virtue of its authority, financial capacity and persuasive powers. Such debates revolve around the need for radical change of both constitutional and cultural nature (Christoff, 1996; Dryzek, 2002; Eckersley, 1992). Empirical evidence, however, suggests that change remains weak and incremental (Baker and Eckerberg, 2008), framed as ecological modernisation, and attributed to capitalist and neo-liberal values that favour principles of competitive advantage (Carter, 2007; Eckersley, 2004).

States which govern according to neo-liberal values are more inclined towards structuring public services entirely within markets, where devolved autonomy and competition are deemed to be the driver of best value, and markets ensure accountability. More socially democratic minded states, such as Wales, tend to commission services through devolution and partnership, with governance as a mechanism for accountability. Economy, in the latter, is therefore embedded in society, rather than in markets. Empirical studies are also beginning to identify emerging, stronger forms of ecological modernisation (Kitchen and Marsden, 2011), suggesting that long term change comes from more localised governance and also perhaps from a smaller spatial scale.

The primary economic activity of the state is the delivery of public services, governance concerns at this level being how services are structured and delivered to achieve desired outcomes. Outcomes, such as value for money and sustainable development, are however, politically defined and often originate beyond the state, although they can also be integrated into structures by the state as part of a regulatory framework at national and sub-national level. Political values also determine the extent to which the structures of public services are exposed to market forces, although market exposure is inevitable for products not produced by the state, such as food.

The structures, and consequently politics, of public services have been consistently cited as barriers to engagement with change in public procurement, whether as a result of traditional 'silo' or departmental fragmentation, or the resultant loss of

mandate from devolution (Preuss and Walker, 2011; Walker and Brammer, 2010; Deloitte, 2009, SDiG, 2004; House of Commons Environmental Audit Committee, 2005; Accounting for Sustainability Group, 2005; NAO, 2005, Defra, 2006; NAO, 2006). Much of the public procurement literature originates from a narrow managerial task or function, rather than strategic or governance, perspective and associates procurement with sourcing and purchasing activities at the interface of the organisation, as agent of the state, and markets (Murray, 2009). Green procurement relates to environmental concerns, with sustainable procurement extending along the supply chain or network (Miemczyk et al, 2011, Walker et al, 2008; Walker and Preuss, 2008), and social outcomes as a matter of organisational responsibility (Carter and Rogers, 2008).

The concept of the 'Public Plate' is synonymous with sustainable public food procurement, democracy and social justice outcomes brought about through the provision of healthy nutritious food and localised supply chains, within a moral economy founded upon an ethic of care (Morgan et al, 2006, Morgan 2008). Influences on procurement practice are nevertheless political and structural, but cultures also play an important role (Morgan and Sonnino, 2008). Although progress has been made in terms of school food in the UK (Kersley, 2011; Orme et al, 2011; Teeman et al, 2011) similar successes in hospital food procurement have been shown to be both scarce and partial (Sustain, 2009, 2010, 2013; Soil Association, 2011).

Research into the governance of nutritional care in alternative publicly funded organisations, such as hospitals, enables the study of the interactions between agency and existing structural forms over time, to understand how alternative structures emerge and evolve, and thereby provide some explanation of how change is brought about in practice. A processual view also enables outcomes to be related to the contextually contingent conception of sustainable development, as well as deeper understanding of how the governance challenges faced in practice might be overcome.

A search for explanation in context steers the study towards in-depth, qualitative case study methods, and the complexity of meta-processes such as governance the use of theoretical frameworks to guide empirical study. Thus theoretical development precedes field work, the data from which can be used to refine the initial theory, or as in this case, direct the researcher to the patterns within the data where casual explanation might be found.

The context of the case study, Wales, has a constitutional commitment to sustainable development which has also been integrated into the structures of healthcare governance. The constitutional structure of healthcare governance in Wales comprises hierarchy, network and process, service delivery guided by political and ethical frameworks. Organisational processes nevertheless exist beyond objective entities, or 'what is done', in a more abstract process thinking view of 'how things are done'. Thus continuity and change are intrinsic to a processual conception of governance, within which the interactions between stakeholders and structures bring about continuous change.

Within this Welsh healthcare context, the research findings demonstrate that emerging structures for nutritional care in hospitals have been planned, designed and adapted over time. Equity provides a guide for action, linking individual patients' needs and outcomes, whilst values of dignity and respect guide activities of caring. Quality, patient experience and safety provide evidence of effectiveness outcomes from those care processes. This primary operational concern for effectiveness, as a driver of efficiency, has been achieved by restructuring service delivery from function, as a meals service, to process, as the Nutritional Care Pathway. Efficiency is being achieved through the elimination of systemic, as well as physical waste and has been enabled by simplifying and standardising processes. The use of best practice benchmarks enables organisations to demonstrate operational outcomes and improvement for accountability, those benchmarks being determined through democratic processes of leadership, collaboration and learning.

Although these activities have been enabled and are reinforced by partial integration of NHS and Welsh Government structures, there has also been a political commitment against market structures and competitive principles. Effectiveness, put into practice as quality and safety, guides specification and evaluation of hospital food at the point where public bodies are ultimately exposed to market forces in their purchasing activities.

The overwhelming governance challenge for the future, in this context, is to continue to prioritise effectiveness as the primary driver of efficiency and economy, whilst improving, or at least maintaining, stakeholders' outcomes, in an environment where political and economic pressures have shifted from cost containment, to cost reduction.

This thesis is structured in four parts. Part 1 relates to theoretical development and research methods, and sets the background for the empirical chapters. Chapter 1

reviews and synthesises different bodies of literature in order to arrive at conceptual frameworks for governance which guide the research aims, questions, data collection and analysis, as well as the written form of the thesis. The constitutional framework represents the political and ethical frameworks that influence economic activities, and represents structural continuity within which governance processes take place.

As a process, governance represents a cycle of needs assessment, action, outcomes and accountability. Action, in this framework, represents the dynamics of social interaction with structures, and is necessary for abstraction of causal explanation.

Chapter 2 defines the study, outlines the methods used and explains how the critical realist ontology has guided the research design, data collection, analysis and reporting, Pettigrew's theory of emergent change (1997) contributing to the strategy and structure of the study. The governance of nutritional care in hospitals defines the boundary of the study, takes place within the immediate context of healthcare governance, but is also influenced and structurally tied to the Welsh Government. The practice of nutritional care is, however, represented by the Nutritional Care Pathway as an objective and identifiable process, which becomes the embedded case study in the context of the governance of nutritional care.

The critical realist perspective, in seeking to access interviewees' understandings of a particular phenomenon, invites the use of an in-depth case study and multiple methods, with documentary and historical data collection triangulated with open interviews. The role of the interviewee is, therefore, that of informant rather than research subject or respondent, the underlying assumption being that understanding exists independently of the person (Cassell, 2009, p.505). The role of the researcher is independent and of minimal influence on the interview itself, but nevertheless allows for reflexivity in that emerging themes can be interrogated in greater depth. Multiple data analysis techniques contribute to '*the quest for theory*' (Yeung, 1997 p.62) inherent in realist research, but also limits the researchers' reliance on the direct use of quotations in the written thesis, thereby meeting the need for anonymity, a pre-condition of access to case study organisations and informants.

Part 2 of the thesis relates to the context of the study. Although stressing the logic of what, why and how, what relating to the object of study, Pettigrew's early work, from

which the theory was derived, was based in a private company operating in market structures.

In line with the concept of 'nested' structures and processes (Pettigrew, 1997), the immediate context for nutritional governance is healthcare governance. The wider context is, however, the governance of public services in Wales and this is described in Chapter 3. Despite the functional divisions between political portfolios, cross cutting policies and strategies are designed to guide service delivery based upon values of equity, social justice, public health and sustainable development. These are supported by an accountability framework that sets the template for service delivery by devolved organisations, and attempts to hold government accountable to citizens through democratic processes and transparency. Chapter 4 describes the historical developments of healthcare governance in Wales since devolution, the point at which the Welsh Government was able to influence healthcare governance structures through its own governance frameworks.

The way in which nutritional care is designed, delivered and accounted for forms the basis for Part 3 of this thesis. Chapter 5 describes the activities that take place within Local Health Boards and represents the assessment and management of needs that precede sourcing and contracting. The activities of non-Local Health Board actors, in terms of technical standards, menu development and accountability, are included in this section. Empirical evidence is firstly presented as the constitutional structures of nutritional governance, followed by the processes of nutritional care, which includes catering, food service and the accountability frameworks. Descriptions are supplemented by narrative vignettes from interviews and documentary evidence, to demonstrate how principles are evidenced in practice, as well as to highlight the differences in practice between organisations, individual hospitals and at ward level.

The delivery of nutritional care is, in practice, a process which is structurally and functionally divided between the Local Health Boards and the Shared Services Partnership, each having differing constitutional objectives, powers and responsibilities. Chapter 6 therefore relates to the functions of the Shared Services Partnership in its role of the sourcing and contracting of food provisions. An example is provided of the particular case of the procurement of yoghurt in order to demonstrate how best practice principles are put into practice during this stage of the Nutritional Care Pathway.

The final two chapters form Part 4, which draws from Part 3 in order to understand and explain change. Chapter 7 relates to governance, as the overriding mechanism of change. Firstly, the political actions of government over time in shaping healthcare structures, is argued to be a fundamental enabler of transition to a pathways approach, and thereby individual nutritional care and public health. Secondly, espoused values are discussed, reaching the conclusion that an embedded set of values exists to link higher order moral theory to action and outcomes, as sustainable development, but that despite being a concern associated with organisational culture, there is no evidence of a culture of care in this particular healthcare context. Thirdly, the discussion moves towards more specific mechanisms of change and identifies devolution and collaboration, integration and differentiation, standardisation and simplification as constitutional mechanisms, with leadership, learning and collaboration as contingent social mechanisms of change.

Chapter 8 brings the thesis to a conclusion by summarising the research outcomes according to the research questions. The discussion raises the proposition that the underlying causal mechanism of change, in this context, is that of capabilities. The Chapter concludes by expanding on the notion of capabilities as an integrative concept linking structural empowerment, as devolution of authority and responsibility with both cognitive and behavioural conditions. The freedom to choose, inherent within the concept of capabilities from within political and moral philosophy, accounts for differences in outcomes, the policy relevance coming from the way in which poor performance can and is being overcome. Coaching, as a social process of reasoning between peers, enables understanding. The experiences of actors is that this is the most effective means of affecting behavioural change, challenging the view that top down actions such as mandating, or merely providing knowledge and skills through teaching, are sufficient to change behaviour.

The Chapter, and thesis, concludes by considering the limitations of the research, clarifies the contribution to both academic knowledge and policy, and identifies some opportunities for future research.

PART 1 BACKGROUND

TOWARDS A FRAMEWORK FOR NUTRITIONAL GOVERNANCE

METHODS

CHAPTER 1
Towards a Theoretical Framework for Nutritional Governance

1.1 Introduction

The research is intended ultimately to contribute to debates about the sustainability transition, theoretical propositions being largely divided between strong and weak versions of change, with empirical evidence of action heavily weighted towards the latter. The state is viewed as a key actor, with governance the primary mechanism for bringing about sustainable development within democracy. The economic capacity of the state is ultimately enacted by subordinated or sub-contracted organisations and it is actions within governance that tie those organisations to the objectives of the state. This study therefore focuses on the structures and processes of governance as a means of studying the economic activities of the state.

The strategy for this research is to adopt a retroductive approach (Danermark et.al, 2002), which situates the research within what is already known about the subject of interest (Tsoukas, 2009, p.286). As such, the aim of this Chapter is to develop a broad theoretical framework from existing bodies of literature. The resultant frameworks, presented as heuristic devices, are intended to guide fieldwork and aid analysis.

This Chapter begins by considering alternative perspectives which contribute to debates on the sustainability transition, and presents the argument that as public services are delivered by subordinate organisations, as agents of the state, those organisations have the primary role of putting principles into practice. Organisation theory is therefore proposed as an appropriate theoretical perspective from which to consider how change is being brought about. The second part of the Chapter synthesises the emerging themes with that of the literature on sustainable public procurement, firstly to identify the gaps in academic research, and subsequently to situate that study within the existing literature on hospital food procurement. Finally, as a contextual in-depth study, the literature on healthcare systems makes a further contribution to theory development.

The resulting theoretical frameworks for nutritional governance create, firstly a conceptual framework for a 'constitutional' form of governance, based upon regulatory frameworks of structures, politics, values and cultures, each influencing

actors at differing layers. The second conceptualises governance as process, in a cycle of needs assessment, action, outcomes and accountability. This processual view of governance conceives that organisational processes are structurally and relationally embedded in the organisation, and as such are inextricably linked to the constitutional conception of governance. Thus governance can be linked to an intended outcome, in the case of this study, sustainable development.

1.2   Sustainable Development and the State

1.2.1   Values Goals, Targets and Indicators: All or Nothing?

The emergence of sustainable development as a political concept and as the driver of subsequent debates on the meanings thereof has been attributed to *Our Common Future* (WCED, 1987) (Kirkby et al, 1995).

Kates et al (2005) provide a succinct overview of these debates, viewing sustainable development as a multi-dimensional but contextually dependent concept originating from an international desire for peace, freedom, development and concern for the environment as a support system for human activity. Whilst they refer to a multitude of definitions, these are broadly categorised as goals, targets, indicators and values, the underlying principles of which are equity through democracy, basic and essential human needs, and economic growth, reduced in practice to the normative conception of economic, social and environmental pillars of sustainability.

This reductive, fragmented approach ensures continuing contradiction and contestation, although this ambiguity, as Kates et al (ibid) argue, enables the principle to become the subject of negotiation to enable it to be put into practice. Enduring contestation does however politicise the concept even further and invites preferentialism not just in definition, but in deciding what changes need to be brought about as well as how and where, situating the concept comfortably within the piecemeal approach inherent in the transitional paradigm of ecological modernisation, and commensurate with an outcomes based definition of sustainable development.

An alternative view by Langhelle (2000) is founded upon the principle that the primary goal of sustainable development is social justice, which provides a theoretical and normative framework of sustainable development within which ecological modernisation is a necessary pre-condition. Thus the implication is that ecological modernisation offers only a weak or partial pathway at a local-national

level within a sustainable development framework that encompasses local-national-global scales. This view is, however, now being challenged, with empirical evidence of strong ecological modernisation emerging from economic activity at a local scale (Kitchen and Marsden, 2011).

As a political concept, Langhelle (2000) argues that there is a necessity for a hierarchy of priorities with human needs at the top of a list of base-line concerns that includes ecological issues. This values-based approach, where genuine consensus can be achieved through democratic participation and convergence to a set of shared values, suggests there is potential for cultural and thereby long term change, notwithstanding its anthropocentric bias.

Whilst critics of this more abstract values view of sustainable development rely upon the fact that values are inherently personal and subjective, the approach can be put into practice through a framework based upon broader political theories of democracy and justice, within which government has a significant role leading sustainable development. Meadowcroft et al (2005) and Baumgartner (2011) theorise sustainable development as a strategic and a continuous process of social advancement, within which the government role is to reform social institutions to enable and maximise opportunities for continuous progress concerned with quality of life, flourishing and ecological respect. Sustainable development from this perspective becomes a process with values guiding actions, yet does not preclude the practical use of goals, targets and indicators contingent on context, including place and spatial scale.

Whilst there is consensus that the values of social justice differentiate sustainable development from ecological modernisation, the separation of the social from the environmental and economic dimensions of sustainable development accepts, rather than challenges, the normative pillars approach. The idea of embedded values is a principle within moral theory founded from a general deontological, rather than consequentialist approach to justice[1] and enables a form of reasoning for the often assumed, but underdeveloped, connections between sustainable development and moral theory.

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[1] A broad approach to deontological and consequentialist moral theory is proposed here, the former relating to moral principles that guide action and the latter 'just' outcomes of action.

1.2.2 A Political Theory of Justice: Embedding an Institutional Ethic of Care

A need for social justice within conceptions of sustainable development (Langhelle, 2000; Morgan et al, 2006; Morgan, 2008) provides a theoretical link with moral as well as political theory, although the emphasis on 'social' does emphasise human, rather than eco-centric concerns. Engster (2004, 2005, 2007) proposes a more general theoretical position that retains a human bias, but nevertheless offers an opportunity to integrate concerns about distant others, non-humans and the environment by drawing from moral theory and an institutional ethic of care to develop an, albeit partial[2], theory of justice. Initially developing an argument for a political, institutional theory of care, he suggests that the basic goal of caring is "*to help individuals to at least a basic level of well-being*" (2005, p.53), and as such neither precludes self-help, nor state interventions, countering the feminist notions of an ethic of care founded upon individual relationships. Engster synthesises these previously dominant feminist ideas (for instance Gilligan,1982; Tronto, 1993; Noddings,1984; Held, 2006) with natural law theory (Nussbaum, 2000), and the virtues of attentiveness, responsiveness and respect to arrive at a definition of caring as: "*everything we do directly to help individuals to meet their basic needs, develop or maintain their basic capabilities, and live as much as possible free from suffering, so that they can survive and function at least at a minimally decent level*" (Engster 2005, p.54).

Engster proposes that a general theory of justice has an implicit rational obligation to care arising from the inherent and continual interdependency of individuals, communities and society. Such a broad theory is therefore commensurate with the needs of distant 'human' others, non-humans and the environment (Engster, 2004, 2005), linking his political theory of justice in a holistic manner to the core principles of sustainable development.

Engster (ibid) expressly links his theory with economic, international and cultural justice and domestic politics through subsidiarity: localising the delivery of care practices through developing the capacity of individuals to help themselves, with government providing a supplemental, supporting role through political institutions and policies which manifest caring values and support caring practices, but ultimately providing a safety net through direct provision. Thus economy is embedded in society (rather than markets) but economic justice enables individuals to care for themselves in a hierarchy of care that ultimately ensures that the state

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[2] The theory ignores any form of retribution as part of a theory of justice

takes responsibility for direct care, but only should the need arise and individuals retain the freedom to choose whether or not to be cared for.

A political theory of justice therefore embodies caring at a more basic needs level than capabilities, but nevertheless is hierarchical, so that basic caring for needs is the primary aim, but will enable individuals to develop their own capabilities which will in turn enable them to care for others, non-humans and the environment. The main criticism of Engster's approach is the lack of any explicit relationship with future generations, but as an abstract concept, intergenerational justice is not precluded. Whilst the theory lacks the prescriptive nature of the goals, targets and indicators for the practice of sustainable development, it nevertheless provides a political framework within which both moral values and empirical measures can be embedded.

The adoption of a values-based approach to sustainable development as a strategic practice (Baumgartner, 2011) representative of justice and democracy can, therefore, accommodate spatial and temporal differences in politics, cultures and structures and perhaps overcomes some of the constraints that contextual dependency places on theorising sustainable development. Practising sustainable development within such a political framework therefore becomes a democratic process of learning and adaptation, but is fundamentally linked to moral theory through an institutional ethic of care.

Engster (2007) therefore links moral theory and an institutional ethic of care, to political theory and justice and as a consequence, to sustainable development.

1.3 The Role of the State and Devolved Organisations in Governance and Sustainable Development

1.3.1 'Greening the Realm'[3]: from Government to Governance

Debates on the role of the state in sustainable development draw from differing academic perspectives, but are dominated by green political philosophy and its inherent emphasis on environmental and economic concerns. The reasons for lack of progress are laid directly on western governments, the economic imperative intrinsic in the capitalist and neo-liberal values suggested as the primary reasons lack of progress (Carter, 2007; Dryzek, 2002; Eckersley, 2004). As Baker and Eckerberg (2008) conclude, however, the pursuit of sustainable development above environmental or ecological sustainability is a process of societal transformation,

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[3] Morgan (2008)

where the policy process "*guards the future, promotes equity, and pursues the common good*" (p.227).

Discussions within the literature seek to reach consensus as to the characteristics of a green state, how change should be and is brought about, primarily through the actions of the state as government, and the barriers to transformation. The consensus is that there is a need for structural change (Christoff, 1996; Dryzek, 2002) towards a more social democratic philosophy in a post-liberal state (Eckersley, 2004). In Eckersley's (1992) opinion, whilst political objectives might contribute to transition, the adoption of such an eco-centric culture will be necessary to bring this about. The process of transition would, however, involve a change in the role of the state from protector and provider within a welfare state, to facilitator and co-ordinator within governance.

A truly green state as the outcome of a process of 'greening the realm' (Morgan 2008) is founded from a need for politically led, cultural transformation, whilst a notion of a weak green state originates from a market orientated conception where the state is one of many actors within a process of ecological modernisation. Whilst authors such as Langhelle (2000) and Baker (2007) are critical of the way in which the two paradigms appear to have been conflated, and Baker and Eckerberg (2008) have demonstrated the continuing dominance of the ecological modernisation paradigm in practice within the European policy community, it has been suggested that new paradigms of development are emerging within ecological modernisation that enable social justice on a local rather than global scale. These emergent new economies are representative of weak and strong ecological modernisation. Emergent 'strong' economic pathways reflect social justice on a local-regional-national scale and are spatially embedded through sustainable communities of place and interest with a more steady state view of economic growth than the alternative 'weak' version, deeply attached to competition, profitability, growth and global markets (Kitchen and Marsden, 2011). Communities based social justice can therefore be attained by localising development through democratic processes of learning and governance alongside, and co-dependent upon, a non-degrading use of environmental resources (Kitchen and Marsden, 2011, p.762) suggesting that social justice emerges from locally generated economic activity within the eco-economy paradigm, rather than any planned or strategic approach to development.

Unsurprisingly, the green political theory perspective views the state as a prime driver of change, but in practice the state is one of many actors involved in bringing about change, which suggests that to achieve the paradigm shift envisaged by

proponents of radical change, the state, markets and society need to be aligned in a process of transition affected by 'new governance'. Governance theories view state activity through governing and government as one of many actors in the state, market, society nexus. The role of the state becomes one of governing by guiding and steering, but also by devolving power and responsibility to 'others'.

The socio-political structures that underpin 'new governance' comprise many actors involved in different contextual institutions and processes. Berger and Steurer (2008, p.30) distinguish the role of the state in governance from its role as government by its use of soft policy instruments, participation in networks and the strengthening of collaboration between the different levels of government. The state nevertheless retains a strong role in governing (Kooiman, 2003; Baker and Eckerberg, 2008), but adopts the position of steering and guiding rather than a totality of command and control in law. The state can, however, only steer and guide as part of a set of institutions where boundaries and responsibilities are blurred, collective action can take place through autonomous networks with underlying inequalities of power (Stoker, 1998) or as a multi-layered, dynamic, socio-political system of state, markets and institutions based around processes that solve problems and create opportunities and conceptions of modes of governance of 'self', 'co' and 'hierarchical' (Kooiman, 2003).

The state nonetheless has the potential for a greater role than just steering and guiding through policy and strategy development. Lundqvist (2001), for instance, suggests a need for more traditional forms of governing alongside a more subtle coercive approach where the state adopts a cognitive-informational approach to manipulate the context of individual choice, thereby countering liberal objections to the 'nanny state'. The role of the state in governance, he argues, can further be expanded to monitor sustainability, create knowledge and umpire disputes arising from conflicting ideas and priorities.

Thus the state is, in practice, politically and culturally contingent as a key actor alongside markets and civil society, within these structures of 'new governance'. Central to Kooiman's (2003) socio-political view of governance is the dynamic nature of action being embedded in the structures of governance through concepts of leadership (individual), social movements (collective) and co-ordination (bureaucracy), the latter being deeply rooted in hierarchical modes of governance, with the state engaged in steering as a political process and control by administrating complexity and diversity (Kooiman, 2003 p.118).

Within this governance paradigm, governing in practice is more aligned with broad conceptions of a regulatory state (Martin, 2010), where government uses soft policy instruments, sets standards and ensures accountability through self-regulation and audit and inspection by arms-length bodies.

1.3.2 Political Frameworks for Sustainable Development

The leadership role of government within a dynamic political framework enables reform of social institutions and maximises opportunities for continuous progress concerned with quality of life and flourishing. This continuous process of social advancement can be put into practice through a framework within which government can encourage innovations towards transformation. Such a framework approach, however, does not preclude a process of change that is both incremental and differentiated (Meadowcroft et al, 2005). Theory and practice can therefore be linked through a legal and regulatory framework consisting of laws, policies and strategies underpinned by shared values, which gives the concept of sustainable development both flexibility and a dynamic dimension, without reducing it to static measured ideals.

Although Meadowcroft suggests that sustainable development strategies reflect an iterative process of continuous learning adapted and expanded from existing planning processes (2007, p.154), he highlights that most operational strategies lie between the polar extremes of ideal and cosmetic. An ideal strategy is characterised by integration within the processes of strategic decision-making, across the pillars of sustainable development and with truly democratic participation (ibid, p.156). An ideal type could thus be argued as representative of a situation where sustainable development has political commitment and is embedded in structures and culture within a 'new governance' paradigm. The opposite scenario, the hollow shell, is devoid of political commitment and operational status and has neither practical implementation nor monitoring processes.

The key points made by Baker and Eckerberg (2008) Meadowcroft et al (2005), and Meadowcroft (2007) are that neither definitions, policies nor strategies alone are sufficient to bring about change, but as a strategic process within a democratic system of governance, success can be achieved, albeit dependent upon embeddedness in structural socio-economic and political processes. Change within this system of governance accommodates planned and emergent changes in an on-going, reflexive, multi-directional, rather than linear, process of learning.

Fundamental to this process are societal value choices and democracy, inevitably context dependent.

Nevertheless, liberal values of freedom within existing political and social values constrain the capacity, if not capability, of the state to apply sanctions. Thus fragmentation within this governance framework relies heavily upon integration and convergence to a common set of guiding societal values such as democracy and justice, beyond the limits of the politically loaded terms such as 'co-operation' and 'co-ordination'.

1.3.3 Barriers to Radical Change

Barriers to radical change focus on the constraints of capitalism and neo-liberalism, in particular the effects of globalisation and markets. The constraining influences of markets, for instance, determine the extent to which state actions through environmental or sustainable development policy-making can achieve any substantive outcome, as markets ensure that emergent properties or imperatives take effect, not by direct corporate influence, but as a reaction to perceived threats to profitability, the consequences of which are economic downturn, loss of tax revenue, policy failure and political mistrust. Thus successful policy can only be possible where there is either marginal damage or economic benefit to those within the market (Dryzek 2002, pp.142-143). Crouch (2011), however, contends that civil society, rather than the state, has the power to constrain the practices of markets, although in its operational role, the state itself can be a significant actor in the market for goods and services.

In addition to the points raised by Meadowcroft (2007) and Baker and Eckerberg (2008), Carter (2007 p.180) cites barriers to change in more general terms within government as conflicts between policy areas, structures and departmental priorities. He criticises the policy and administrative sectors displaying a "*blinkered pursuit of narrow sectored objectives*" and observes that bureaucrats instinctively break down problems into separate units, whereas the interdependence of issues contained within sustainable development do not respect administrative or policy boundaries. He further suggests, after Weale (1992, cited in Carter, 2007), that the traditional 'old politics' are reactive, enduring and piecemeal, therefore can only deal with the symptoms, rather than the causes. In order to deal with the root causes of the complex problems posed by ideas of sustainable development Carter (ibid) claims that policy needs to be anticipatory, comprehensive and strategic, requiring

changes that bring convergence, collaboration and co-operation between departments and administrations, thereby taking a longer term processual view.

Thus policy and strategy for sustainable development need to be embedded within all policy areas; the existence of specific policies or strategies in isolation insufficient to overcome alternative dominant concerns within other self-contained and fragmented policy areas.

Concepts of governance nevertheless tend to view the process of governing from the government perspective, and thereby focus on structures of governance as an objective, entity. Governance as the context or framework for the study of processes enables the study of complexity, reflecting multiple and asymmetrical powers in actors and structures, social differentiation, as well as dynamic, adaptive and on-going processes, but can also accept the presence of hierarchies, markets and networks. Nevertheless, subsidiary governance, contingent within devolved and fragmented public services at national and sub-national level, suggests that understanding such processes of change in greater depth can be informed by the alternative and perhaps a more specific perspective of the organisation.

1.3.4 Devolution and the Organisational Perspective on Change

Where the state, as an actor in governance, devolves responsibility for delivering public services, central authority is exercised through setting standards and procedures and controlling resources, accountability demonstrated through a regime of audit, inspection, adjudication, authorisation and certification (Martin, 2010). Publicly funded organisations, from within this management perspective, retain operational freedoms which are subject to their capacity by virtue of devolved powers, responsibilities and resources.

The particular theoretical perspective of the devolved organisation as an actor in delivering public services nevertheless places emphasis on the 'particular' as either the context, as in healthcare or education, or through operational roles and processes, such as procurement.

Within organisation theories, change is approached from many perspectives and focuses on the way change is designed, implemented and managed and how the organisation is firmly embedded in markets for goods and services. Operational roles, such as public procurement therefore place devolved public organisations and the practices of the state within the state, market, society nexus as both consumers and producers of goods and services.

Organisation studies are generally contained within academia as a business or management discipline, with multiple sub-specialities and a core focus on the firm or sector, and overall concerns with competitive advantage. Sustainability within this managerialist perspective is consequently viewed through a quasi-private sector lens, as efficiency, through greening production processes, or as the socially responsible outcomes of the organisation's activities. The perspective naturally favours a functional view of organisations and the view that change can be planned, managed, radical or incremental. Alternative disciplinary perspectives within organisation studies, however, adopt a societal (Morgan, 1990) or metaphorical (Morgan, 1989) approach to organisations, and are perhaps more appropriate to governance. These sociological conceptions relate to dynamic processes rather than functional or structural models of change, and thereby accommodate the concept of emergence to accommodate history, contextual legacy, a multiple layered reality, and explanation (Pettigrew, 1987, 1997, 2012). As an academic discipline, therefore, organisation studies provides a robust and appropriate theoretical foundation for the study of micro contexts and processes, such as those within devolved public organisations.

Nevertheless, the primary distinctions between the private firm and public organisations are that the latter must be accountable for public expenditure and therefore need to demonstrate mandated regulations such as value for money (Martin, 2010), and potentially, sustainable development. Public sector organisations must also manage multiple and potentially competing stakeholder objectives, as well as achieve plural, complex and contested quality based outcomes. Ensuring accountability for quality and outcomes places emphasis not only on inspection for quality and outcomes but also audit for stewardship and financial viability. As well as self-regulation, as Power (1997, cited in Martin, 2010) notes, there has been a trend towards convergence of the roles of inspection and audit, with a greater emphasis on dialogue and subsequent support. Adjudication, authorisation and certification, the other activities of regulation suggested by Martin (2010) increasingly relate directly to quality considerations in outcomes as well as compliance with process.

Conceived as an agent of government within a process of governance, the organisation can be considered as embedded in a socio-political system of multiple, asymmetrical influences emanating from different sources. Perhaps as a consequence of the limited perspective of organisation theory, management perspectives and associated empirical studies, the organisation theory literature as

a whole fails to integrate with the wider governance and green political theory literature that links sustainable development and environmental sustainability with views of change. This is attributed by Carter and Rogers (2008, p.363) to the difficulty for organisations to put macro-theoretical concepts such as sustainable development into practice at a micro-level, and the problem that organisations have in defining their role within the bigger picture.

Nevertheless, the organisational perspective delivers an alternative, critical response to existing state-centric debates relating to sustainable development and change, whilst the governance perspective provides a structural link between middle range and higher order theoretical perspectives.

1.4 ' *Catching Reality in Flight'[4]*: A Processual Approach to Organisational Change

Langley (2007, p.271) describes process thinking as concerned with the consideration of phenomena in a dynamic fashion, so that movement, activities, events, change and temporal ordering are essential constituent considerations. Nevertheless, most process studies in business and management are associated with strategy and change, and by implication governance.

Process theory, argues Sminia (2009) is most clearly classified according to epistemological and ontological positioning, Johnson et al (2006) having developed a typology according to positivism, neo-empiricism, critical realism, and postmodernism. The first two reflect an objective epistemology, the latter two being more subjectively inclined, although critical theory retains the emphasis on a realist concern for an objective social reality. Choosing a theoretical perspective for study thereby refines the researcher's choice of change theory, and is best informed by the research aims and questions. Sminia (2009 p.110) relates different process theories relating to strategy formation to three key scholars in the field: Mintzberg, Pettigrew, and Van de Ven, their research orientation and how that relates to practices of strategic management.

Pettigrew, for instance, is associated with the contextualist approach, to which he associates critical realist ontology and a view of strategy formation that is based upon structuration theory, thereby enabling the existence of continuity and change to be recognised in a stratified reality; structuration as a fixed point in structure enabling and limiting human agency. Although the contextualist nature of such

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[4] Pettigrew, 2012, p.1305

studies is argued by many as flawed in terms of its ability to generalise, it does make some contribution to substantive theory by exploring mechanisms to explain action; the mechanisms implicit in the Pettigrew approach being dialogical (Van de Ven and Poole, 1995) to capture the tensions, trade-offs and power relations in practice. The realist distinction between structure and agency therefore separates process as an entity from process as action, and the context within which both exist.

This study conceptualises the organisation as part of an open, multi-directional political-social process of governance and thereby adopts a holistic view that accommodates multiple stakeholder perspectives. Organisational processes are themselves constitutionally 'nested', on-going, relational and contingent, the purpose of contemporary, in conjunction with historic analysis, providing an opportunity to "catch reality in flight" (Pettigrew, 2012 p. 1305).

This dynamic dimension of process is a *"sequence of individual and collective events actions and activities unfolding over time, in context"* (Pettigrew, 1997, p.338) and envisages that the context itself is complex and multi-dimensional, with changes constantly taking place and emanating from different parts of, and actors within and external to the constitutional organisation. In addition, external influences exist and exert influence on actions from beyond the sphere of control of actors and organisations. Actors and actions therefore drive and shape both processes and their contexts, each in turn being shaped by history, whilst simultaneously shaping the future direction of change to achieve desired outcomes (Pettigrew, 2012).

Pettigrew views his theory as a framework that can guide the entire research project based upon an understanding of "*the what, why and how of the links between context, processes and outcomes*" in an approach which is overtly analytical and iterative in nature, thereby enabling the researcher to capture and accommodate complexity and contingency, as it happens.

Although sharing common themes, as influences on organisational change, with other change theorists (Burnes, 2009), Pettigrew's theory is founded upon key guiding principles of embeddedness, temporal connectedness, explanation, holistic rather than linear processes, and links action to both context and outcomes (Pettigrew 1997, p.340).

1.4.2 The Five Guiding Principles of Processual Change

1.4.2.1   Embeddedness

Embeddedness is reflected in the idea of constitutionally 'nested' and related processes within organisations as well as the embedding of processes within specific historical, social, economic, cultural and political structures and contexts, thereby reflecting perspectives of individuals, groups and organisations. The idea of embeddedness from this critical realist perspective does not, however, preclude fragmentation between different structures, nor between processes, but suggests that objective structures and processes are linked by actions in agency. Structural embeddedness therefore connects structures through hierarchy, and relational embeddedness represents the processes of governance where interaction actions between interrelated social processes and structures are intended to converge towards selected outcomes.

1.4.2.2   Temporal Interconnectedness

Time and history provide the antecedent conditions and are conceived as the building blocks for potential explanations of change (Pettigrew, 1997). The study of both retrospective and contemporary accounts of change from numerous sources enables emerging patterns to be uncovered that can have an explanatory focus, but also links the extent of change to outcomes. Whilst the historical context can be deterministic, the interrelationships with contemporary processes of leadership and learning sees such behaviour as being challenged, especially where change processes are related to values based outcomes.

1.4.2.3   Explanation

Explanation is the "*convergent interaction and interconnected loops among. explanatory features in the firm over time.*" (Pettigrew, 1997, p.342).The theoretical framework sees explanation as existing in either or both context and action, agency only providing explanation in conjunction with contexts, where actors learn and shape on-going processes, including change. Potential explanations are therefore drawn from patterns that emerge from multiple sources, the most plausible explanations resulting from the elimination of alternative competing explanations.

1.4.2.4   Holistic

The holistic, rather than linear, approach to change reflects the necessity of historical and real-time study as well as the qualitative nature of enquiry. The principle acknowledges that such analytical studies, inherently dependent upon

context, are not necessarily generalizable to formal theories, but as applied research the holistic approach can generate substantive theories which contribute to evidence and 'how-to' rather than 'what-is' knowledge. Thus the holistic nature of explanation that moves beyond a variables or content approach enables understanding of how process and context is linked to outcomes and thereby have policy relevance (Pettigrew 1997, p.340).

1.4.2.5   Linking outcomes to process

Pettigrew's theory suggests that by linking outcomes to process in the research aims provides a necessary focus for any study characterised by complexity. Whilst studies can legitimately explain change without linking to outcomes, the value in the research for policy development is in this theoretical linkage with potential policy outcomes.

Whilst these principles underpin the entire research project, and guide and inform the research questions, the crux of Pettigrew's theory is that the key themes of processual analysis need to focus on the content, process and context, as well as the past, present and future, explanation being in the linkages between those concepts, action and outcomes.

1.4.3 Context, Content, and Process

Pettigrew (1987, 1997) further suggests that explanation is within the interactions between content, context and process, but also follows the logic of what, why and how. Explanation therefore requires an understanding of context and content, process being an abstract term relating to action and therefore agency. Inherent influences within this framework are, he argues, multiple and generated both externally and internally to the organisation, but are interrelated, interdependent, and have blurred boundaries that make them difficult to separate or define. Nevertheless, the critical realist perspective guides the way in which those concepts are defined. Analysis to abstract concepts as underlying mechanisms, rather than descriptive identification of content variables, also enables interrelated themes to be understood which, in turn, enables causal explanation.

This linear logic of what, why and how, is nevertheless challenged by the content, context, action triangle within his framework. The context of this study, the governance of nutritional care, is arguably influenced by government policy and strategy to a greater extent than a privately owned and operated company, that particular context forming the object of Pettigrew's original work (1987). Thus

consideration of content and context collectively become what and why, with context perhaps preceding consideration of content, as the specific object of study.

1.4.4 Content

The 'what' of the content – context – process nexus represents the descriptive elements of theme of the study, and is seen as the product of the legitimation process that is shaped by contextual influences. This study focuses on governance, as the way in which particular services are delivered, and therefore reflects both uniform and varied practices and procedures across a wider governance context that includes regulation, policies, strategies as well as enacted processes. Nevertheless, historical as well as current political and ethical frameworks are critical considerations in explanations of change. Content therefore has a historical element as well as action in contemporary processes.

1.4.5 Context

Context takes the central role in explanation and represents the "*interactionist field of multi-levels of analysis*" and represents the '*why*' in the '*what, why and how*' of change processes (Pettigrew, 2012, p.2). Fundamentally the need to understand 'why' in order to explain 'how' is expressed by causal links between process and context and requires consideration of outer and inner influences where "*structures cultures and strategies are not just being treated as neutral, functional constructs to some system need, such as efficiency or adaptability*" but have the power to enable and prevent action in the change process (Pettigrew, 1987 p.659).

Contextual influences external to the organisation are broadly concerned with cultural, political (including legal) and economic factors that set the context in a particular time and locale, but nevertheless provide a loose and all-encompassing view of the potentially legitimising forces in change processes. Whilst the critical perspective might view these influences entirely as constraints, a realist perspective neither precludes the optimistic nor the pragmatic view of influence.

Pettigrew's emergent paradigm does not seek to separate these themes but stresses their interdependence and interconnectedness, necessitating a greater detail of definition in order to both understand and use the framework for empirical study. The following sections provide further explanation of the definitions that form the basis of this study. The conceptualisations adopted are guided by the realist perspective.

1.4.4.1 Structures

The realist perspective emphasises the nature of structures as contingent and causal powers that simultaneously enable and constrain, comprising rules and resources which can shape interactions as well as serving to protect dominant interests (Burnes, 2009, p.181).

Key qualities relevant to structures in emergence theories move away from the ideas of structures as hierarchies, markets, matrices and networks, to embrace the softer elements of social interaction such as flexibility and communication, although these are usually contextualised by reference to networked structures. Such structures can accommodate both umbrella frameworks for top-down steering, guiding and legitimisation, and bottom-up initiatives and innovations as experiments that are outcome focused rather than functional in purpose.

Whilst the emphasis is on multiple potential power bases within structures, such conceptions overlap with notions of behaviour inherent in ideas of cultures, leadership, learning and politics; the structural component of which retains an emphasis on the interactions and interdependencies of differentiated layers and levels.

Process, however, is two-dimensional form in its own right, as a constitutional or objective structure, or as an abstraction, in process thinking with explanatory powers (Langley, 2009). The constitutional view of process implies boundaries, whilst process as an abstract form is perhaps more aligned to ideas of emergence within an open system such as governance. Governance therefore becomes a matter of the interactions between structures, and between actors and structures, rather than merely the relationship between structures, cultures and politics.

1.4.4.2 Culture(s)

Debates about the nature of organisational culture reflect disciplinary and philosophical perspectives, which Ogbonna and Harris (2002) suggest reflects optimism, pessimism or realism. Whilst politics and power represent potential turbulence, radicalism and prescription in respect of process, culture suggests continuity and consistency, notwithstanding its interdependence with power and politics in protectionism and resistance and as a coercive influence ever present in the background (Schein, 2010, p.3).

In their work on the NHS in the UK, Pettigrew et al (1992, p.279) suggest that there are multiple sub-cultures in institutions such as the NHS. Schein (2010, p.1)

suggests that culture is structured and layered, with the macro-level representing higher order cultures of ethnicity and nationality, the organisational level the sectoral perspective, sub-cultures as occupational groups and micro-cultures at the base level representing micro-systems that exist within and beyond the organisation. The central argument by Schein is that culture points to patterns of shared and integrated basic assumptions: phenomena below the surface initiated by leaders but continually created from a shared history and learning experience. The content of culture is described by Schein as layered, with artefacts such as language, style, uniforms, values, myths, rituals and stories relatively easy to observe, but difficult to understand; espoused beliefs and values embodied in ideologies and strategies; and basic assumptions, representing consensus and taken for granted behaviours that are neither debatable nor easy to challenge.

Adopting a realist approach, Ogbonna and Harris (2002) argue that radical comprehensive changes to culture cannot be brought about intentionally other than by guiding and steering in manipulating those more superficial aspects of culture, artefacts and symbols, which in turn can influence a change in values which ultimately might result in true cultural change, in other words, working with existing cultures rather than deliberately striving to achieve radical change.

Drawing from these discussions for the purpose of this study the definition of culture adopted by Ogbonna and Harris (2002) is adopted as a:

"dynamic set of assumptions, values and artefacts whose meanings are collectively shared in a given social unit at a particular point in time".

1.4.4.3 Politics and Power

Mintzberg et al (2009) view the power school of strategy as the mirror image of the cultural school, where power fragments rather than knits together the organisation. Pettigrew (1987) suggests that the political context is essentially about the management of meaning, protectionism and enabling legitimacy, and represents bias in both the positive and negative sense. He links the political context to culture through the subliminal action of promotion of symbols, language, beliefs and ideology, but at the same time accepts that the public face of power is represented by possession, control, position, expertise and resources. His later work (2012) gives primacy to legitimisation as the central issue of power and politics but reflects on his earlier work to suggest that through centralisation and decentralisation successful change needs to enable freedom at the local level, guided by the centre.

Mintzberg et al (2009) helpfully seek to expand on Pettigrew's writing by linking strategy, power and politics, the former shaped by contextual elements, but in contrast to the cultural view, argue that emergence is based upon markets and manoeuvres rather than values embedded in the way in which things are done. These authors suggest that the value of politics is as an alternative to authority, which enables pluralistic leadership, ensures a variety of voices are able to contribute to strategy, can challenge both culture and authority to enable change and can ease the path of change in enabling the formation of alliances. Beyond the organisational boundaries, they suggest that macro elements of power and politics open up structures to stakeholders, collective strategies and actions, and co-operation. Linking these ideas to collaboration and learning, political behaviour can enable innovation and diffusion of ideas and good practice, and offers an alternative to competitive strategies.

Lukes (2005) theorises the content of power and politics in terms of dimensions by building from existing one and two dimensional theories of power proposed by Dahl, (1957) and Bachrach and Baratz (1962). Critical of the limitations of both Dahl's pluralist view of power as representative solely of the existence of conflict, and Bachrach and Baratz's suggestion that power represents bias within predominant values, he proposes a third, dynamic, dimension of power founded upon the need to shape perceptions and understandings, with the resultant acceptance of an emergent order of things that excludes the possibility of manipulated consensus envisaged in the two dimensional notion of power. Thus the third dimension of power can be overt, in the form of coercion and force, sanctioned by authority where there is a conflict of interest but also latent as manipulation where there is no such conflict. This version of power requires action, and suggests a transformation of power into political behaviour in the third dimension. Thus whilst power is a property of a system, inherent in structures, positions, sub-cultures and leadership, power in action represents political behaviour (Pfeffer , 2006, cited in Pye and Pettigrew, 2006).

1.4.4.4   Leadership and Learning

Whilst conceptions of leadership are contested, and are arguably embedded in the concepts discussed in this Chapter so far, Pettigrew's theory of processual change places emphasis on leadership as a key influence in enabling change. Leadership links strategy to action in change, and represents the action in the relationship between strategy and process (Pye and Pettigrew, 2006) or strategy and organising

(Collville et al, 2006). Whilst conceptions of leadership include ideas of heroic individuals, the key to leadership in theories of emergent change conceive leadership as subtle, diverse, and pluralistic, underpinned by an element of continuity (Pettigrew et al, 1992, pp.278-9). The key activity of leading suggests that bringing about a climate that encourages strategic and cultural change to emerge from converging patterns of behaviour, is brought about by enabling and supporting experimentation, leadership and collective learning, and sense-making based upon experience (Minzberg et al, 2009; Weick, 1995), which illustrates the interconnectedness of leadership with both culture and politics.

Whilst Pettigrew views leadership as distinct from management, other theorists place significance on managerial behaviour as crucial in bringing about change. (Burnes, 2009, p.393) suggests the difference between management and leadership is represented by differences between transactional and transformational qualities where the need to manage is founded on enabling continuity and a stabilising effect within a change paradigm.

Nevertheless, Burnes (2009) suggests that within theories of emergence, the role of the manager is as a facilitator, shaping change by manipulating the environment to enable experimentation, learning, risk-taking and empowering others, which is not entirely in conflict with Pettigrew's vision of leadership. Managerial behaviour is also an inherently political role in that it can control the agenda or prevent change taking place, although Ackroyd et al (2007) observe that management lacks power in the NHS in England. Mintzberg et al suggest that management differs from leadership in that it crafts relationships between thought and action, control and learning and stability and change (2009, p.216-217). Management can also frustrate change but can bring about successful change if managers adopt an open style which encourage initiatives and tolerates risk taking (Carnall, 2007).

Leadership itself is also considered to be a learning process, whilst the role of managers is to foster a learning environment which empowers all members of an organisation to contribute to learning by experimenting, innovating and sharing good practice. Senge (2006) focuses on the prescriptive approach to becoming a learning organisation, characterised by attributes of the organisation itself and brought together through the concept of systems thinking. The systems thinking approach to management learning is, however, founded on the idea of complex and dynamic organisational structures, and management behaviour that seeks to learn through a dynamic process of observation that builds from patterns rather than an accumulation of distinct forces or events. Senge's work (ibid) places emphasis on

characteristics of learning as displaying individual and collective learning, sharing assumptions and values embedded in organisational cultures, and a collective understanding of the organisational vision.

The layered nature of learning is central to the work of Argyris and Schön (1978), who theorise learning in three layers: a simple form of adaptive learning which identifies and corrects errors and variations, a process of reconstructive learning which challenges the strategic aspects of the organisation, and the transformative approach that questions the rationale and seeks radical changes that can be structural or cultural.

Learning is therefore viewed as a process that involves individuals, groups, the organisation and other stakeholders, within a system that encourages and supports positive development through empowerment and learning from shared experiences. The aim of such processes of learning is to reach convergence and consensus for the adoption of a framework strategy that can accommodate the plurality of differences that exist in practice. Thus within this theoretical framework, learning is viewed as a pluralistic and interactive process embedded within the organisation and its processes rather than representative of the organisation itself. Change represents a shift in direction, with strategy an outcome of convergence of ideas legitimised by managers and leaders (Mintzberg et al,2009, p.196).

Thus management and learning are perhaps integral to a conception of leadership as a dynamic concept. The link with action also suggests that it is associated with processes of governance, rather than attached to hierarchical structure.

1.4.6 Process as Action

Pettigrew's theory of process, the 'how' of change, is described as the "*search for mechanisms which drive processes*" (2012, p.2) and represents the actions, interactions and reactions of key actors, structures and processes. This represents the underlying reasoning, or potential explanation(s), for change and draws from the empirical evidence within the content and context of the study.

Despite the complexity and multi-directional properties of emergent change theory and the asymmetrical influences and interactions on organisational processes over time, Pettigrew's context-content-action triangle and the logic of 'what, why and how' provides a robust framework for an analytical and iterative approach to researching the study of organisational practices as on-going processes, rather than historic events. Those processes can then take particular forms, either as

purchasing, procurement or as governance. As action takes place in both context and content and context has greater significance to publicly funded, rather than private, operations, the theory is, perhaps, most appropriate to the study of strategic processes such as governance.

The 'Public Plate', the public provision of food in schools and care settings, has been described as the litmus test of the political commitment of the state to sustainable development (Morgan, 2008). It is therefore an area for empirical study that links sustainable development, and thereby political and moral theory, with the concept of a moral economy and thereby an institutional ethic of care.

1.5   The 'Public Plate' – a Moral Economy of Food

The power of public procurement is emphasised in academic writing as arising from of the size of the budget and the persuasive power in setting an example (Lundqvist, 2001; Coote, 2002; McCrudden, 2004; Morgan, 2007, 2008, Morgan and Sonnino 2008). Morgan argues that as part of the market for goods and services the role of the democratic state extends beyond that of its legislative and fiscal powers and "*amounts to a powerful set of incentives and sanctions to change the behaviour of the public, private and third sectors, as well as the behaviour of individuals and households*" (Morgan, 2008, p.1238).

McCrudden (2004) and Coote (2002) also argue that devolved organisations, as agents of the state, can lever innovation in the private sector as a result of their procurement activities, delivering of a wide range of environmental and social objectives, whilst supporting existing and developing markets.

The procurement activities of public institutions and organisations also take place within a global economy, thereby enabling reflection of more than local or national priorities. This global economy carries with it contractual responsibilities for those beyond the immediate polity via a series of international agreements and regulation, and a set of moral obligations towards 'distant others', an inherent consideration within the concepts of both sustainable development and justice, discussed earlier in this Chapter, and the foundation of academic work relating to the 'Public Plate'.

Whilst links have been proposed between the concept of sustainable development and political and moral theory through Engster's (2007) general theory of justice and an institutional ethic of care, the literature on the ''Public Plate'' also emphasises the role of an ethic of care in a transition from a global market based food economy to a moral economy of food that meets local and global needs (Morgan et al, 2006;

Morgan 2007, 2010, 2011; Morgan and Sonnino, 2008). There is also consensus that an ethic of care reflects the practice of caring, which as an economic activity that is embedded in society, creates wealth in terms of health and wellbeing and produces ethical and economic responsibilities for the externalities of production, not only towards third parties, but for a wider ecological responsibility (Sayer, 2000, Morgan, 2010).

Morgan (ibid.) seeks differentiation from the dominance of local thinking in food systems, and suggests that social justice requires us to consider globally sourced food as part of our wider responsibility to other local food systems and communities. In reflecting social justice and equity in purchasing decisions, he suggests inevitable trade-offs between idealistic notions of appropriate or sustainable outcomes. The local-global dichotomy also needs to preclude rational decision-making by 'distant' consumers: as Engster (2007) suggests any idea of justice requires democratically and locally determined needs to avoid paternalism. Prioritising the local and the global where local economies can be supported through localised natural rather than global market economies is therefore a political activity.

Debates on how such a moral economy of food might be brought about broadly follow ideas of both radical and emergent theories of organisational change. Morgan and Sonnino (2008) have, for instance, demonstrated that such a moral economy of food can emerge from a dominant liberal ideology which supports and promotes individual rights and choices over social justice. Embedding ethically positive principles in the organisation, its policies and processes can potentially avoid political and cultural resistance to radical change, particularly where such principles are aligned within institutional, regional or national policies, thereby making change contextually dependent.

Whilst the literature relating to the concept of a moral economy of food reflects a food system perspective, and asks that we consider the impacts of the food products we purchase, the moral economy as a whole is also concerned with caring as a value that guides action. This suggests that procurement is concerned not only in terms of outcomes for the food system and local economies, and therefore what we purchase, but also a matter of how social justice can be brought about as a result of the way in which public services are delivered, albeit within the ultimate political and economic constraints of the public purse.

1.6 Sustainable Public Procurement in Practice

The preceding sections have highlighted the significance of the national, organisational and governance context to the empirical study of the economic activities of the state, and the ways in which the public sector can demonstrate its commitment to sustainable development through the sustainable public procurement paradigm of the 'Public Plate'.

The following review of empirical studies draws from academic peer reviewed texts and public sector and NGO commissioned research, illustrating the diverse range of stakeholder interests in sustainable public procurement. The review synthesises the literature from the business school and food studies[5] perspectives on procurement practice, as it relates to sustainable development. In doing so it will capture the alternative academic disciplinary perspectives that reflect debates and trade-offs between cost and quality in public purchasing. The aim of the review is twofold: firstly to identify the gaps in knowledge relating to public food procurement and sustainable development, and secondly to arrive at the research aims and questions.

Whilst there is a growing body of literature on green procurement, there is a lesser, but growing concern with the separate social strand, framed by management scholars as social responsibility. Nevertheless, there is a lack of empirical studies into sustainable *public* procurement (Walker et al 2008). As Walker and Brammer (2009) point out, there is no obligation for the private sector to engage with social responsibility. Consequently the drivers to engagement within the private sector cannot reflect the same obligations associated with the public sector and its broader needs, goals and societal objectives. The public sector also has stronger moral obligations to comply with international agreements, plus explicit obligations to comply with directives from regional bodies such as the EU.

Prior sustainable public procurement research has focused on specific projects, initiatives and sectors, such as employment (Erridge and Hennington, 2007); forestry (Bull et al, 2003); construction (Hall and Purchase, 2006); IT (Matthews ad Axelrod, 2004); or food (Jochelson, 2005; Rimmington et al, 2006; Morgan and Sonnino, 2008, Sonnino and McWilliam, 2011). The case study approach widely adopted also tends towards specific countries or regions (Walker and Preuss, 2008; Walker and Brammer, 2009; Preuss 2009; Morgan and Sonnino, 2007; Sonnino,

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[5] Food studies in this context comprises the social sciences disciplines of geography, planning and sociology

2009; Sonnino and McWilliam, 2011), reflecting the respective national political and cultural contexts. Brammer and Walker (2011) and Morgan and Sonnino (2008), however, have undertaken international comparative studies through which they were able to demonstrate more critically the importance of the national and regional policy environment as an influence on practice.

The following review is presented through a number of content and methodological themes which emerge from an analysis of the sustainable public procurement literature.

1.6.1 Research Perspectives in Empirical Studies

Despite the subject of sustainable public procurement being in its infancy, there are emerging differences in methods adopted between the two main disciplinary perspectives of business/management and food studies.

Whilst both commonly adopt case studies, there is a marked, although not exclusive, tendency for in-depth qualitative studies within food studies based upon exploratory or inductive data collection (Morgan and Sonnino, 2008; Sonnino, 2009, Walker and Preuss, 2008).

The business/management perspective, on the other hand, favours an approach which adopts the extensive use of theoretical frameworks and measurement to guide studies. These are either drawn from the existing theoretical and empirical literature (Rimmington et al 2006; Walker et al, 2008; Carter and Rogers, 2008; Seuring and Muller, 2008); adapted from existing frameworks (Walker and Brammer, 2009; Brammer and Walker, 2010; Preuss and Walker, 2011), or as a result of an analytical approach to the literature review, in many cases validated through qualitative scoping interviews with experts engaged in practice (Rimmington et al, 2005). Data collection follows this theoretical development and is used to refine theory to particular contexts. The potential drawback of the sole use of existing frameworks as a basis for empirical   study is the way in which those frameworks have been adapted from previous work relating to environmental sustainability from a private sector perspective. As such they reinforce, rather than challenge extant perceptions. Although the same could be said for theory building from the literature, in a changing and emerging field of research, new material and insights are reflected and continuously updated.

Those studies which rely upon structured questionnaires in data collection likewise build upon pre-existing interpretations of earlier research, themselves contextually

and temporally dependent. Although they allow comparability, structured interviews and questionnaires do not have the same scope for uncovering richness and depth in data that might contribute to understanding rather than observation, but nevertheless enable quantitative assessments. Such quantitative techniques been used, for instance, to enable relationships between multiple variables to be established and ranked in terms of importance for informing policy imperatives (Brammer and Walker, 2010; Preuss and Walker, 2011).

Brammer and Walker (2011) have carried out an international comparative study of public procurement, as well as across central government departments within the UK (Walker and Brammer, 2010). The advantage of the comparative study is the ability to demonstrate differences, and conclusions support the theory that a layered or hierarchical policy environment influences practice.

Morgan and Sonnino (2008) also present an international comparison through a series of case studies in respect of publicly funded school food and in doing so demonstrate the many forms which good practice can take. Jochelson (2005) uses mixed qualitative and quantitative measures in an attempt to define a sustainable hospital food system in England, and Rimmington et al (2006) within the public contract catering sector.

Many of these studies seek to understand the perceptions of practitioners, for instance the barriers to engagement, whilst others seek to understand the variations they illustrate in their empirical findings. Although they explore the barriers, outcomes, and adaptation processes, like most of the sustainable public procurement studies, they adopt a 'flat' ontology.

The review of the literature therefore suggests that adopting a realist ontology (critical or otherwise) to find evidence of mechanisms for change as a means of explanation, will fill a critical gap in existing knowledge.

1.6.2 Conceptualising 'Sustainable Public Procurement'

The theoretical literature has started to consider the nature of sustainable procurement, in particular its emerging strategic role (Murray, 2009) and networked structures (Miemczyk et al, 2011). From the business studies perspective, Cousins et al (2008, p.13) theorise private sector procurement as part of a strategic supply chain paradigm and chart the evolution of procurement from purchasing as an operational function, confined but fragmented within the organisation as an administrative operation, through a phase which championed principles of

competitive advantage where purchasing evolved into a more strategic function, to a position where purchasing has become a strategic process aligned with overall corporate strategies and consequently able to deliver much wider outcomes than minimising the cost of purchase of goods or services.

Thus a strategic approach to supply chain management focuses not only on competitive advantage, but on cost reduction and systemic efficiency improvements in a more integrative approach. The development of sustainability, in this supply chain paradigm, is framed in terms of separate environmental and ethical strands, in practice driven by consumers, regulators and stock markets, with corporate social responsibility as the "*endeavours of the company to achieve sustainable development*" (Cousins et al, 2008 p.195), as "*economic behaviour, environmental impact and social policy*" (ibid p.199). This perspective therefore adopts a risk-based approach, purchasers aligning their priorities with markets. Sustainability is viewed as the need to extend business related concerns beyond the organisation, but along the supply chain, rather than as a societal concern.

Public procurement is differentiated from private sector procurement by Cousins et al (2008) by virtue of the use of public money, for which value for money and accountability for decisions have to be demonstrated in the goods and services purchased, how transactions are carried out and in terms of outcomes of the services delivered. Thus this conception of procurement as the purchase of goods and services, places the public sector within global commodity markets where large multi-national corporations exert their influence on governments and supply chains, notably in the food and pharmaceutical sectors. The authors nevertheless fail to make the connection with their conception of procurement as a strategic purchasing process, and alternative conceptions of governance.

Cousins et al (ibid) do, however, argue that publicly provided services operate outside of competitive markets and therefore regulation provides a proxy for the constraining effects of markets and suggest that efficiency is the main driver of public procurement in practice. The public sector operates, however, within a set of core values differentiated by locally determined political and cultural preferences and priorities. Economic efficiency therefore vies with principles such as social justice and ecological integrity, and Cousins et al's (ibid) view, although agreeing that sustainable procurement is a strategic process, ignores the need for public services to be effective, as well as efficient.

Miemczyk et al (2011, p.479) outline the varying scope and definitions of sustainable procurement from a detailed structured literature review of 113 supply chain management papers and suggest there is a lack of consensus within the business and management discipline, but nevertheless conclude from their analysis that studies can be categorised through analysis of structural relationships. Although the overall bias within the literature they reviewed was towards environmental concerns as outcomes of procurement, the definitions that adopted societal concerns were more recent and strategic within supply chain and network structures than those of the firm, where sustainable purchasing is generally defined an internal function relating to contracting or sourcing. Studies concerned with networked structures were more concerned with ethical and social responsibility outcomes and multiple stakeholder interests, whilst those of a supply chain perspective tend to focus on products and environmental concerns, rather than power and influence. The social elements within the sustainable purchasing and supply chain studies they consider demonstrate concerns about ethical trading, social equity in terms of minority supplier selection, compliance with industry standards and conflicts of interest.

Miemczyk et al (2011, p.491) conclude that there is much confusion within those studies, and no consensus of definition for procurement outside of the public sector, where there are relatively few studies. As a consequence, studies adopt or arrive at definitions that suit the purpose of the study, rather than critically address the higher order theoretical concept of sustainable development. Although the study by Miemczyk et al (ibid) highlights the importance of structural form, the majority of studies they review are undertaken at the level of the firm, rather than supply chain or networks, which is attributed to a continuing need for in-depth empirical study. Such in-depth studies are dominated by private rather than public procurement and have a narrow focus on specifying and achieving particular outcomes, rather than adopting a holistic approach towards sustainable development. One explanation offered is that (private) organisations have difficulty in defining their role within a bigger societal picture (Carter and Rogers, 2008).

Their review also highlights gaps in existing research, with internal concerns for 'make or buy' highlighted as potentially part of a sustainability paradigm and observes that supplier involvement in the planning and design of specific procurement processes is under-researched. Although the aims of their study do not focus on methodology, the studies they consider suggest that a processual study could provide additional and alternative insights to the body of existing literature.

Murray (2009) also highlights the confusion over policy definitions of procurement, quoting separate definitions for purchasing, procurement and commissioning. The purchasing cycle is a process of determining need, supplier selection, contracting, ordering, expediting and evaluation. The procurement cycle differs from this as it includes the extra tasks of options appraisal, sourcing and delivery, and commissioning cycle adds strategic needs assessment, prioritising outcomes, planning and designing services to the beginning of the cycle and monitoring and review as the post-contract phase. Differing UK policy and stakeholder definitions also demonstrate the lack of consensus.

Defra (2006) promote sustainable procurement as synonymous with good procurement, compatible with private sector economic efficiency drivers. This definition also stresses that sustainable development should be an organisational priority that procurement should not only question *why* there is any need to spend, but interrogate *what* needs to be purchased and *how* money is spent, with decisions based upon the whole life cost of products and services, and outcomes apparent not only for the organisation, but for society and the economy. The alternative definition from Sustain (Peckham and Petts, 2003) has suggested a stronger definition seeking environmental protection. Whilst each focus on process and outcomes, there are notable differences in conceptions of the degree of environmental impact: protection versus minimising damage.

Whilst the NGO definition overcomes the problems of scale and heterogeneity of particular processes and their desired outcomes, it is also commensurate with an idea of sustainable development as a cultural rather than economic concern, underpinned by shared values, but nevertheless refined by local-global concerns. The policy definition, on the other hand, accommodates fragmentation and differentiation between particular processes, but is weak in that it enables political prioritisation and specific measurement of outcomes at differing scales and in different contexts, potentially conflicting with the fundamental holistic and societal aims of sustainable development as a higher-order construct (Carter and Rogers, 2008, p.360).

Empirical research into public food procurement has largely focused on management and supply chain perspectives, ostensibly in order to define a sustainable food system in particular contexts (Jochelson, 2005; Rimmington et al 2006; Morgan and Sonnino, 2008), to examine good practice in respect of specific projects (Walker et al, 2008; Preuss, 2007, 2009) or to evaluate particular policy initiatives (Erridge and Greer, 2012). Mikkelsen et al (2005, 2012) have considered

public food service, although explicitly detach this from procurement in their 2012 project evaluation for the introduction of organic food onto the public plate in Denmark, and Sonnino and McWilliam (2011) evaluate elements of food service, catering as well as supply chain outcomes, but not the essential middle: the planning or contracting processes. Collectively these authors have largely failed to critically address the precise nature, scope and definition of procurement in practice, taking policy definitions as given.

Rimmington et al, (2006) do however, attempt to develop a model for practice in contract catering to align with policy. Preuss (2009), on the other hand, seeks to understand local authority procurement managers' perceptions in order to define a concept of sustainable public supply chain management. As an adaptation of Carter and Rogers conception of public procurement as "*the strategic and transparent integration and achievement of a public sector organisation's social, environmental and economic goals in the systematic co-ordination of key inter-organisational commercial processes for improving the long-term performance of the organisation and the territorial base for which it is democratically accountable for, in line with overarching public policy priorities.*" (Preuss, 2009, p.220) Preuss concludes from empirical research that sustainable development is a strategic process within the organisation and that sustainable supply chain management involves the "*systematic achievement of an organisation's social, environmental and economic goals*" (p.218).

A broader governance lens, does however, shed some light on the apparent confusion, enabling Murray's three terms (2009) to be viewed in terms of complexity, purchasing being the demand decision of 'if and what to buy', commissioning relating to 'how to deliver (or purchase) services' and procurement as a strategic purchasing role, focusing on 'whether, what and how to purchase'.

Nevertheless, the literature suggests that sustainable public procurement, as the economic activity of the state, is not merely a matter of the arrangement of structures or functions and how they relate to markets through purchasing decisions, but a process of governance which addresses the way in which services are delivered, as well as stakeholder outcomes from purchasing activities.

1.6.3 The Case for Change

The primary difference between private and public procurement arises from differing objectives, with social goals an imperative for the public sector alongside a need to take into account multiple stakeholders' needs. Non-governmental organisations

(NGOs) are also good arbiters of acceptable and unacceptable standards in public service provision, and the goods provided as part of those services.

Non state actors have been instrumental in promoting more sustainable procurement in the public sector, particularly apparent in respect of food. Sustain have achieved this through the 'Public Plate' campaign and the Food for Life Partnership in respect of school food. Building from the successes of the Food for Life programme (Kersley, 2011; Orme et al, 2011; Teeman et al, 2011), the Soil Association have devised a Food for Life Catering Mark as a measure of quality in other public catering settings, such as hospitals, achieved through promotion of standards based on the use of fresh, seasonal and unprocessed food.

The NGO commissioned research literature relating to hospital food procurement, primarily commissioned by Sustain, the Soil Association and Healthcare Without Harm, has a primary focus on the provenance, freshness, and production method as drivers of sustainability and quality in public food procurement, thereby focusing on food system and health related outcomes.

The involvement of state and non-state actors in challenging existing practices in hospital food also highlight the importance of assessing economic need through business principles *and* social needs through the public sector obligations towards citizens. In hospitals, poor practice in meeting nutritional and care needs of vulnerable patients continues to be demonstrated by NGOs (Sustain, 2009, 2010; Soil Association, 2011; Dispatches, 2011; BBC, 2011).

The political impetus for improving hospital food came about through the Department of Health's (DoH) Better Hospital Food Programme, which involved celebrity chefs in devising standardised and nutritionally assessed menus. Nevertheless, the driver of the programme was research commissioned by BAPEN into the prevalence and cost of malnutrition, particularly in respect of the additional costs of supported and artificial feeding in hospitals (McWhirter and Pennington, 1994; Allison, 1999). Rather than rely on the moral dimension and ethical issues of rights, care or dignity, the estimated cost of malnutrition provided a business case for government action. Research has, however, repeatedly considered the prevalence, prevention and cost of malnutrition in hospitals (Allison, 1999; Beck et al, 2001; Bistrian et al, 1976; Garrow,1994; Hill et al, 1977; Kelly et al, 2000; McWhirter and Pennington, 1994; Stratton and Eliah, 2000). BAPEN (undated), for instance, estimated the annual cost of malnutrition, assessed by the cost of supplementary feeding, to hospitals alone in the UK at £3.8bn in 2003.

The links between these issues and sustainability were highlighted in successive conferences arising from the Better Hospital Food Programme in 2003 and 2004, sustainability being viewed as a driver of quality and improvement in the practice of procurement and catering in hospitals. Whilst the programme offered a view of best practice, NGOs have subsequently demonstrated that there has been little evidence of any impact. Whilst the heightened profile of food as nutrition promoted the direct link between health and sustainability, subsequent academic research attempted but failed to provide a suitable single theoretical definition of a sustainable hospital food system (Jochelson et al 2005a; Jochelson, 2005).

Research by Rimmington et al (2006), commissioned by the Department of Environment Food and Rural Affairs (Defra) in connection with the Public Sector Food Procurement Initiative (PSFPI), focuses on the contract catering sector in the UK. Their study illustrated a general lack of resource and political commitment to supply chain development and particularly the social aspects of purchasing, despite an explicit commitment to food being an important part of corporate social responsibility. The participants also took a narrow view of sustainability, bounded by largely environmental and economic concerns, health considered a private issue of choice, rather than sustainability.

This research suggests that policy and guidance alone are instrumentally weak when it comes to changing corporate behaviour in the supply chain, but also that NGOs have been particularly strong in highlighting poor practice and finding ways to translate theory into practice through partnerships with the public sector. Nevertheless, the focus remains on what good practice should be, rather than how change can be brought about.

1.6.4 Good Practice

A recurrent theme in governmental reports regarding sustainability in procurement is the dissemination of case studies to illustrate good practice. Learning from others' experience and example is common in the private sector, but 75% of public sector respondents to government commissioned research did not consider such learning important in public procurement (PWC, 2011).

The study by Rimmington et al (2006) also sought to involve the contract catering sector in developing a set of good practice standards and indicators that were both acceptable and feasible for public sector contract catering companies. The researchers and a small panel of industry experts from Defra and the hospitality industry initially developed nine principles for sustainable food procurement from the

literature on sustainable food systems. They then discussed these with the participating contract caterers. Of the nine principles, only five were deemed to be acceptable or feasible, although the authors reflect that they were not necessarily evident in practice (Figure 1).

Figure1: Standards for Sustainable Food in Public Contract Catering (adapted from Rimmington et al 2006)	
Acceptable and Feasible	Unacceptable and Not Feasible
Source local (UK) where possible, i.e. when available in quantity, quality and price	Ensuring transport energy efficiency outside the company
Provide menu information to enable choice based upon provenance and sustainability	Using animal food products and minimal welfare standards
Avoid buying goods known to be environmentally and ethically unsound	Minimising additives, salt, sugar in products and processing
Collaborate within the industry on purchasing and supply chains and supplier development	Embedding international Labour Organisation standards in supply chains
Prioritise resource efficiency in processing (water, waste, energy)	

Although not necessarily win-win, the unacceptable / unfeasible principles reflect a relatively weak commitment and a fairly narrow, rather than strategic, perspective of sustainable public food procurement, the unacceptable principles essentially being supply chain or network management issues and consequently outside of the immediate control of the organisation. The study illustrates the lack of public sector power and consequently the need for genuine convergence of values to achieve desired outcomes, particularly in the absence of contractual obligations. The responsibility (and accountability) for sustainable food appears, from this study, to have been abdicated, in which case the values and commitment to sustainability of the contractor will prevail unless government mandates through regulation or contract, rather than merely sets an example.

Local authority procurement initiatives for sustainable development in England have been studies by Preuss (2007, 2009). In an initial exploratory study, he identified good practice initiatives undertaken by local authorities, categorised through the conventional social, environmental and economic pillars of sustainable

development, and followed this up through a further analysis which revealed that the initiatives often applied across more than one of the pillars, but could be categorised as strategic, product, support or process based (Figure 2).

Figure 2: Summary of categorised initiatives: Local Authority Procurement in England (Source: Author; data drawn from Preuss, 2009)				
Strategic	Product Based	Support based	Contract based	Process based
Policy instruments Knowledge dissemination Sustainability risk assessment in eye contracts Knowledge and skills through training Certification (ISO 14001; EMAS) Supplier risk assessment Awards system	Local food SMEs (1st and 2nd tier suppliers) Encourage Fair Trade Low energy Recycled products Avoidance high risk products Alternative Fuel Vehicles	Transparency (meet the buyer; e-procurement) Supplier development (capacity and capability building) Management (measuring expenditure with local suppliers)	Building design Recycled products Standards specification	Specification (Community Benefit Clauses) Green energy Avoid use of disposables

Although not using Carter and Rogers' (2008) framework as a basis for the study, Preuss suggests that his findings correlate strongly with their theory and that strategy, culture, risk management and transparency are present in practice within public sector procurement activities. His suggestion is that good practice in sustainable procurement needs to be strategic at the organisational level, and as such extends along the supply chain, although as previously noted, there is no overt consideration of the detail of how demand is established within sustainability principles, or embodied in the contractual relationship. The conception of process within Preuss' analysis is also rooted within the managerial perspective of process as a discrete object rather than philosophical position.

The food systems approach to public procurement considers good practice as more spatially localised, with equitable and democratic food chains that can simultaneously deliver economic, social and environmental benefits (Morgan and Morley, 2002; Morgan and Sonnino, 2005, 2008; Sonnino, 2009, 2010). The role of procurement managers within this paradigm is one of creativity; good practice

illustrates how politics and local and organisational cultures can mutually support markets locally and globally but also their power to hinder progress. Creativity within legal boundaries and the structures and politics of neo-liberalism has been shown in practice to bring about health benefits to pupils through school food in different contexts. Political commitment at local and national level, through the setting of nutritional standards and targets for local, organic, and speciality foods such as PDO, PGI and Fair Trade, as well as using food to educate communities about broader issues such as sustainable production and healthy consumption, are all shown to have overcome the commonly perceived barriers discussed in the literature. Nevertheless the dependence upon political commitment at multiple scales perhaps indicates why there are only islands of good practice, long term commitment coming, in theory, from embedded values of caring and justice in cultures and through structures that support democracy.

Case studies of hospital food and sustainability as local economic development through re-localised food chains have focused on the exemplars, in particular Cornwall (Thatcher and Sharp, 2008; Foster et al, 2005; Kirwan and Foster, 2006, 2007; Russell, 2007). Thatcher and Sharp's research (2008) uses the existing theoretical framework for the local multiplier effect (NEF, 2005) in order to estimate the quantitative economic effects of local purchasing by the NHS Trust, on behalf of the Cornwall Food Programme, and whilst concluding that it has limitations, there are seen to be positive local effects of maintaining economic activity as a result of money recirculating in the local economy. The study refined the methodology to combine qualitative and quantitative data, and concluded that a more simplified approach, the lower order multiplier, LM2, did not result in any significant difference in outcome. The qualitative element also enabled a deeper understanding of the critical local issues and impacts, potentially extending the focus beyond economic concerns.

These examples of good practice are, however, variable (Walker et al, 2008; Brammer and Walker, 2010) few and far between (Morgan and Sonnino, 2008), issues also highlighted in Russell's research into hospital food (2007).

The difficulty in prescribing best practice models is illustrated in Jochelson et al's work in respect of hospital food (2005). Their project was an evaluation of the Better Hospital Food Programme, and had multiple aims:

–   to benchmark existing practices in hospital food procurement and catering;

- identify opportunities for sustainable food procurement and healthy eating promotion in acute hospitals;
- raise awareness of sustainability in procurement, catering and consumption of healthy food, and
- show the costs and benefits of positive action to hospitals, public health, the environment and local economies and communities.

Their conclusion, that there can be no single sustainable hospital food system model, concurs with Lang & Heaseman (2004, p.127) that a "health-centred" food system is needed to bring about positive environmental, economic and health benefits. Jochelson et al proposed three alternative models for sustainable catering in hospitals (Jochelson et al 2005, pp.30-31):

- Health Protection Model, which seeks to protect and improve individual and environmental health by promoting good diet and limiting use of products and processes with high environmental impacts.
- Healthy Menu Model, which focuses on a healthy diet via healthy menu development and improvement of the patient experience. This model promotes fresh seasonal and minimally processed food, low in harmful ingredients such as salt.
- Health Promoting Supply Chain Model, which develops a market for smaller producers, organic and fair trade products, addressing sustainability issues via the contract specification and selection criteria.

The authors also acknowledge that the selection of model will depend upon the operational aspirations of individual organisations, and the relative importance they attach to hospital food. They also acknowledge that none of the models they propose will address all areas of sustainability simultaneously, but their suggestions do allow Boards and Trusts to identify priorities in a pathway to more sustainable procurement practices, thereby linking operational practice to political action.

The reference to circles of control and influence (Jochelson et al, 2005, p.26) acknowledge external layered influences at differing scales from multiple origins, suggesting a more integrated system of governance than a closed organisational system, with asymmetrical and contingent influences playing a significant role in any sustainable procurement process. Again Jochelson et al (ibid) do not critically address the definition, nature or characteristics of procurement, in particular the integration or separation of the catering, purchasing and procurement roles.

1.6.5 Barriers, Drivers and Enablers for Change

Good public procurement practice, through the use of case studies of exemplar organisations, also demonstrates empirically the barriers to engagement with sustainable development.

Evidence of the lack of engagement with sustainable food procurement, particularly in the health sector is illustrated in the evaluation report of the PSFPI (Deloitte, 2009), where only three health organisations responded to the survey questionnaires, those organisations known to be exemplars in their sector. Although competing priorities in healthcare might partially explain this, the response rate from other public sector organisations was sufficient to gain some insights of the range and types of barriers, and whether responses were context dependent.

Whilst Walker et al (2008) and Walker and Preuss (2008) expressly consider green, rather than sustainable public procurement in their studies, their methods and conclusions inform subsequent research from the supply chain and purchasing and supply management perspective. If, as suggested, practising green procurement is less problematic than sustainable procurement, then consideration of barriers to engagement might also inform debates on transition to enable procurement to meet sustainable development objectives. Their study of perceptions of drivers and barriers to sustainability integration took place across the public and private sectors. In studying a number of exemplar projects and organisations in the UK, the authors were able to show that both drivers and barriers were predominantly external to the organisation and broadly in line with that cited in existing literature. Their key findings are summarised in Figure 3.

Key internal drivers across the study were found to be the culture and the nature of the organisation, particularly values; an element missing, in their opinion, from the public sector case studies, despite the broader goals and objectives of the public sector. The findings were, however, contextually dependent rather than generalizable, as the variety of projects and number of case studies was small (7). The community health sector, for instance, was more aligned with the consequential benefits of localising food supply chains for economic activity and well-being; risks associated with public embarrassment from poor supplier performance and the role of value champions as powerful drivers of integration of green values. Although remarking specifically on the lack of values by comparison to private firms, the authors do not relate this to concepts of organisational culture, taken for granted

values in behaviour rather than symbolic values being representative, albeit in part, of organisational culture.

Figure 3: Key findings from Walker et al (2008)	
Public Sector Drivers:	Public Sector Barriers:
Internal:	*Internal:*
	Cost (need for business case)
	Localised projects
	Lack resources
External:	*External:*
Regulatory compliance	EU legislation
Environmental risk minimisation	Confidentiality – supplier commitment (transparency)
Environmental performance monitoring	Exposure of bad performance
Customer/client pressure	Supply base (too broad or too restricted)
Regeneration	Culture (clinical preference; food choice)
	Inertia
Source: Author	

Internal barriers included costs, although less so for the large single organisation, where there was strong procurement experience and expertise, but also an oligopolistic supply chain. The need to provide a business case for green procurement was found to be a particular issue in the public sector, although somewhat in contradiction to the cited example of innovative practice in the healthcare community, where the necessary capital funding was brought about in collaboration between purchaser and supplier. The use of partnerships and innovative thinking also helped to break down a lack of trust between suppliers and purchasers, particularly the lack of supplier engagement with the public sector due to the perceived business related risk to the contractor in revealing their green credentials in such a public arena. Collaboration also enabled a mutual learning process along the supply chain to enhance knowledge and thereby reduce risks to purchasers and suppliers alike.

Whilst regulation was considered to be both an external driver and barrier, it was perceived as setting the minimum level for compliance. The evidence from Walker et al's (2008) study, however, tended more towards regulatory compliance being a barrier in the public sector, potentially an indication of an inertia to innovate or culture of compliance. The fragmented nature of the SME supply chain, particularly relevant to public food procurement, indicated a general lack of commitment within the supply chain to green issues, either as a result of perceived costs of innovation or lack of appropriate knowledge and skills.

Other studies of sustainable public procurement have also focused on practitioner perceptions in order to identify barriers preventing change being brought about, or perceived key priorities for sustainable procurement within specific sub-sectors of public practice. Brammer and Walker (2010), for instance, have studied public procurement in 20 countries and conclude that both the national and international policy environment and the level of national engagement with the concept of sustainable development are major influences on practice, concurring with Walker et al (2008) in respect of the significance of external influences.

The aims of Brammer and Walker's (2010) study were twofold; to assess differences in practical approaches to sustainable procurement, and to find out what the perceived barriers to sustainable procurement were, their view of the purpose of sustainable public procurement being to reduce the organisational social and environmental footprint, and stimulate sustainability in the private sector. The emphasis on environment within EU policy and guidance is cited (ibid. p.458) but also that public sector engagement with sustainability was most developed within the UK public sector. This propensity to engage with sustainable procurement was also investigated by these authors (2009) in a systematic evaluation of procurement practice, differentiated between categories of general public services, health, education and 'other'. Although the studies aimed to find generalisation to enable barriers to be overcome, the individual behavioural focus was constrained to perceptions of relatively elite respondents, each within the dominant influence of their respective sectors. The study also provided evidence of the lack of professional procurement personnel within those elites. Despite being based upon a sample of 68 UK respondents, this only represented 3.6% of qualified public sector members of the Chartered Institute of Purchasing and Supply in the UK.

A further key finding of their research was that different perceptions of barriers that exist between public sector departments. Respondents in the health sector, for instance, emphasised cost constraints, finance, lack of resources and time

constraints as key barriers, the latter three to a far greater extent than other public sector divisions.

Walker and Brammer (2011, p.129), also conclude that whilst there is an emphasis on supporting local economies within government elites in general, this is less apparent in health care, which they attribute to different contextual priorities. Within the local authority sector, concerns for local employment and regeneration enable deeper consideration of regeneration benefits to offset costs within that sector whereas the priority in health care is deemed to be the patient, often as a discrete episode of treatment, rather than any resultant benefits beyond the organisational function or accountability.

A qualitative study was undertaken into the psychological barriers to implementation of sustainable procurement in the public sector by Preuss and Walker (2011). A theoretical framework was developed from a literature review prior to undertaking qualitative interviews. The findings were compared with the framework, which considered cognitive and affective factors influencing individuals, groups and organisations. They found that influences affecting engagement with sustainable public procurement initiatives emanate from within and external to the organisation and occur at small group, intra-organisation and inter-organisation level. Although perceptions of the psychological barriers repeat findings such as lack of knowledge and skills; and the difficulties in integrating long term and social issues into operations; cost cutting priorities; cultures and decentralised structures, the processes of change as adaptation at the differing scales provides a different perspective as well as extending knowledge of public procurement from a practitioner perspective.

Individual factors that impact on whether actors engage with procurement initiatives were both cognitive, in terms of knowledge and skills, and affective, such as motivation, attitudes and perspectives. Organisational factors were found to be structure, roles, competing priorities and sub-cultures[6] (Preuss and Walker, 2011, p.505). The difficulties in co-ordination between organisations and conflict between demands for aggregating demand, sectoral priorities and market structures were key external factors. Factors that refined the theoretical framework, specific to public procurement, were found to be the increasing complexity of public sector supply chains, the legal framework for procurement in the UK, and particular concerns for local economic development (in Local Authorities). Key issues common to these

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[6] The authors actually refer to norms, routines and cultures.

academic studies, which can be re-interpreted as focusing on barriers to change, illustrate that such barriers are inherently power laden, influences displaying differential contextually and temporally dependant interrelationships and dependencies. It is, however, important to note that although these studies were published from 2007 onwards, the original data collection took place in 2005-6 and preceded published guidance on procurement for social objectives (EU, 2006; OGC, 2006), notwithstanding the recommendation by the SPTF to do so was in 2003. To that extent, the common complaint about lack of knowledge and skills might not necessarily be one that endures.

In addition to the academic research, there have been a number of reports prepared for the UK government relating specifically to the issues surrounding sustainable public procurement, each identifying, albeit a-theoretically, perceived barriers to implementation (Figure 4), and making recommendations for action (Figure 5) (SDiG, 2004; House of Commons Environmental Audit Committee, 2005; Accounting for Sustainability Group, 2005; NAO, 2005, Defra, 2006; NAO, 2006).

The 2005 report by the NAO followed interviews with actors in procurement across 20 central government ministerial departments in order to ascertain whether the commonly perceived barriers cited in the literature were merely perceptions of, or were real barriers to, sustainable procurement. Whilst they concluded that there were high level processes available to enable sustainable development, with environmental purchasing policies in place, practice varied from policy and mechanisms to put sustainable procurement into practice were missing. In total, 72 barriers were cited, although it was notable that some participants cited as few as 4.

Both 'health and social care' and 'food' feature in the top three in the SPTF (Defra, 2006) list of areas for prioritisation for public procurement, in what they describe as a critical sector. The methodology underpinning their assertion considers the potential extent of and influence from gains by sustainable procurement, but only in terms of monetary value of the public sector spend.

Figure 4:   Perceptions of Key Barriers to Sustainable Public Procurement in Government
Commissioned Research (Source: Author)

- *conflict* between sustainable procurement and reducing costs, needing a culture change for long term planning and budgeting
- costs perceived as priority over sustainability
- OGC instructions placed value for money at the award stage rather than at specification stage
- whole life costing
    - leads to uncertainty – how to measure and justify
    - no incentive or motivation because of separation of budgets between capital and revenue (purchase cost and maintenance)
    - lack of 'buy in' to the concept across teams
    - lack of scope to consider whole life costs because of short term budgetary cycles
- *lack* of leadership commitment to sustainability across government and departments
- *lack* of integration of sustainable procurement into process
    - sustainable development is not a core business for their department and therefore no senior management commitment
    - positive correlation between the lack of priority (management commitment) given to sustainable development and perceptions of lack of resources to further sustainable development
    - lack of integration leading to the belief that sustainable development is a peripheral concern
- *lack* of central control within departments
    - central ministerial departments do not directly control local procurement teams (agencies, non-ministerial departments and sub-contractors)
    - central procurement role can be limited to policy, authorising and managing some contracts
    - decentralisation poses problems due to lack of central oversight
        - autonomous decentralised procurement teams, resulting central role is advisory
        - lack of professional procurement in small and localised areas
        - difficulty in obtaining robust data for monitoring and evaluation from decentralised procurement teams
        - inability to mandate and enforce sustainable procurement
- *lack* of knowledge of sustainable procurement
    - insufficient knowledge about sustainable procurement
        - about why sustainable procurement is important
        - lack of skills in contract specifications and clauses
    - no prioritisation of training
        - lack of awareness of opportunities for training and lack of uptake on available courses
        - lack of resources to deliver training on sustainable procurement as not part of core business
        - lack of leadership and priority given to sustainable procurement
        - guidance on sustainable procurement insufficient
        - reliance on Joint Note (OGC, 2003) voluntary hampering central procurement teams to ensure implementation
        - poor access to OGC guidance

49

Figure 5: Summary of Key recommendations of the Sustainable Procurement Task Force (Defra, 2006)

- ___Lead by example___, using the power of public purchase to drive and embed change in all sectors

- ___Set clear priorities___, by rationalising sustainability guidance to a single framework, and giving ownership to a single body, which they suggest is the OGC (rather than Defra)

- ___Raise the bar___, by introducing mandatory and enforceable standards

- ___Build Capacity___, by increasing knowledge and skills and professionalising sustainable procurement

- ___Remove___ _actual and perceived barriers_ to sustainable procurement

- ___Capture___ _opportunities by innovation_ and embracing the idea of wider social benefits that stimulate local economic growth, equality and employment opportunities

Source: Author

1.6.6 Bringing About Change

Whilst barriers feature across academic studies and government commissioned research, the presence of barriers is linked to the need for change. The SPTF made recommendations in 2006, summarised in Figure 4.

The framework used for the study by Preuss and Walker (2011) explicitly considers change, but as psychological processes of adaptation, and concludes that such processes in this context could actually create barriers to individuals developing initiatives. Within their selected exemplar organisations, adaptation processes occurred at group level, within and between organisations. Risk aversion and inertia are claimed to be embedded in the culture of procurement, but there was some evidence of success in changing behaviour through soft approaches, such as education and communication. At group level, structures were deemed to be particularly important, especially the need to strategically embed sustainable development, but also in allowing procurement to lead on sustainability within the organisation, which could be interpreted as a process of professionalization.

Internal adaptation processes arose at group level and from the need to overcome problems related to trust, resistance and co-operation, in structures and cultures, with solutions found though collaboration. The need for external adaptation arose from perceived policy and legal conflicts and contradictions, contextual priorities and isomorphic pressures to follow best practice. Adaptation processes in re-structuring,

as decentralisation by outsourcing, were found to have a negative impact on sustainability initiatives although maintaining the momentum of change was seen as crucial to overcome individual and group psychological barriers. Re-structuring could, however, be interpreted as disempowerment and de-professionalization of the remaining procurement personnel, rather than any devolution in status of a strategic procurement role. The key recommendation for overcoming the barriers is for adaptation rather than radical change, through collaboration, both within and external to the organisation.

Sonnino (2010) provides examples of the way in which devolution has enabled positive change in the procurement of school food. In Scotland devolution enabled priorities to be reviewed, to focus on health and well-being rather than economy. In Wales, Carmarthenshire County Council found innovative ways to cut across traditionally and structurally fragmented policy areas in the procurement of school meals. Despite strategically prioritising health outcomes in both of these cases, cultural barriers that embed a neo-liberal priority of lowest cost, both within the organisation and potential suppliers, needed to be overcome. However, in the studies Sonnino (ibid) refers to, positive social and cultural outcomes ensued as a result of initiatives that started out from a desire to source food locally.

Governance as a process embodying change features in case studies of school food provisioning (Morgan and Sonnino, 2008). The authors refer to the importance of developing and sustaining relationships across the entire food chain as essential to the efficient procurement of healthy nutritious food, but also the need to plan and implement change progressively in order to calibrate supply and demand, as illustrated in the successful case of Rome. Whilst food in Italy reflects a national culture of food that values quality and provenance, they suggest that political intervention that embeds health in food and food in the education system is more influential than national culture, identity or tradition. In the UK and New York, other case studies from their research, the creative adoption of neo-liberal principles, was shown to bring about a change in culture: from one of deeply embedded social preferences for unhealthy food to one where healthy food is accepted as the norm within schools. This was achieved by focusing on pupils as consumers and deploying private sector practices such as social marketing, thereby catering to choice, but within determined limits that prioritised nutrition. By focusing on outcomes, and working within structural constraints, the schools were able to overcome a hostile political environment that would have prevented radical action at

a local level. Whilst responsibility in the public food system in these studies is decentralised, the power to regulate remains with government.

Further school food case studies from the UK and Ghana consider school meals in differing contexts where structural cultural and political influences in governance were critical factors in the success or otherwise of the initiatives. Whilst in Ghana attempts were made to design and impose a system from scratch with the intention of replacing imported food with locally grown, power struggles within the newly imposed structures reflect top-down decision making rather than decentralised local system. The pace of the planned and radical changes also contributed to the problems of implementation and calibrating supply and demand in the food chain.

The re-fashioning of the food supply chain in the NHS in Cornwall has been studied in depth (Foster et al, 2005 and Kirwan and Foster,2007). Foster et al (2005) illustrating that co-operation and collaboration in the form of partnerships between health organisations and other stakeholders in the food system was necessary to bring about positive change in Cornwall. Innovative and creative ways of financing the development of a new CPU was seen as a key enabler to the development of the programme, the ability to lever EU Objective 1 and NHS Local Improvement Finance Trust (LIFT) funding being critical to its development. Such sources of capital funding would not necessarily be available in other locations, LIFT funding only available in England as a public-private venture. Furthermore, the recipient of the funding is not the NHS trust itself, but the LIFT company, and therefore outside the formal structure of the public sector and with no operational role in procurement or production. The lessee, the hospital trust, retains operational control, but is an external supplier to other public organisations and consequently in direct competition with the major outsourcing catering and facilities companies rather than an internal supplier within the NHS Trust. The need to compete has, in practice, resulted in ready meals being produced 'locally' in Cornwall being available anywhere in the UK via NHS Supply Chain, although whether this is a competitive need to enable the production facility to survive economically, as a means of regional resilience, or of driving up the quality of the food itself, is not apparent.

The actor-network methodology adopted in Foster et al's (2005) study considered the major risks to the network itself, including the need for political will within the NHS Trusts to commit, as far as legally permitted, to purchasing from the new central production facility. Neither this, nor Thatcher and Sharp's (2004) economic impact study, consider the wider consequences and economic impacts on other localities where economic activity may have been adversely affected by the

Cornwall re-localisation agenda, or the possibility that on a national scale there is no net economic gain. Although the Cornwall project was initiated and is underpinned by a sense of loyalty and local identity, as identified in Foster et al's study, the commercial and economic priorities underpinning the practice, combined by the relatively low proportion (3% in 1999) of the local economy employed in agricultural production (Foster et al, 2005, p 3), suggest that the re-localisation rationale is not necessarily one of engendering sustainable modes of agricultural production, even if it can support the local service businesses that together provide 65% of Cornwall's GDP.

1.6.7 Hospital Food Procurement: Assessing Needs

The body of literature on sustainable public procurement suggests that good practice is reflected in a dynamic strategic process embedded within governance. Whilst private procurement processes assess need in 'make or buy' decisions throughout their internal processes, the public procurement process is concerned with multiple and differentiated needs and outcomes, underpinned by a set of public sector values, goals and moral considerations, such as justice.

Whilst there is a large gap in the 'Public Plate' literature which considers the strategic procurement process as an organisational demand process, particularly in relation to food, there is relatively little research into sustainable public food procurement in the health sector. Focusing on the procurement of hospital food, second in aggregate UK public expenditure to school food, will contribute to current knowledge on sustainable public procurement and the 'Public Plate'.

Nutrition and malnutrition have been researched from the clinical, nursing and health economics perspective. BAPEN's study (undated), demonstrates that nutrition is an issue of care and management integral to the delivery of healthcare and thereby a strategic procurement process. As such, the assessment of needs for hospital food prior to sourcing and contracting the ingredients for meals is likely to bring together a number of stakeholder interests representing not only nutrition and care, but facilities management and catering.

Studies into hospital catering, facilities and hospitality, meal production and food service, have explored operational policy, and the roles and relationships between nurses, caterers, patients and housekeepers in hospital settings and catering performance (Bond, 1998; Wood, 1998; Hwang et al, 1999: Donnelan, 2000: Horan and Coad, 2000; Paisley and Tudor-Smith, 2001; May and Smith, 2003; Savage and Scott, 2005: Baum, 2006, 2007; Richmond, 2007). Although studies into

practices within hospitals, they generally adopt a functionalist dyadic approach, rather than any strategic relationships between multiple roles within or external to the organisation.

Baum (2006), for instance, focuses on the nature of change within hospital catering management as a response to the changing clinical environment, patient expectations of services in general and the role of catering within healthcare governance, particularly the transition of catering to a facilities management paradigm. He describes how this has been accompanied, in some organisations, by a rise in status within the management structures, the responsibility moving from kitchen to facilities managers, and the symbolic status derived from generic titles such as catering management, hotel services, hospitality and facilities management.

Patient experiences and perceptions of catering, facilities, food and food service have been explored (Edwards et al, 2000; Hwang et al, 2003; Edwards and Hartwell, 2006; Hartwell et al, 2006; Hartwell et al, 2007; Dickinson et al, 2008) with little evidence resulting that hospital food fails to meet patient expectations, or that different technologies affect perceptions of quality. Miller and May (2006) have also suggested that clinical factors champion over facilities in terms of patient choice of hospital, whilst May and Pinder (2008) seek, but fail to find any robust evidence, of the contribution of facilities services (food and cleaning) to patient outcomes in terms of satisfaction and length of in-patient stay.

Edwards et al (2000), Edwards (2003) and Edwards and Hartwell (2003) have used food waste to consider the economic and moral implications of avoidable and unavoidable food waste; the potential relationships between food quality, palatability and waste, as well as the relationship between the nature of the meal production and delivery system and waste (Hartwell and Edwards, 2001, 2003; Edwards et al (2000). Edwards and Nash (1999) have also studied potential links between food waste and nutritional intake. The study by Edwards et al (2000) sought to find the causes of food waste by mixed quantitative and qualitative methods; weighing plated waste, questionnaires, observation and qualitative interviews. Their conception of a food cycle (p.264), however, sees food service as a self-contained process within the organisation, ignoring, for instance procurement and the provenance of the food. As such the food cycle is viewed as food service management, with appropriate feedback loops that create opportunities for organisational learning, failures in the system being multi-faceted, relating to the meal (food patient and environment), the situation (experience and environment), assistance with eating, and lack of communication between the ward and caterers.

The management perspective adopted for these studies does not, however, overtly address the issues of systemic waste in processes, the cost or efficiency implications of waste, nor how food and nutrition inform food purchasing decisions.

Sonnino and McWilliam (2011) seek to use the lens of waste to study sustainability in hospital food procurement. Through a case study and a tested methodology for food service by Edwards et al (2000), the authors explore catering and food service practice within selected hospitals within a single devolved healthcare organisation in Wales. The study does, however, extend beyond the organisation itself and considers provenance. Whilst their study demonstrates that there is little apparent integration of the process between actors involved with hospital food provisioning in its broadest sense, there is no critical view of the procurement paradigm. In particular the authors fail to overtly acknowledge the significance of, or report on, the planning and contracting stages of the procurement process: the assessment of needs and how this feeds into decision-making for purchasing as sourcing and contracting.

Despite the study originating from the food systems perspective, many of the conclusions suggest issues arising within the organisation, either at a strategic level in terms of planning and service delivery, or within management of existing practices. The authors' conclusions also conflate the potential of the state as government through its policy-making powers and its own constitutional commitment and the actual power of devolved organisations who deliver the services on their behalf. Despite a stated focus on waste, there is no explicit critique of the nature of waste, the empirical study failing to take systemic waste within operational processes into account. The study also fails to consider the effect of the dominant departmental policy paradigm of health, widely cited in the procurement literature as a key barrier to implementation of sustainable public procurement.

1.6.8 Hospital Food Procurement: Gaps in Knowledge

Few authors who consider sustainable public procurement have contributed directly to the sustainability transition debates, and those who have made a contribution to the 'Public Plate' literature focus on the supply side from a food system perspective. There are no holistic studies of hospital food procurement that consider the nature of public food procurement as nutritional governance, rather than a discrete operational function, nor the relationships between actors, structures and practice.

Nor do studies directly address nature of relationships within the institutional context of healthcare governance.

1.7   The Healthcare Context

1.7.1   Governance: Structures, Power and Cultures in Health Systems

The context of this study is healthcare governance, defined by the WHO (2007) as 'leadership and governance ' and considered, according to Smith et al (2012), as the most complex and important governmental function in relation to health systems. Healthcare governance, they argue, provides a policy framework and a set of prevailing values within which all institutional and organisational processes are carried out on a day to day basis. Thus any objectively defined organisational process will be enacted within an arena where health (care) policy dominates alternative policy areas such as food.

The WHO describe leadership and governance in healthcare systems as ensuring the provision and effective oversight of strategic policy frameworks, building coalitions, providing regulation and incentives, designing appropriate systems, and ensuring accountability, thereby adopting a process view. Smith et al (2012) refer to governance as a social system in terms of markets, networks and hierarchies, the relative power of which is central to Barnett et al's (2009) consideration of new modes of governance within publicly funded health systems, particularly in relation to small states. The conceptualisation of leadership by Smith et al (2012) is that of a stewardship role, commensurate with debates on the role of the state outlined earlier in this Chapter, and is complimented by reference to managerial perspectives that consider the process of leadership in designing, implementing and assessing interventions. In an empirical comparative study of approaches to leadership and governance as steering processes, they compare healthcare systems in developed countries based upon a framework of priority setting, performance monitoring and accountability. Key points which could be argued as representative of a transition from public administration to active public management (Ackroyd et al, 2007) raised by Smith et al (2012) include:

- Priority setting, although an overtly political process is more effective if "*clear national goals are set, agreement is reached on how they are to be made operational, the detailed work of setting priorities can be delegated to an arms' length organisation*" (ibid, p.45), but in practice involve trade-offs between national and local priorities;

- National performance frameworks should be set based upon an agreed specification, enabling benchmarking and comparison, but need to be based upon meaningful measures;

- Accountability mechanisms depend upon context but the presence of sanctions is seen to be paramount. Accountability can therefore be choice based in a market system, be of electoral accountability, incentivised through greater autonomy or payment mechanisms, or by professional oversight and control;

- The congruence of goals of cost effectiveness, public health maximisation and patient safety across the case studies.

Governance and the organisation of healthcare within national health systems is framed by authors in terms of the way in which the service is designed, planned and delivered as integration and differentiation, centralisation, decentralisation, and competition (Mosca, 2006; Mur-Veeman et al, 2008; Ahgren, 2010; Ovretveit et al, 2010). Continuing this process view of governance, change is considered in terms of reform or implementation (Barnett et al, 2009; Toth, 2010). Empirical studies consider individual nations and make international comparisons, but discourse is dominated by structural concerns of hierarchies, networks and markets, with stress on the importance of multi-directional co-ordination, and a need for appropriate macro-level structures to enable change at that level (Ovretveit et al, 2010).

Whilst integration in these studies envisage a national holistic integrated health and social care system, barriers to the implementation of integrated care are cited as procedural, financial, cultural and competition (Mur-Veeman et al, 2008) with the extent of decentralisation in terms of hierarchical devolution of powers and accountability as well as ability to impact on delivery of care and allow for experimentation and dissemination of good (and bad) practice (Mosca, 2006, p.115). For example, Mur-Veeman et al (2008, p.180) cite tight centralisation and uneven distribution of power between historically and politically generated sub-cultures as a disadvantage to the necessary conditions for co-ordination in integrated systems, particularly apparent, the observe, in less collectivist national cultures.

The historical development of publicly funded health system structures across the developed world suggests consensus that political ideology drives fundamental structural reforms, based upon principles of social democracy, integration and regulation, or liberalisation, markets and separation in "reform waves" (Toth, 2010, p.82). Whilst not entirely rejecting ideas of path dependency, Toth suggests that

policy processes are contradictory, recurrent and circular (ibid. p.88) and consequently do not follow the linear trajectory inherent in path dependency theory, but are nevertheless underpinned by political ideology and political systems that fail to provide sufficient time to judge the efficacy of reform. Nevertheless, as Dickinson and Ham (2008, p.10) suggest, "*governance of health services cannot be considered in isolation from the historical and cultural context in which governance arrangements have evolved*", but that governance is very much an adaptive process, with an eternal search for service improvement in a complex and constantly changing environment.

Salient questions in relation to health system structures are raised by Dickinson and Ham (2008) following their review of health systems in countries with less than 10m inhabitants. These include the relationship between size and scale in relation to the number of statutory bodies; the level of devolution and integration in non-market health systems; the role and scope of regions, and citizen engagement and involvement in health boards. These structural concerns do not, as they point out, remove the need for adequate funding, nor leadership and performance management, but suggest that accountability to public and patients is equally important.

The primary focus of the empirical research by Mannion et al, (2005) was the relationship between organisational culture and performance, with the aim of informing policy on the use of culture change strategies to bring about improved performance in the particular context of healthcare in the NHS in England. Adopting a sociological approach and institutional economics perspective, the authors consider organisational culture to affect economic performance by:

- driving efficiency through shared values and internalized norms;
- affecting equity by inculcating shared moral principles of concern for others;
- influencing economic and social objectives, mitigating against purely economic goals;
- encouraging co-operation in complexity through identifiable shared values. (p.13)

Culture, they argue, offers an alternative mode of economic governance for healthcare, supportive of and substitute for both markets and hierarchies. Their study adopted mixed qualitative and quantitative methods and multiple case studies and was based upon Schein's (2010) layered conception of organisational culture observed through artefacts, beliefs and values, and tacit assumptions.

Relating their findings to policy recommendations they conclude that culture is significant but cannot be the sole means of bringing about change, as structural and procedural reform are also necessary. Whilst not proposing any causal relationship, the authors noted divergence in performance between NHS organisations in particular aspects of:

- leadership and management orientation, especially the relationship between transactional and transformational leadership, with more devolved participatory forms of management following evidence of sound accountability systems of informational infrastructure and performance management architecture
- middle management functionality, through devolved resources and capability development
- human resource policies that support workforce development
- inter-relationships and integration with the local health economy
- policy alignment to reflect shared values of transparency, openness, corporate outlook, team working and a focus on patient safety and quality
- anticipation and management of potential dysfunctional consequences
- an open systems approach where multiple policies, strategies and support systems (such as professions) are aligned, and the organisation relates itself to the wider economic, political and social environment   (ibid. pp. 208-214).

The research focuses on the case study organisations as bounded entities and the institutional economic perspective pre-determines a blinkered, albeit strategic, management view, which fails to critically observe the similarities between their recommendations and non-economic conceptions of governance, such as those proposed by Kooiman (2003). As such the research provides a partial view of change, rather than offering any form of explanation, although demonstrating empirical evidence of sub-cultures and differentiated power within organisations, as well as the critical role of leadership as '*dispersed leadership'* and thus enabling '*multiple points'* of entry for bringing about change (Mannion et al, p.42).

Structures have provided the specific context for empirical research into power relationships in the NHS (Addicott and Ferlie, 2007). Networked healthcare structures have been established to overcome the traditional power and political domination of the health care by the medical profession. The authors demonstrate, however, that the outcome of these new networked structures has been the transfer

of control and power to a dominant sub-group of medical professionals, who were able to exert their control over local strategic decisions. Within that medical professional group, the researchers observed that power was differentiated and directed towards resource allocation, the only option remaining for non-medical professionals being to resist decisions after they had been made. Inability to bring about change was attributed to a lack of skills and resources, but the continuing embedded and fragmented patterns of power are also indicative of enduring sub-cultures. Strong boundaries between professional groups as communities of practice were also observed to prevent the spread of innovation by Ferlie et al (2005).

The enduring power differentials between professional groups and management in relation to service reform in the NHS in England have been studied by Ackroyd et al (2007), who note that entrenched patterns of custodial administration persist, and express the view that management patterns have been shaped, if not captured, by clinical professional ways of thinking. Of the three sectors they studied, the NHS was the most painfully slow to change. Nevertheless, they do argue that expectations of rapid change and the way in which changes were designed and implemented were significant in constraining change. They attribute this to a coercive rather than collaborative approach, which was ultimately reliant on the degree of external occupational closure and autonomy.

1.7.2 Conflicting Ethical and Value Perspectives in Healthcare

Academic writing on healthcare systems emphasises structural, political and cultural influences within governance processes, the national cultural context and drive for efficiency and effectiveness of health systems as a whole being a common political priority. Such critical studies fail, however, to consider the specific and inherent and differentiated ethical positions and values within the respective health systems, supported by existing structures but also historically linked to political behaviour and the presence of professional sub-cultures.

Nettleton, however, describes the transformation of healthcare as a diffusion of the health agenda, reflecting a need for partnerships rather than technical interventions and a 'social turn' in healthcare, where traditional boundaries between public health as a social good potentially conflicting with biomedical conceptions of individual health as an objective state limited to an absence of disease (1995, cited in Cribb, 2005). This 'social turn' envisages a more holistic approach to healthcare, founded upon caring as an activity, inherent in debates about the ethics of care that underpin

conceptions of a moral economy (Sayer, 2000, 2000a; Morgan et al, 2006) and justice (Engster, 2007). Attributed to feminist scholars, an ethic of care has evolved from a second order, particular ethical theory akin to virtue and professional ethics, to a more general moral theory applicable to *" medical practice, law, political life, the organisation of society, war and international relations "* (Held, 2006, p.538), as a system of values ideas and concepts arising from the practice of care in response to material needs (Bubeck, 1995, p.11).

The act of caring within healthcare remains both gendered and associated with nursing and therapies, rather than clinical decision making or governance. Biomedical ethical theory remains focused on the patient individual autonomy (Beauchamp and Childress, 2009), whilst the management and evidence based practice requirements of clinical governance rely upon aggregated clinical outcomes at organisational level, thereby creating and sustaining cultural and structural differences that pose barriers to fundamental change. Ferlie et al (2005, p.128) describe this, in practice, as social and cognitive or epistemological boundaries, the outcome of which is to inhibit the spread of innovation in healthcare in the NHS. Nevertheless, the diffusion of the health agenda provides an opportunity for healthcare institutions and organisations to rethink their position as ethical organisations within a moral economy that views the positive side of the potential arising from local, global, human, non-human and ecological concerns as well as the values of sustainable development. However, as Morgan and Sonnino (2008, p.192) argue, values of "public health, democracy and environmental integrity" have to be actively pursued as political objectives. Within organisations, such changes have to be embedded in everyday practice as cultural change in order to endure, but political prioritisation and leadership are imperative in overcoming existing patterns of behaviour and structural obstacles. As the literature on health structures suggests, such change must be institutional as well as organisational, and thereby a matter of governance.

As a public service, healthcare operates within the realm of public service ethics, more usually referred to collectively as a public sector ethos as a set of values that underpins practice dependent upon national culture, political priorities and economic circumstances. This dynamic conception of public service ethos is described by Lawton (1998, p.48) as based upon honesty, probity, integrity, accountability, with the goal of acting in the public interest. Ackroyd et al (2007, p.23) suggest, however, that there are tensions between public service and a more commercialised professional ethos in practice, with the commercial emphasis on technical ability,

managerial skills and economic rewards, notwithstanding the inherent potency and relevance of notions of public service.

Ethical considerations suggest what ought to happen in the broadest sense, and in organisations where an ethic of care is fundamental to the core objectives of the sector, putting theory into practice is both legitimate and mandated. Nevertheless, empirical studies suggest that there remain extant professional and cultural differences, within which public service values are being moulded by commercialised, albeit professional values, that qualify core ethical concerns to those of cost control and customer care. This is, however, embedded within extant power relations that favour dominant professional interests which have an interest that, at best, mediates the pace of managerial reform.

1.8   Theoretical Frameworks for Nutritional Governance

The potential complexity of the study of governance processes invites the use of heuristic devices as a means of bringing the multiple issues, identified from the literature, together into a conceptual guide for fieldwork and analysis. Clarity is provided by adopting alternative frameworks for governance as an objective entity; firstly as a constitutional framework and secondly as a structural process. The constitutional framework provides continuity, whilst the actions of agency on those structures within a process of governance, enables emergence, adaptation and thereby change.

The abstract view of process inherent in the critical realist ontology requires a further alternative; that mechanisms of change are represented by the interactions of actors with structures. Although Pettigrew (1997), in line with other organisational theorists, concurs that politics, cultures and structures are primary influences on change (Burnes, 2009), his assertion that leadership is the mechanism that brings about change is challenged by the wider bodies of literature that contribute to this study, which stress the role of learning, either as intrinsic to a process of leadership, or as integral to organisational change. The outcome particular to this study, sustainable development, also emphasises moral theory as a primary political concern, rather than merely intrinsic to culture as revealed behaviour, or implied by justice or care as part of a moral economy.

1.8.1 Constitutional Framework for Governance

The constitutional perspective of governance suggests that political and ethical considerations are mutually necessary conditions for sustainable development outcomes, particularly in the context of the 'Public Plate', as nutritional care in publicly funded organisations. Pettigrew (ibid), however, makes the assumption that values are implicit in cultures, as a behavioural outcome, rather than as an intrinsic part of process. Politics, cultures, values and structures, however, exist both within and external to the organisation as hierarchical layers, and collectively affect the discrete organisational processes that are collectively provide the social dimension to governance. The state also uses a regulatory framework of devolution, regulation, policy and strategy to govern those subordinate organisations which actually deliver, and are accountable for, public services.

Figure 6 draws together all of these themes into a single constitutional framework for governance, as a heuristic device to guide study.

Figure 6: A Heuristic Framework for Constitutional Structures of Governance Source: Author					
	Political Framework		**Moral Framework**		
Supra-National	**POLITICS:** Regulatory Framework	**STUCTURES** Markets, Hierarchy, Network, Process	**CULTURES:** Shared Values, Artefacts, Assumptions	**MORALS:** Ethics and Values	
National					
Institutional					
Organisational					
Individual					

1.8.2 Governance as Process

Process is, however, a particular form of structure that has its own embedded characteristics guided by deontological and consequentialist moral theory. The literature review suggests that a generic process, for publicly funded economic

activities, is a cycle of needs assessment, action, outcomes and accountability (Figure 7), underpinned by an ordered set of embedded values.

Figure 7: Governance as Process

Source: Author
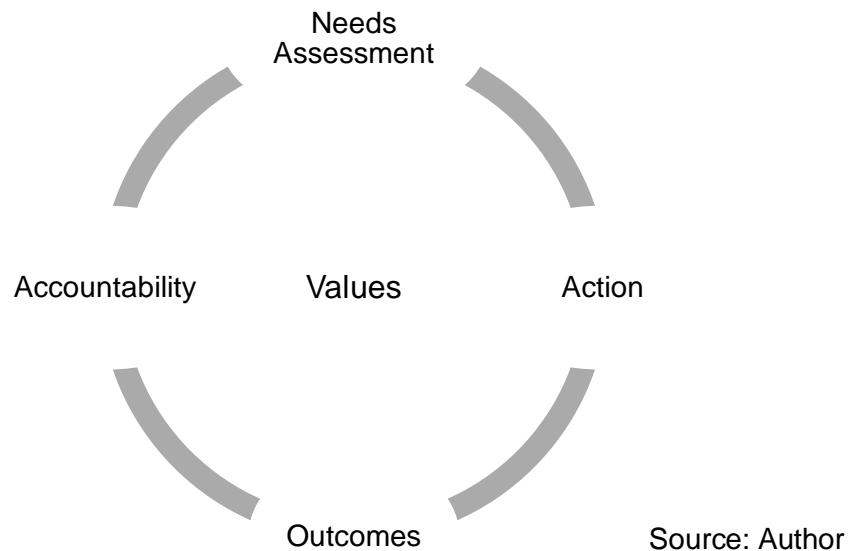
Thus an objective view of process, and thereby governance and other organisational processes, represents the actions of agency on structures, and thereby change.

1.8.3 The Processual View: What, Why and How?

Although Pettigrew's theory of emergent change (1987, 1997) relates to strategic organisational change, the generic conceptual view of process proposed in Figure 7 is also theoretically appropriate to the study of governance.

Four of Pettigrew's (ibid) five guiding principles of emergent change: embeddedness, holistic nature, temporal dimension, and outcomes, appear within the heuristic representations in Figures 6 and 7. The fifth, explanation, is related to the critical realist perspective, and is based upon the linear logic of what and why leading to understanding how. Explanation arises directly from action as an abstract, rather than objective, concept, and is found within the particular process being studied and its context, thereby the constitutional and process frameworks of governance.

1.9   Research Aims and Questions

The literature review has synthesised different ideas and empirical evidence on the role of the state in the sustainability transition. The operational and economic activity of the state has also been shown to be a matter of how things are done, as governance, in addition to what is done, to achieve those outcomes.

The 'Public Plate' provides an appropriate lens for the study of how public food services are designed, planned and delivered in order to meet sustainable development objectives. Whilst sustainable public procurement has been the subject of research at an individual and organisational level, existing research has primarily used middle range theories and related them to sourcing and contract management or supply chain outcomes. Other social science researchers have used inductive research methods to explore relationships between practice outcomes and higher order concepts such as sustainable development or have considered what practitioners' perceptions of barriers to change are. Existing research has not, however, addressed questions such as why, when there is evidence of change in the procurement of school food, change has not been successfully implemented elsewhere in the public sector, or how successful change has been brought about. Studies relating to hospital food, only occasionally categorised by authors as part of a procurement paradigm, have considered discrete parts of service provision, individual roles and relationships and outcomes.

Research into how the provision of food in hospitals is integrated into healthcare governance therefore fills gaps in existing knowledge relating to public food procurement, and when related an outcome of sustainable development, the sustainability transition.

The primary aim of this research is, therefore, to understand how change is being brought about in the governance of nutritional care in hospital settings and how this relates to the contextually contingent principles of sustainable development.

In order to achieve this objective, the following questions will be addressed:

- What changes have been made in the governance of hospital based nutritional care?
- Why have those changes been made?
- How have these changes been implemented and accounted for?

What are the governance challenges of implementing 'sustainability' in the context of this study?

CHAPTER 2
Research Methods

2.1 Critical Realist Perspectives on Structure and Agency: Duality or Dualism?

This research adopts a critical realist perspective, which as Reed (2009, p. 430) argues, is a distinct meta-theory that guides the research questions towards seeking explanation or understanding, as a relativist rather than deterministic or reductionist claim to knowledge. In doing so it seeks to find the conditions and consequences of change by linking the empirical, '*what is this?*' to the normative, '*what is this a case of?*' requiring a deeper analysis than that required by either social constructivist or positivist perspectives in order to uncover the conditions under which generative mechanisms operate. In this study '*what*', as sustainable public procurement, is therefore linked through empirical study to the abstract mechanism, governance, but also links middle range organisation theory to the higher order theory of sustainable development.

Nevertheless, critical realism, in seeking understanding of complex problems, neither rejects constructivism nor positivism, accepting that the world exists independent of our knowledge of it, but is distinguished from other ontological perspectives by virtue of the claim that structures exist external to and separate from agency. As a passive study, this researcher adopts a detached position, as a consequence of which explanation arises from events and interactions between structures and agency, the mechanisms that explain being the invisible forces that shape action. The role of the researcher is, therefore, to reflexively challenge given interpretations to locate and then validate potential explanations. Thus structure and agency are analytically separate to enable the researcher to elucidate how things come about, although debates within academic circles about the nature of the relationship between structure and agency within critical realism remain.

Pettigrew (1997), for instance relies upon Gidden's (1979) structuration theory, and thereby a dualist conception of structure and agency, within his realist framework of change. Structures are defined as rules and resources, whilst agency is assumed as enacted through knowledge, as a consequence of which structural change becomes the product of simultaneous production and reproduction through interaction. Both time and the relative power between structures and agency at differing moments are collapsed into a continuum, with no discernible end product (Archer, 2010, p.228). Although Pettigrew (1997) suggests that structuration theory

is merely a sensitising device, his assumptions represent a weak social constructivism, a potential over-socialisation of action and reliance upon visible patterns and regularities for explanation. Critically, as Archer (2010) suggests, there is an over-integration of structure.

An alternative perspective within critical realism tends towards structuralism and enables a much deeper analysis of the interactions between structures as well as between structure and agency, founded upon structure and agency as a dualism. This view accommodates multiple objective structures and modes of agency, differentiated powers at alternative moments in time, and agency contingent on the conditions that prevail at that time. This morphogenic approach (Archer, 2010) is dependent upon sequential ordering, where structures pre-exist action, resulting in outcomes that demonstrate structural elaboration as an end product of change, which then forms the antecedent structure for subsequent action. The approach rejects the positivist idea that causation is merely a matter of identifying succession, but nevertheless accommodates the notion of structures as sets of 'internally related objects and practices' (Sayer, 2010, p.92) in addition to objectively identifiable structures such as hierarchy, bureaucracy and network. Unlike structuration theory, however, morphogenesis enables the researcher to interrogate the data to find out what doesn't work, as morphostasis (Archer, 2010), as well as what does work. Explanation arises from the interactions between multiple modes of agency and alternative structural forms in an altogether deeper process that requires structural analysis rather than solely upon discursive practices and linguistic forms.

Although considered to be an eminent critical realist scholar of organisational change, Pettigrew's theoretical position was considered by the researcher to be weak for the study of public procurement. Despite his acknowledgement that the external context influences the organisation, the external context in this case was identified as being both differentiated and hierarchical. The significance of policy and EU regulation as barriers to change in the public procurement literature, for instance, suggested that a deeper analytical approach, such as that of retroduction, would result in more robust and dependable research outcomes in addition to having the policy and practice relevance of '*how to do*' research.

Pettigrew's (1997) theoretical triangle of content, context and explanation nevertheless contributed to the strategy and structure of this study through its overarching logic of enquiry that suggested understanding '*what*' and '*why*' is a necessary precondition to the explanation of '*how*' change comes about. The five principles of embeddedness, holistic enquiry, temporal interconnectedness, the

need for outcomes, and explanation, were also significant in terms of validating the results of the data analysis.

Adoption of a critical realist morphogenic perspective also enabled a critical gap in the body of empirical literature relating to sustainable and public food procurement to be addressed, how to overcome perceptions of barriers to change. It also, by accepting the normative discourse of political and moral theory, enabled the study to be related to both middle range theory, as in organisation, and higher order theories, such as sustainable development, potentially offering a view as how to overcome the practice based difficulties of supply chain managers identified by Carter and Rogers (2008).

The realist approach is also consistent with the prevailing research context of public service delivery in the UK, particularly healthcare, where the dominant logic of enquiry is that of the scientific empirical tradition as the legitimised form of gathering evidence in formulating policy, shaping the healthcare research agenda and allocating resources (Gordon, 2006; Lambert et al 2006, cited in Learmouth 2009 p.97). Aligning this research with the dominant evidence-based-practice paradigm might also enable a greater understanding of what the future governance challenges might be as well as how they might be overcome.

2.2   Retroduction as Method

By adopting the organisational perspective, the organisation having been identified from the study by Jochelson (2005) as the decision making body for public procurement, Pettigrew's theory-come-method was rejected, in part, in favour of retroduction, in order to enable the identification of underlying and interrelated mechanisms from events, as actions and outcomes (Danermark et al, 2002; Reed 2009, p. 432). As such the perspective was aligned towards a more positivist and interactionist stance. This also defined the nature of the use of narrative, within the thesis, as an analytical tool to make a meaningful whole of numerous lay narratives within the interview data, and for the composition of the thesis as a narrative account of explanation.

The principles of retroduction reject the linear logic of method-data collection-theory process within, for instance, constructivist studies, as well as the principles behind grounded theory[7] (Goulding, 2009) in favour of an iterative approach for the entire

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[7] Yeung describes grounded theory as antithetical to realist research for relying too heavily upon borrowed theories and the narratives of research subjects rather than a process of simultaneous deduction-induction from multiple data sources. Grounded theory also uses

project, initially situating the particular theory built from what is already known to *"demonstrate that the phenomena investigated is a case of some larger forces that take particular shape and give results in a particular setting"* (Tsoukas, 2009 pp. 296-7). The researcher therefore finds explanation through an analogical process moving continuously between the concrete and the abstract to hypothesise and then test potential mechanisms of explanation in context. Understanding therefore emerges *"in the sense that it is situated in and developed by recognizing patterns of relationships among constructs within and across cases and their underlying logical arguments"* (Eisenhart and Graebner 2007, p.25).

The overall research strategy for this study, summarised in Figure 8, also provides the basis of a research protocol, which Yin (2009) suggests is a means of demonstrating reliability and validity. The nature of retroduction is however, one of working back (Reed, 2009), which required a flexible approach, as a consequence of which the protocol was revised as the project proceeded. The need to amend the number of embedded processes as case studies, to include an example of a specific procurement contract, the creation of the Shared Services Partnership (NWSSP) and consequential changes to procurement structures, each required the protocol and strategy for both data collection and analysis to be reviewed and amended. As a result of the addition of the yoghurt procurement contract, the second phase of interview data collection was extended and the overall design of the written thesis adjusted to accord with the embedded process design.

A major concern with retroduction is the refinement of theoretical propositions as a guide to locating and corroborating the operation of mechanisms. The inductive-deductive process is inherently reflexive, theoretical refinement guiding the researcher towards discovering the conditions that bring about events and actions. As a study of generative institutional analysis (Ackroyd, 2009), this study attempts to locate the interactions of context and mechanism in history as well as the wider healthcare and regional governance context. Explanation is known to have been achieved when the generative mechanism has been located and elaborated, the conditions of the mechanism are apparent and accounts of the mechanism and conditions have been located in the broader socio-economic context. The focus on explanation therefore guided the structure of the written thesis, with description

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experimental data collection methods to reach empirically grounded, rather than theoretically refined conclusions, whereas retroduction requires some theoretical guidance to precede data collection (Yeung, 1997, pp.61-63).

Figure 8: The Research Strategy and Protocol				Source: Author

<table>
<tr><td rowspan="13">Theory Development: Research Design: Ethical Approval</td><td colspan="2">Initial literature review
Scoping Interviews</td><td colspan="2">Establish contribution of research

Generate research aim, lacunae and locus of study</td></tr>
<tr><td colspan="2">Identification of relevant bodies of literature and key themes</td><td>Literature</td><td>Key themes emerging from analytical review</td></tr>
<tr><td rowspan="6">Literature included in initial and final review</td><td rowspan="6">Theoretical literature</td><td>Green political theory</td><td>Transition
Sustainability governance</td></tr>
<tr><td>Moral economy</td><td>Justice and Care</td></tr>
<tr><td>New governance</td><td>Processes of governing</td></tr>
<tr><td>Organisations</td><td>Process and change</td></tr>
<tr><td>'Public Plate'</td><td>Moral economy</td></tr>
<tr><td colspan="3">Develop initial heuristic framework(s)</td></tr>
<tr><td colspan="3">Literature review:</td></tr>
<tr><td></td><td>Empirical literature</td><td>Sustainable public procurement</td><td rowspan="2">Lack of holistic process research (rather than distinct functional parts of process)

Lack of critical realist or 'how to' rather than 'what is' perspective</td></tr>
<tr><td></td><td>Academic and other studies</td><td>Sustainable public procurement of food

Hospital food procurement

Hospital food</td></tr>
<tr><td></td><td></td><td colspan="2">The Context: Healthcare systems and values</td></tr>
<tr><td colspan="3">Refine heuristic framework and develop secondary research questions</td></tr>
</table>

Data Collection: Stage 1	Documentary analysis; In-depth qualitative interviews (WG, LHB Z, NWSSP)
Preliminary Data Analysis	Open coding of interview data; timelines and temporal bracketing; visual mapping of relationships in order to identify key themes
Data Collection: Stage 2	In-depth qualitative interviews In-depth qualitative interviews (WAO, LHB X, NWSSP) observation in order to challenge and corroborate Stage 1 data analysis results; development of narratives from interview data
Data Analysis, Theoretical Refinement and identification of causal mechanism	Data added to that collected in Stage 1: refinement and identification of key themes; search for rival explanations in data (raw and analysed)
Writing up: Development of the thesis narrative for explanation	

preceding discussion of the interactions between emerging mechanisms, leading to conclusions and responses to the research questions.

2.3   The Development of Theoretical Frameworks

The first stage of the research strategy was the development of theoretical frameworks as conceptual tools, or maps, to guide the empirical phase of the study, act as an aid to data analysis and provide some structure for the written thesis.

2.3.1   Systematic Literature Reviews

Denyer and Tranfield suggest that a systematic review is founded on the principle that the literature review plays a critical role in research, as a means of creating bodies of knowledge that inform policy and practice (2009, p.671). The literature review also provided construct validity in this case study research by locating and evaluating academic and non-academic literature to identify a practice-based problem as the primary research aim.

The outcome of the review was considered to be a robust and dependable theoretical framework, potentially but not necessarily transferrable across contexts, which identified the lacunae in existing research. Whilst critics of this approach suggest that it is particularly biased towards disciplines such as management, Denyer and Tranfield (ibid) propose that by synthesising the strengths of the systematic review methodology and a realist perspective, the potential is created to inform policy, practice and alternative or future research. The explicitly analytical approach also enabled inter-disciplinary research through abstraction from differing bodies of literature to establish common themes, as potential concepts for heuristic development as well as headings for the written review.

The origins of a systematic review are within scientific, rather than social science, in particular, medical research (Cochrane Collaboration, 2008), but in that particular form neither meet the more reflexive, iterative and interpretive approach to theory building needed in social science research, nor a focus on causal explanation. Denyer and Tranfield (2009) propose revisions to the strict Cochrane principles to embrace transparency, inclusivity, explanatory and heuristic in nature, which are particularly appropriate to organisation studies. The explanations, conditions and an overview of how these were met are shown in Figure 9.

Figure 9: Key principles for a Systematic Review in the Social Sciences – adapted from Denyer and Tranfield (2009)		
Principle	*Explanation and Conditions*	*Demonstrated by*
Transparency	Open and explicit processes and methods of review; a review protocol that is reflexive and adaptive rather than determined and bounded	Protocol and Strategy
Inclusivity	Accommodates plurality in perspectives and methods without assuming quality, by assessing the appropriateness of the literature (Boaz and Ashby, 2003, p.4). Heterogeneity in sources to compensate for value judgements and enable study of contextual factors, which increase validity of findings	Literature selected for relevance Multiple data sources Alternate templates strategy (Langley, 1999)
Explanatory	Interpretive and explanatory synthesis (rather than aggregative synthesis) extracts descriptive data from exemplars from other studies, creatively reinterprets and conceptualises to provide feasible explanation which is greater than the sum of the parts.	Open coding of primary data Development of narratives of events from multiple sources Use of alternate templates Testing rival explanations Narrative approach to construction of thesis Thesis structure aligned with theoretical frameworks
Heuristic	Alludes to what works but in an abstract form as a way to find solutions to problems, rather than detailed solution. Creates knowledge which can inform policy and practice	Use of heuristics as generalisation of abstract concepts

The relevant literature was located using internet searches on the Cardiff University Voyager Library, Scopus, Web of Science and EBSCO Business Support Premier electronic databases, supplemented by manual searches linked to references and authors cited within relevant texts. The search criteria set for the academic phenomena related texts were for content and relevance, the critical realist perspective suggesting that the hierarchical range of theoretical literature, the role of the state, governance and organisation, would be required to capture the institutional context.

An initial draft written review of the literature was conducted, defined by the role of the state in the sustainability transition, sustainable public procurement of food, hospital food and sustainable food systems. Having determined the organisational perspective, a more thorough review of the literature relating to organisation theory was undertaken, from which the idea of organisational change emerged, the detail of which was then confined to that which was relevant, the critical realist perspective of change. The body of literature on sustainable food systems was also judged to be no longer relevant at that stage and was replaced by a review of literature from business and management discipline on sustainable public procurement.

During the course of this literature review a number of scoping interviews were undertaken, in order to validate the selection of the focus on change. Those interviews, the roles of informants (Appendix 2) revealed, for instance, that changes were taking place within catering within one LHB, and that there were some structural changes being made to form a shared services partnership. There had also been inspections of catering and nutrition by the Wales Audit Office (WAO), and therefore the initial focus on change was confirmed to practice relevant and achievable.

This abstraction to themes across differing bodies of literature was necessarily analytical and therefore inherently critical, but nevertheless differed from methods such as grounded theory by its sole reliance upon secondary data. Reflexivity is also demonstrated in the thematic presentation of the review. Abstraction within the review process enabled consideration of asymmetrical influences, acknowledging potential contextual dependence, demonstrating alignment with the principles of morphogenesis and transparency. Thus the systematic review enabled the linking of higher and lower order theories and interrelated concepts in a framework approach.

2.3.2 The Preliminary Framework

The preliminary framework commenced with the development of conceptual maps from an analysis of a broad body of distinct but existing literature on the role of the state in sustainable development. The need for social justice outcomes and a moral economy, introduced by the concept of the 'Public Plate' (Morgan et al, 2006; Morgan, 2008), steered the literature review towards incorporating a higher order theory of justice, whilst the devolved practice of public procurement activities introduced the idea that devolved organisations, rather than the state, are key actors within strategic change. Thus the theoretical positioning was identified as the organisation, the significance in Pettigrew's theoretical framework (1987, 1997) being its focus on processual change and the influence of context, history and outcomes on multiple and embedded processes.

Thus the first stage of theoretical development identified the broad research aim, to study change processes, the practice perspective of the organisation, the ontological view of critical realism and the context as governance. The broad but common influences on change, politics, cultures, structures and values were identified from this body of literature.

2.2.2 Theoretical Refinement

Although Eisenhart and Graebner (2009) suggest that theory can be drawn entirely from existing case studies, validity would be dependent upon the availability of a large number of studies and conditional upon the underlying epistemology, ontology and research questions. The use of food procurement case studies, as secondary data within the literature review, was therefore solely to refine and validate the concepts identified from the body of theoretical literature.

The systematic review protocol (see section 2.3.1) was followed in order to identify existing studies on sustainable public procurement, public food procurement, hospital food and the context, health systems and values relevant to that particular context. This was expanded, as a result of identification of culture and politics in the preliminary framework, to cover cultures and power in UK healthcare systems. The purpose of this section of the review was to confirm the lacunae in existing studies of public food procurement and to refine the theoretical frameworks developed in the first phase of the literature review to what was known from practice.

The academic literature relating to public food procurement suggested that there was a significant body of empirical work on the procurement of school food and

sustainable development, a less significant body of empirical studies relating to the procurement of hospital food, and a body of work relating to sustainable food supply chains, some of which were in relation to hospital food. Thus an early focus on sustainable hospital food procurement enabled a more focused and detailed review of the academic literature.

Further reviews of the texts relating to hospital food suggested that there was one primary study that attempted to define a sustainable hospital food system in the NHS in the UK (Jochelson, 2005). That study also suggested that NHS Trusts as devolved organisations, rather than the NHS as an institution, was the locus of decision-making in procurement, those organisations having the power, responsibility and capacity to specify principles of sustainability in purchasing decisions. Thus the literature review relating to hospital food identified the lacuna as the organisational, rather than supply or food chain perspective. This was apparent without detailed critical appraisal of the methodology and content of empirical studies and suggested an appropriate middle range theory might be found within organisation studies, aligning organisational change with the sustainability transition.

In practice, however, public procurement is also a key policy area that promotes a working definition of sustainable procurement as an organisational process. The 'Public Plate' also forms the theme of considerable writing from outside academia, identified through general web searches and searches within known NGO websites. This body of literature suggested that hospital food in the UK may be particularly resistant to attempts to change attitudes and purchasing behaviours, and that the quality and sustainability of hospital food remains generally poor and in some cases not fit for purpose (Sustain, 2009, 2010, 2013; Soil Association, 2011; Despatches, 2011; BBC, 2011; CQC, 2011).

Although improvements in sustainable food procurement have been demonstrated in empirical studies of school food, the multiplicity of guidance available to actors in the procurement process, and persistence in range and perceptions of actors as to what the key barriers to sustainable procurement might be, suggested that there might be an underlying reason for the apparent lack of progress. The initial research aim was therefore established, to understand change processes in order to seek explanation for the apparent resistance to changing practice in the public procurement of hospital food. Once data collection commenced, however, it became apparent that positive change was being brought about within the case study, and the overall research aim was amended from the negative to the positive to try to

understand how change was actually being brought about. The nature of the critical realist approach meant that there was no need for any fundamental change in the research design, causal mechanisms being present, but not necessarily active (Sayer, 2000).

2.2.3   Heuristic Frameworks and Research Questions

The overall aim of the research, to understand change, remained broad and unstructured in terms of the constituent parts of change. Although there are alternative change theories within organisation studies, the critical realist perspective was a determinant of the particular middle range change theory to be selected. Pettigrew's (1987, 1997) theory provided a guide to the primary and secondary questions which would ensure that in the analysis of data, change could be explained. As discussed, however, the perceived shortcomings of Pettigrew's theory meant that it was only adopted in part.

A realist perspective of change, as a process, suggests that multiple influences act at multiple levels, on the organisation and its internal processes, and as a result of structures existing independently of agency, with differentiated powers linked to time. The complexity of the concept of governance and the separation of structure and agency, were ultimately most clearly defined through linked, but separate conceptual maps. Thus the twin heuristic representations of governance, as constitution and process, embed an alternative templates strategy (Langley 1999, 2009, p. 416) in the research strategy and design, ensuring rigour and validity throughout.

Pettigrew's (1987, 1997) theory provided the strategic framework of what, why and how, used as the basis of the research questions, as well as the analytical framework of context, content, and action. It also suggested that outcomes ought to be considered separately from accountability, thereby linking process to outcomes and enabling the research to contribute to policy.

2.3   Case Study Strategy and Design

The literature review suggested that there were likely to be a number of possibilities resulting from empirical enquiry, but that context is particularly significant influence and driver of action at any particular time. Locating the study in context directed the use of an in-depth case study, which Yin (2009) describes as an all-encompassing method that deals with design, data collection and analysis. Although not exclusively confined to in-depth studies, critical realism research favours the use of

case studies, either as in-depth single studies, either of a particular phenomenon, process, or place, or as a comparative study embracing any of these designs.

The use of embedded case studies within an institutional context enabled the comparative perspective to be incorporated into a single project and was designed to enable patterns and differences to be discovered as well as to test rival explanations in context. The retroductive methodology steered the selection of case study towards organisational processes, rather than the spatially defined organisation[8] countering the potential criticism that case study research fails to generalise, as it situates the particular in the general through analytical refinement and heuristic generalization (Tsoukas, 2009). Yin (2009, p.41) provides a detailed account of the main four elements of the research explicit to the design that test the validity of a research project, shown in chronological order in Figure 10, accompanied by detail as to how this study meets those criteria.

Figure 10: Research Design, Tactics and Validity Test - adapted from Yin (2009, p.41)		
Operational Phase	*Tactics employed in this study*	*Validity Test*
Design	Replication logic through embedded case studies for comparison and heuristic representation of nested process structures	**External**
Data Collection	Use of multiple sources of evidence: primary interview data and observations and secondary data from concurrent and historical documentation	**Construct**
	Maintaining Case Study protocol	**Reliability**
	Case Study database	
Data Analysis	Pattern matching to interrogate mechanisms from events and interactions	**Internal**
	Explanation building by constructing narratives and identifying potential mechanisms	
	Addressing rival explanations by hypothesis and testing possible causal mechanisms in primary and secondary data	
Composition	Key informant review of draft report.Synchronicity between initial and refined theoretical frameworks as evidence of mechanisms in context and action	**Construct**

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[8] For instance LHB or NHS

2.3.1 Defining the Case Study and Units of Analysis

The validity of processual case study research requires the study to be defined in terms of the temporal dimension and the units of analysis. The intrinsic multi-directional nature of process, however, meant that there was no simple objective or spatial boundary that could be drawn. The temporal boundaries were relatively straightforward, with Welsh devolution as the natural starting point for the historical data, as the point when sustainable development became a constitutional commitment in Wales. This defined the outer context as the governance of public services, as the economic activities of the state, within the Welsh economy. December 2012, as the end of twelve months for data collection, was viewed as an appropriate end point for data collection within the context of the PhD. As the regulatory context extended beyond Wales, however, UK and EU public procurement were essential supra-national considerations for the regulatory framework.

Healthcare and the multi-layered structures within governance were more problematic in terms of defining a single unit of analysis for a focus on process, but as the study was concerned with the 'Public Plate', either the Nutritional Care Pathway (NCP), as a discrete objective process, or the process of governance of nutritional care were potential boundaries for the case study and analysis. Pettigrew's concern for embedded, or nested structures, steered the case study towards a process of nutritional governance, which also enabled the use of embedded case studies as objectively definable processes, the NCP and the particular sourcing and contracting process in respect of yoghurt. The comparative element was included by studying the NCP in two LHBs, to ensure rigour and validity, but also because of the need for consent to be obtained from individual LHBs. The choice of nutritional governance, as process, also accommodated the on-going structural changes that were happening during the research period.

As a consequence of the case study choice, healthcare governance provided the immediate context relating to NHS Wales, and governance in respect of public services in Wales the external context.

The spatial fix was provided by confining the study to the provision of patient food in hospital settings, as nutritional care in healthcare also embraces community settings and public health. Figure 11 illustrates the how the case study, the process of governance of nutritional care, relates to the external contexts and the embedded

process case studies of the NCP in hospitals and the 'All Wales' central sourcing and contracting case study.

The initial thinking was that the context might be confined to healthcare governance, but as the study progressed the degree of integration and collaboration with WG effectively added another layer, and chapter, to the analysis and explanation.

Figure 11:
Embedded Case
Study Design

Governance of Public Services

Healthcare Governance

Governance of Nutirional Care

Nutritional Care within Hospital Settings

'All Wales' Sourcing and Contracting Process for Yoghurt

Context

What is this a case of?

Content: What is this?
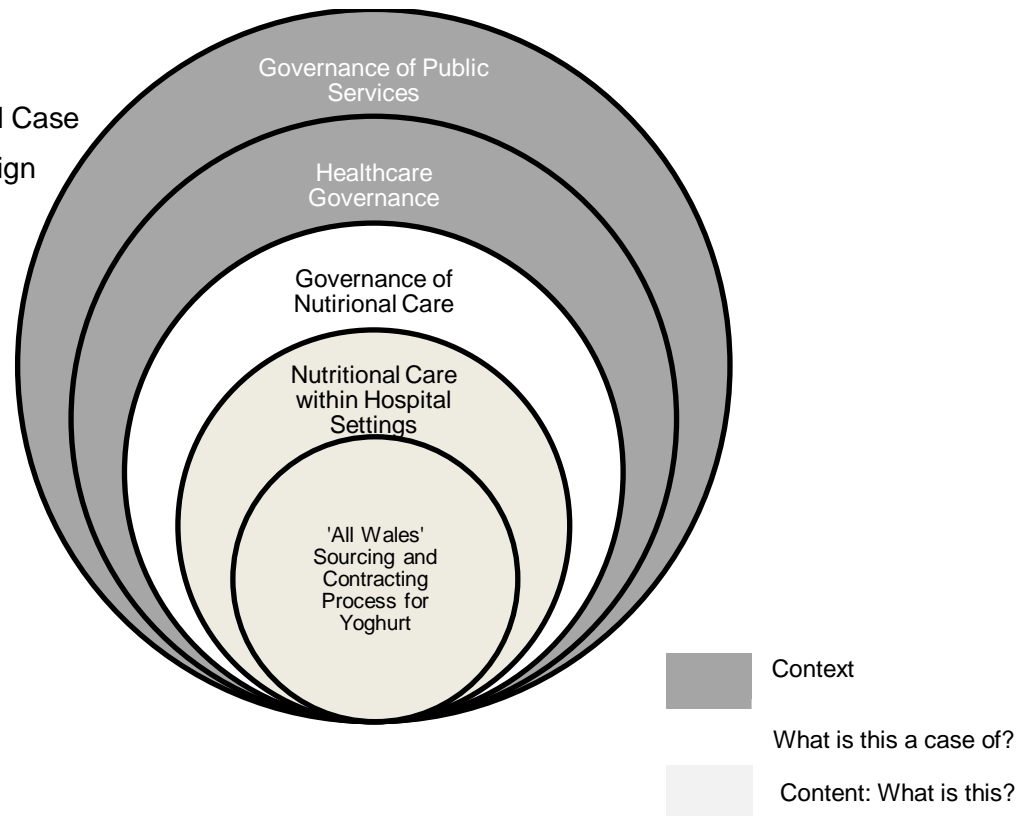
Source: Author

2.3.2 Selection and Anonymity of Local Health Boards and Informants

The adoption of an organisational studies perspective and the need for a comparative element to uncover differences as well as similarities to enable explanation, directed the original design towards comparing action in different subordinate organisations. The structural, cultural and political links with the organisation, as a legally bounded entity, and its external political, cultural and economic environment suggested that individual LHBs in Wales, and Trusts in England, are embedded in differing institutional and constitutional contexts. Whilst initially it was intended to select case studies across constitutional boundaries within

the UK, the turbulent nature of the political environment and the radical structural changes being brought about in England suggested that the selection of an English case study might fail to find a plausible explanation in response to the primary research question. In Yin's terms the rival explanation could be both 'societal' and 'super' (Yin, 2009, p.135).

The relatively sparse volume of in-depth qualitative research into non-clinical aspects of healthcare in the UK, and the on-going public criticisms relating to care and nutrition in hospitals suggested access to case studies might be problematic. Initial approaches to a Hospital Trust in England confirmed that gaining access to such bodies might be difficult for the purposes of this particular study and so access to LHBs in Wales was explored through scoping interviews with potential informants within NHS Wales.

The research aim and design were considered to be critical in obtaining consent both to carry out the research and to gain access to informants, in particular the need to provide anonymity to informants and their employing organisations. The adoption of a case study based on process, rather than an inter-organisational comparison explicitly supported the need to maintain anonymity, there being only 7 LHBs in Wales, each with their distinctive demographic, organisational characteristics, and histories.

Links with potential informants within Wales were made initially through scoping interviews, access enabled through a personal contact, with informants subsequently providing introductions to other potential informants. Thus the early scoping interviews were a means of testing whether access to individual informants would be forthcoming. However, once data collection commenced, proposed structural changes within this healthcare context came to light in relation to the centralisation of procurement, which suggested that the original tri-organisation, comparative approach, was no longer the optimum design for meeting the research aim. The three LHBs were reduced to two, which still provided a comparative element for the governance activities within hospitals, but a single in–depth case study of the procurement process for a particular food contract was added to provide detailed description of changing practice. The yoghurt contract was one which was already underway, and access was agreed to enable that contract to be part of the study.

Although this decision was taken part way through the data collection, wide differences in local practices were becoming apparent between the first two LHBs

within the context of a nationally agreed standard for the NCP. This led to some confidence that the research objectives could still be met, the reason for difference being to corroborate initial findings or search for rival explanations. Validity for construct and reliability were therefore maintained, and reinforced by the additional process case study within NWSSP-PS.

Although a study of process, the criteria for selection of LHBs within which the NCP could be studied was considered to be important. There are a number of hospitals located within the geographical boundaries of each LHB which eliminated a deliberative strategy based on type of hospital, nor urban or rural location.

The LHBs were therefore selected on three criteria:

- that they would have both urban and peri-urban hospitals
- that they were responsible for different local cultures and socio-economic populations
- that they had acute and community hospitals within the LHB area

These broad selection criteria would help to disguise the identity of the LHB and informants, as these criteria could in practice apply to 4 of the 7 LHBs. Nevertheless, the relatively small number of LHBs in Wales, well integrated socio-political structures, volume of publicly available data and the recent high profile media coverage of hospital food, meant in practice that the identity of the LHBs could not be completely disguised. The nature of the critical realist perspective and the detached role of the researcher in the retroductive methodology suggested that direct quotations needed to be linked to role, for relevance and understanding, the attendant risk being the inadvertent identification of informants in the written work. This was overcome within the research design, firstly by the study of process, and secondly by developing third party narrative accounts of events, either from single informants, or as a collation from a number of interviews, minimising the use of direct quotations in the written text and actively refraining from identifying the role of informants.

Where publicly available material was available to support evidence from interviews, the public source was quoted, and therefore material from a number of LHBs across Wales has been included in the study, leaving the detail of internal processes as the main potential source of identification of the LHBs and as a consequence, key informants. The small procurement and catering community within NHS Wales and the way in which experiences are shared through collaborative supporting structures, nevertheless meant that complete anonymity was almost impossible.

The nature of the study, to understand change, and the decision not to carry out an evaluation of individual, group or organisational performance, was also considered to be non-controversial, reducing the risk to both informants and their organisations. In order to maintain construct validity one of the LHB case studies was approached as it was perceived to be an exemplar in terms of its catering management practice.

2.3.3 Researching Abstract Concepts

The constitutional governance framework identifies structures, politics and cultures as primary variables and influences on organisational processes and change. A strategy was therefore developed in order to ensure that data collection methods would be able to identify or categorise data within that framework.

Structures are represented by the broad formal arrangements of hierarchy and network, but are also sets of internally related objects or practices (Sayer, 2010 p.92), associated with resources, rules, and constraints and exist when socially reproduced, such social reproduction being historically contingent and change difficult, yet possible to emerge from within enduring structures. Sayer (ibid) also suggests that structures have independent but contingent existence, such that the question to be addressed is what the intrinsic properties in structures might be brought about by the interaction with agency. This interaction with agency, from the morphogenic perspective, also produces outcomes. The focus of the data collection and analysis was therefore on events and interactions, the researcher maintaining the perspective of an independent observer.

The differences between structures contribute to conceptions of culture in organisations as being tacit knowledge or taken for granted behaviours that can deviate from policy and stated behaviour. Schein (2010) offers a conception of culture in the context of organisations that exists at three levels, as artefacts, espoused values and tacit knowledge, which he argues also provides a method for the empirical study.

This study conceptualises politics as the enactment of power. Critical realism also envisages power inherent within structures, in the objects of Sayer's 'real' dimension of a stratified ontology. Thus political behaviour can potentially be observed in the form of organisational prioritisation, but lack of action as an expression of latent power, can equally provide explanation of political behaviour. These definitions define the methods by which empirical data was collected, and how they relate to the conceptual framework, illustrated in Figure 12.

Figure 12: An integrative approach to studying culture and politics		
Cultural Representation	**Data Sources Used**	**Political Representation**
Artefacts, Symbols, Rituals, Ceremonies, Myths	Constitutions, policies, strategies, agendas, uniforms, menus, formal structures	Observable conflict in decision-making
Espoused Values, Attitudes, Beliefs	In–depth qualitative interviews with key informants	Observable conflict in decision-making and non-decision-making Predominant values as policy preferences or grievances
Tacit Knowledge and taken for granted behaviour	Observed behaviour in public restaurants: food on offer and dominant choices, range of restaurant users	Observable and latent conflict Control of political agenda, such as food choices 'Non' behaviour, authority, prioritisation (political inactivity)
Source: Author		

Whilst analysis of documents enabled the superficial or symbolic layer within organisations to be investigated, the primary means of researching espoused and predominant values was also informed by in-depth qualitative interviews with key informants, observation and informal discussions.

The deep and unquestioning layer of tacit knowledge, representing the true culture of an organisation, can only be discovered by observation, as it represents the difference between actual and espoused behaviours. Whilst it could be argued that only an ethnographic study over a prolonged period would be the only means of attaining such understanding, the scope of this study, and the potential ethical difficulties of obtaining open access to a hospital case study, precluded such an approach. Nevertheless, observation of public areas and informal discussions also provided a source of data as a means of contrasting practice and policy within the organisation.

In the context of this case, the comparable depth of study of political behaviour is demonstrated by political inactivity; failure to address policy issues relating to

sustainable development and food, and the related health outcomes, within the powers and responsibilities devolved to the organisation.

Leadership and learning were identified from the literature review as potential mechanisms of change, and were anticipated to be linked to events as material or instrumental outcomes of change processes, such as examples of innovation, or *" how change in practices are implemented, and how their influence spreads and interacts with existing organizational contexts, offers a dynamic understanding of how to improve them."* (Langley, 2009, p. 412).

2.4 Data Collection

2.4.1 Strategy

The particular need to find real mechanisms in both context and action (Pettigrew, 1997) directed a more deliberative strategic approach to data collection than would be required for an exploratory study. This enabled knowledge to be accumulated and tested across a period of time.

The temporal dimension is inherent in process and so history, the present and the future having equal significance, if not influence, to the present. Langley (2009) goes on to suggest that this temporal dimension, essential to any research with a practical orientation, is also inherent in explanation rather than description and reflects a strong, rather than weak ontology. Thus the past, present and future of significant events that have brought about change, irrespective of whether radical or emergent, provided a relevant and necessary temporal field within which underlying mechanisms could be anticipated, if not observed. Although the time constraints of a PhD restrict the potential for a longitudinal study, the scoping interviews carried out early in the project revealed that there were recent and continuing contextual changes in connection with hospital food procurement and nutritional care, which suggested that a longitudinal study of contemporary change would be both possible and informative. The data collection strategy for the 'present' was to integrate documentary evidence, qualitative interviews and data analysis over a twelve month period, to enable a body of evidence to be accumulated and tested in real-time.

Interviews for data collection purposes were carried out in two phases and recordings transcribed verbatim after each interview in order to inform searches for documentary evidence and subsequent interviews. Once the initial set of interviews, with informants from WG and LHB Z, had been completed, preliminary analysis of the transcripts was undertaken using open coding techniques to find emerging

themes and compare these to the preliminary theoretical framework. Informants in the second LHB and external bodies were subsequently interviewed, both to obtain their experiences of change, but also to critically test the findings from the initial data analysis and to expand the body of data for further analysis.

The yoghurt case study was introduced later in the data collection phase as it was considered that the sourcing and contracting process should be contemporary rather than relying upon recollections of historic process. Contemporary change also enabled the present to be embedded in the future as well as the past.

2.4.2 Qualitative Methods

Although the use of case studies enable multiple methods to be adopted, the need for intensive research inherent in the critical realist philosophy guided the researcher to the use of qualitative methods, with interviews and documentary evidence the primary sources of data for this study.

Cassell highlights the varied nature of qualitative interviews, as well as the realist researchers' need to access interviewees' understanding outside of the person (2009, p.505) and suggests that complex research supports the use of open interviewing techniques. Interviewees were, in this, instance, informants rather than participants and so the use of open, rather than structured or semi-structured interviews avoided, as far as possible, interviewees' interpretations of the research questions. Although interview data was still compared, insights from the analysis was also used as a guide to future interviews as well as synthesised with documentary evidence. The researcher's prior experience and skills in the use of open interview techniques was a significant factor in terms of designing the research, firstly due to the need to be able to elicit a large amount of relevant information in a fairly limited amount of time, but also experience with dealing with a diverse range of busy elite and front line actors

2.4.3 Scoping Interviews

Yin (2009, p. 92) suggests that pilot studies are a valuable means of testing and refining the research design. The difficulty of gaining formal access to healthcare organisations was, however, observed relatively early in the research design, with key personnel either unwilling, too busy, or denied permission to speak to the researcher. The economic and political climate, which has become progressively more turbulent since conception of the research project, also presented a

particularly difficult set of circumstances within which to approach prospective informants. Thus the opportunity to carry out a full pilot study was not forthcoming.

Nevertheless, as part of the research design, actors within and external to LHBs were interviewed informally, either in person, at their place of work, or over the telephone. Appendix 2 outlines the strategic roles of those actors interviewed at this stage.

Those interviews contributed to the identification of the primary research aim, provided additional validity to the theoretical framework and aided the researcher in identification of key informants. 6 ½ hours of in-depth, open exploratory interviews were undertaken in this phase, enabling the researcher to test her own research skills, as well as the scope of the open interview technique employed. A key gatekeeper was identified at this stage who assisted with access to informants by direct introduction, which also helped the subsequent interview schedule to be undertaken in a systematic way.

2.4.4 Identification of Key Informants

The governance process potentially brings together a number of actors and perspectives on food and its role in (an) organisation and food has different meanings and priorities depending upon those perspectives. The aim of the empirical phase of the project was to establish what happens in practice, and who, whether formally or informally, was involved. As such, prior determination of key informants as stakeholders was intentionally provisional, discovering who or what the key actors in any study being part of the process in intensive research (Sayer, 2000). Probable key stakeholders were identified during the scoping interviews and each informant was asked, at the end of the interview, to suggest colleagues who they thought might be relevant to the study. Within the Welsh Government, estates and facilities, procurement, nursing and dietetics were identified as relevant areas for interview informants, which concurred with the academic literature relating to the provision of hospital food. Within LHBs, catering managers, nurse directors responsible for nutrition, and procurement staff were initially identified as key informants and with NWSSP, procurement (NWSSP-PS) and facilities management (NWSSP-FS). The Community Health Council (CHC) was approached on behalf of citizen stakeholders, and referred the researcher to the WAO.

2.4.5 Informant Access

The National Research Ethics Service (NRES) was approached as soon as the study and methodology had been defined and they confirmed that the study was an evaluation and there was therefore no need to make a full NHS Research Ethics Committee application. Permission for the study only needed to be obtained from the Research Ethics Committee within the University and the respective employing organisations and individual informants.

Board level permission was obtained for access to informants within the respective LHBs. Heads of Departments within WG and NWSSP were contacted, both for permission to conduct the research, and as potential interviewees. Other informants were approached directly by email. Each informant was provided with a consent form which provided some background for and the aims of the study (Appendix 2) as well as an outline of what they would be asked to talk to the researcher about and the estimated time they would be required to set aside for the interview. Although not everyone completed the consent form, confirmation of their willingness to participate was received by email. As well as an ethical concern for anonymity as part of access to informants, the need to guarantee anonymity was considered to be a material factor in gaining informants' engagement in the research.

Introductions to colleagues were sought from informants to ease access. Additional key informants were identified as being within the NWSSP at director and at an operational level in facilities management, procurement, and more specifically food procurement.

2.4.6 Interviews

The different perspectives and roles of actors were identified from the scoping interviews, as a result of which it was felt that replicable semi-structured questions might be inappropriate in this study. Those scoping interviews that were most successful in yielding narratives of experiences of actors were those that adopted an open approach and recorded interviews provided greater depth of data and enabled greater reflection than those where the informant did not consent to being recorded.

The use of open interviews allowed informants to relate their experiences on their own terms, and in relation to their role, rather than to respond to the researcher's perceptions of what might be relevant to sustainable public procurement. This open

approach also had the advantage of enabling potential alternative explanations to be explored at an early stage.

Emails were sent to informants prior to the interview, with an information sheet providing the background to the study (Appendix 2) and requesting approximately 1 hour of their time, at their place of work, for the interview. Informants were told that the interviewer would like them to talk about their role, responsibilities and their experiences of change. Before the interview commenced, informants were asked for permission to record.

A secondary, standard, set of interviewer objectives were set prior to conducting the interviews in order to ensure that all areas potentially relevant to the research were covered during the course of the interview. The main subject of the research, sustainable public food procurement, was used to frame the study, and formed the basis of the approach to potential informants. This was firstly because it represented the starting point for the critical realist search for '*what is this a case of*?' and secondly as a means of exploring the extent of perceptions as to the boundaries of the concept, the literature having failed to provide a suitable definition of the phenomenon. Despite the wide range of roles and seniority of informants, none questioned the relevance of their role to a study of sustainable public procurement, a matter anticipated as a potential concern from the narrow view of procurement as purchasing from the supply chain management literature.

The role of food in hospitals and the way in which sustainable development was framed in this context, were further key guiding questions that the interviewer wished to answer in order to address the guiding principles of emergence claimed to be necessary by Pettigrew (1997). The researcher also wished to find out about accountability mechanisms, the informal structures and interactions between LHBs and different professions, as potential signifier of cultural differences, and who was involved in innovating change, to see whether changes were politically imposed or a product of democratic processes. Thus the interviewer guided the structure, rather than controlled the content of the interviews by asking specific questions.

The open interview style also enabled the researcher to follow up the informant's narrative with questions and queries that arose during the interview itself. In addition to recording the interview, notes were taken which enabled such questions to be formulated and put to the informant as part of the interview. Recordings were also transcribed after each interview and used to inform subsequent interviews.

For example, the use and role of internal multi-interest food groups, the role of volunteers, impact of a dedicated dietitian for catering and procurement management and the methods by which catering cost is planned and budgeted was information offered in one LHB led the researcher to ask specific, relevant questions within the second LHB to ensure that comparable accounts were available for analysis. None of those matters had been revealed in the scoping interviews. The detail relating to the benefits of the computerised management system was another area which was unknown to the interviewer prior to the interview, and was explored further during that particular interview before being used in subsequent interviews with other catering managers. Analysis of the interviews from LHB Z also revealed good and bad experiences of particular organisational structures, so that more specific questions could be asked during the interviews in LHB X. The differences in leadership on the development of catering and food service models in new hospitals, and the use and development of volunteers were issues that were explored as a result of this approach. The use of structured questionnaires might only have revealed the significance of these matters after a full pilot study, which was, after enquiry, deemed to be unfeasible.

Whilst the focus of the second group of interviews remained on actual experiences of change, the initial analysis from phase one enabled the researcher to probe for both corroborative evidence as well as alternative explanations, in particular that of collaboration. Synthesising the interview data with documentary data, for instance, highlighted, in respect of procurement and the NWSSP, co-operation and co-ordination, rather than collaboration, which directed the researcher to explore collaboration more closely in subsequent interviews.

In many cases, 'off the record' opinions were offered after the tape was switched off and although that material was not used in the written thesis, those comments were helpful in triangulating and contextualising other evidence.

A total of 23 formal interviews were undertaken during this data collection stage[9], resulting in 22 hours of recorded data obtained over a period of 12 months. Subsequent queries were raised by email and telephone, and documentary evidence was collated to supplement and triangulate the interview data. Repeat interviews were also agreed with informants within NWSSP-PS and NWSSP-FS, to enable the researcher to gain contemporary insights into the changes that were taking place during the data collection phase. Appendix 2 sets out the number of in-

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[9] These exclude the scoping interviews

depth qualitative interviews and outlines, in order to protect the identity of informants, their strategic roles in general terms.

2.4.7 Observation and Informal Discussion

In addition to formal interviews, informal discussions with managers, caterers and procurement personnel took place throughout the data collection period. These discussions were not recorded, but provided useful background information and signposting to alternative sources of data. General unattributed notes were made after the discussions which contributed to the overall explanation of change, and provided particular insights to the respective organisations' culture as well as indications of the perceptions of attitudes of senior management to frontline staff and the role of food in hospitals. The range of food offered in the staff and visitor restaurant within one hospital changed over the course of the twelve months of study. The first visit by the researcher suggested a relatively limited commercial use of the restaurant, the 'all day breakfast' appearing to be the most popular meal purchased. The later visit was after the introduction of a fresh salad bar and it was apparent that the restaurant users were more varied, in terms of age and gender, with queues for the salad bar rather than cooked food. Similar observations were made in other hospitals within that LHB.

Although the intention was solely to observe areas with public access, such as cafes and restaurants, the researcher was invited to accompany an informant to observe food regeneration in one hospital and food service in two other hospitals, that informant doing so as part of their usual routine. The informant obtained specific permission to do so from the respective LHBs and staff in kitchens and on the wards, in all cases within the two LHBs from whom permission had been obtained from the Board to undertake the study. The wards visited were in new hospitals, the rationale being that physical factors relating to catering facilities and technical obsolescence could otherwise impair comparability. Observation of food service was intended to assist the researcher to interpret the interview and documentary data, but also provided evidence of some of the innovations in action, but also question other matters, such as the different food service models.

2.4.8 Historical and Documentary Evidence

Research into the overall healthcare context and the formal structures was undertaken by analysis of key documents located using internet searches, NHS and WG libraries. One informant offered access to their own personal library of circulars

and correspondence in relation to catering which had been collected since devolution. Textual data was found in policy and strategy documents at constitutional, institutional and organisational scales, but also in the reports and consultation documents that preceded formal policy and strategy documents. Academic and independent evaluation reports were identified from informant interviews and documentary sources, and where not published, original authors were approached for copies and permission to use them in the study. The research also drew from copies of minutes of meetings obtained directly from informants, published minutes of Board meetings, and the annual reports published by those organisations relevant to this study.

The historical context of change provided valuable material to be included in the interviews, such as the potential impact of the change in minister, the apparent non-compliance with the 2002 Catering and Nutritional Framework, but also enabled triangulation of the interview data as well as a data source for testing rival explanations. The longitudinal element of the study also enabled some of the earlier unpublished material provided by informants to be verified by subsequent published material.

2.5   Data Storage

In-depth interviews were transcribed verbatim, and researcher's observation notes attached to the data file. Copies of the digital recordings were retained electronically in a specified, but anonymous, data file, along with the transcribed data. Interview data files were stored electronically and in hard copy, with the LHB's allocated references X, and Z and informants with corresponding sub-references and role to enable cross synthesis in data analysis. Non LHB informants were recorded and stored by reference to role description and type of organisation. Electronic data files were password protected.

A bibliography of the data was created and updated. Descriptive data from documentary analysis was stored with the relevant organisational data, along with the researcher's notes and initial observations on that data. Data provided by informants in hard copy format was noted with the source reference and date, and stored in files according to the subject and source.

2.6   Data Analysis

Processual scholars acknowledge the mysterious nature of the 'behind the scenes' data analysis linked to problem based or critical realist research, which defies

detailed or prescriptive techniques (Ackroyd, 2009; Langley, 2009). The complexity of such research nevertheless necessitated an iterative approach to analysis where the researcher stepped in and out of the empirical data without necessarily following the logical sequence implied by an inductive-deductive cycle. In order to avoid getting lost within the data, however, analysis necessitated continuous referral to the theoretical framework, as a point of reference and guide to where explanation might be found.

Langley suggests seven strategies for processual data analysis to help to "*overcome the overwhelming nature of boundaryless, dynamic, and multilevel process data by fixing attention on some anchor point that helps in structuring the material but that also determines which elements will receive less attention*" (1999, pp. 695-696). Although the appropriateness of each strategy is attached to its ontological position, Langley advocates the use of more than one strategy in order to be able to identify causal mechanisms and ensure rigour as well as validity. Of the seven, alternative templates, grounded theory, visual mapping and narrative strategies were thought to be appropriate to this study, along with Yin's rival explanation strategy (2009, p.135) to test those hypothecated mechanisms for change that arose from those forms of data analysis.

Throughout the data analysis, three underlying questions dominated the search for explanation:

•   What is this?

•   What is this a case of?

•   What are the conditions?

This continual critical process of induction and deduction using different strategies provided confidence that the mechanisms discussed in Chapter 7 were valid. Unlike grounded theory, however, the aim of retroduction is to refine, rather than generate new theory, as a consequence of which the anchor for analysis is the heuristic frameworks.

2.6.1 Heuristic Development from Structural Analysis

The initial heuristic representation, combined with an overview of the map of potential actors taken from the literature review and an initial, if superficial scan of the documentary evidence, is shown at Figure 13.

This representation was, however, devoid of potential explanation, but identified those areas where further empirical investigation might steer the researcher towards potential interactions and events that might yield explanation.   In addition to these holistic approaches, more detailed maps were developed for the structure of NHS Wales, such as that reproduced in Chapter 3 of this thesis. This structural mapping therefore provided a top down data analysis strategy.

Figure 13:   Guiding Heuristic as at 28.3.12
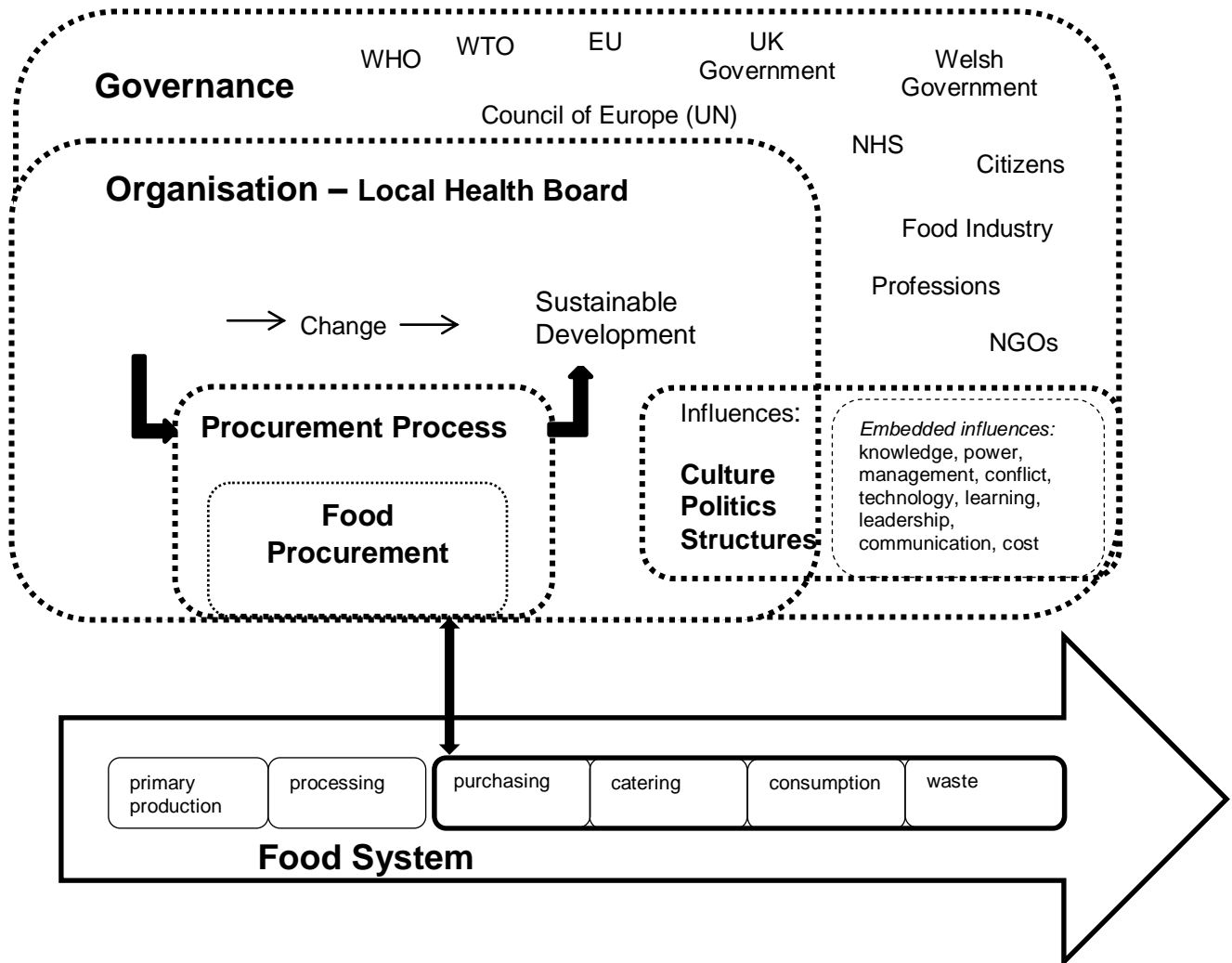
Source: Author

This guiding heuristic continued to be refined from the empirical data, the detail becoming more specific, the greater the volume of data collected. Best value was, for instance, added to sustainable development as an outcome of the procurement

process and the number of actors and stakeholders were refined by abstraction to a hierarchical arrangement of internal and external context, demonstrated in Figure 14, whilst the potential sources of interaction across those dimensions were more clearly defined.

Figure 14: Heuristic Framework as at September 2012

Structures					
Politics & Power		*Culture*	*Process*		
Legal Statute Regulation	**Guidance** Policy Strategy	**Values** Ethics	**Needs**	**Evaluation**	
Supra-National					*External*
National					
Institutional					
Organisation					*Internal*

Structure (vertical label on left side)

Source: Author

Towards the end of analysis, process, as a particular type of structure, was added as the data suggested that explanation was likely to arise within process as part of a broader constitutional structure. The final frameworks, Figures 6 and 7 in Chapter 1, were arrived at after analysis of the structures adopted by NWSSP for sourcing and contracting and catering, both within the process of governance of nutritional care. Thus the outcomes of the structural analysis corresponded to Pettigrew's concept of embeddedness (1997), as nested structures, and by working back (Reed, 2009) the heuristic in the written thesis became one which was fairly well refined by theory and empirical data.

2.6.2 Grounded Theory

Langley (1999) suggests that grounded theory techniques are used as one of several data analysis strategies for processual research. In this study the principles of grounded theory were employed for analysis of the first set of interview transcripts, as an alternative and critical approach to a straightforward analysis solely by reference to the heuristics.

Once interview data had been collected from interviews with informants from WG, NWSSP and one of the LHBs, the transcribed interviews were open-coded using AtlasTi software. Emerging themes and patterns were identified which were then used firstly to refine the initial theoretical framework, and secondly to guide the subsequent interviews with informants in the second LHB, regulatory bodies and NWSSP. This approach uncovered, for instance, the idea of collaboration, which was missing from the empirical literature, and best value as an alternative, separate but related outcome to sustainable development for procurement. This guided the researcher towards a more analytically refined approach to the constitutional structures of governance, and the idea that process could be reflected as a particular form of structure as well as the underlying causal mechanism.

Thus leadership, learning and collaboration became the core themes, or variables, to be critically tested, firstly for rival explanation and secondly to ascertain whether they were mutually interdependent concepts. This was achieved by reviewing existing documentary data as well as within data subsequently collected over the course of the study.

The need to decipher the temporal dimension also guided the analysis towards the use of narratives constructed from the interview and documentary data, identification of key variables insufficient in isolation of other analysis techniques.

2.6.3 Narrative Strategies

Narrative strategies also represent a bottom up, interpretive approach to data analysis, and were considered to be an appropriate analysis strategy to ensure anonymity of individual informants. The distinctive localised structures for catering and foodservice and the close collaboration within catering across Wales are such that any reader of the thesis could, after relatively modest enquiry, identify individual LHBs and therefore individuals from attributed quotations. It was also consistent with the selection of the processual case study, rather than an organisational or area based case study. Four forms of narrative analysis were adopted, intended to

provide accounts of interactions and events, and therefore adopting a relatively positivist stance within the overall interpretivist approach.

The first strategy adopted was the development of narratives from the data collected from interviews, as third person accounts of informants' own interpretations of particular events. As the study was not intended to interpret meanings, this was considered to be an appropriate technique which also reduced the reliance on the use of direct quotations, in accordance with the conditions attached to access to informants.

The second strategy was to develop an account of events from data collected from multiple informants. These were developed by the researcher and a draft sent to those who had contributed, by email, ensuring that the informants were not aware of who else had contributed. Responses were taken into account in the final draft, although none of those comments changed the nature or sequencing of the events. One informant in LHB Z, for instance, felt a certain part of the narrative was not clear or detailed enough, and made suggestions to correct the researcher's original understanding of the sequence and outcomes of the event in question. The risk of identifying the LHB had led the researcher to understate the importance of the sequence and outcomes of particular events, but as the LHB informant's response was also copied to his colleagues, the revisions were incorporated in the written thesis. An informant in LHB X also wished for some information to be taken out, as the particular initiative, although due to be implemented within weeks, had not actually been put into practice. Both amendments were for validity and clarity in the data, as well as for transparency and validity in the thesis.

The third strategy was to use vignettes of initiatives and innovations from written documents and other official media sources, triangulated with interview data where available. These were intended to identify the role of food in hospitals, one of the secondary research questions, and more particularly, whether food was structurally embedded in care practices within the context, as well as the process being studied.

Finally, the composition of the written thesis represents a narrative of explanation, following the what, why and how logic of Pettigrew's (1997) theoretical framework and discussed in more detail at 2.7.

2.6.4 Visual Mapping

The third of Langley's (1999) analysis strategies employed was that of visual mapping, in particular the formation of timelines to map and integrate significant

events across policy and strategy. This was used to make associations between hierarchical levels in governance; for instance EU policy, UK and Welsh policy and strategy as well as other significant initiatives. This particular strategy differs from, but is similar to, that of a temporal bracketing strategy in that clustering of sequential events became apparent within the timelines, leading the researcher to look for other data and alternative explanations.

The production of timelines is also closely allied to the narrative strategy, which, from the interactionist perspective of this study, was used to capture the contextual story of the changes that have taken place since Devolution. The clustering of events in 2008, for instance, coincided with a new Minister for Health, but also the start of an economic downturn. Many of those events were, however, preceded by research and task and finish group projects that were, as discovered from interviews, instigated by practitioners rather than politicians, suggesting an economic rather than purely political explanation and perhaps a concern that sustainability was a matter of either resilience to the economic climate or simply one of sustaining a publicly owned and funded health service. Identifying this cluster of activities caused the researcher to look back at events surrounding the 2002 introduction of the Nutrition and Catering Framework (WAG, 2002a), challenging directly the idea that lack of mandate, one of the key perceptions of barriers in public procurement literature, is the reason for lack of engagement of actors.

Nevertheless, the detail of the text in the timelines was lost when reproduced on paper, as a consequence of which they were not reproduced in the written thesis.

2.6.5 Pattern Recognition and Rival Explanations: Explaining Change

The quest for explanation also required alternative or rival explanations to be identified and considered, which Yin (2009, p.135) suggests are divided between craft and real-life rivals. The former encompass the possibility of chance, impediments to validity or researcher bias, whilst the latter comprise a more nuanced set of possibilities which might include genuine alternatives, coincidental but equally valid alternatives, a need for alternative theories, or some other larger force or trend beyond the scope of the theoretical framework. As Yin (ibid) also suggests, appropriate techniques for analysis, based upon pattern matching for internal validity, matching outcomes and rival explanations and explanation building, is an iterative and gradual process.

Patterns of recurring and related themes were identified from the interview transcripts and the documentary analysis, which directed the researcher towards

potential mechanisms for change. These hypotheses were subsequently tested by further review of the data, separated for analytical purposes according to structure to ensure that explanation was apparent in different contexts. Potential structural-political mechanisms identified through pattern matching, rather than frequency of occurrence, included integration, devolution, standardisation, simplification and differentiation, the latter essential as a result of the ethical framework predicated on equity. The socio-political mechanisms, operating on the process of governance, were found to be leadership, learning and collaboration, concepts that were found to be mutually rather than independently necessary as the conditions of change. Whilst those potential mechanisms represented the conditions of change at a strategic level, they did not fully explain change at individual level, difference in practice having been observed at ward level. As a result the data needed to be interrogated further in order to elucidate a potential causal mechanism appropriate to individual behaviour.

Although governance, in answer to the question '*what is this a case of*?' was identified during the early stages of data analysis, the notion of capabilities did not arise until after Chapters 3 to 6 had been drafted. The drafting of the thesis itself, therefore, formed part of the data analysis. Whilst the literature review linked the concept of capabilities to an institutional ethic of care (Engster, 2005), the concept of capabilities during data analysis came about through identification of structural empowerment, or devolution of authority, responsibility and resources, as a primary condition of individual change. The relativist, or processual, perspective of this study determined a need to link structural empowerment with action, and, therefore, suggested that the concept of capabilities was a more integrative concept and that psychological conditions were paramount in order to explain change. Thus structural empowerment was revealed, from the empirical examples of sequencing of events, as being a pre-condition for action, action being conditional upon cognitive factors enabling agency. Further interrogation of the original interview transcripts and documentary analysis suggested that confidence and competence were critical factors, the latter aligning particularly with the sustainable public procurement literature on barriers to change, where lack of knowledge and skills have been consistently cited as one of the principle barriers.

2.7   Composition of Thesis

Construct validity is a necessary feature of the reporting process (Yin, 2009 p.41), whilst Ackroyd (2009 p.537) suggests that writing up retroductive critical realist

research is "*an account of a process that involves the mutual reinforcement of the conception and the empirical exemplification of a causal sequence*". Writing the thesis therefore favours the use of a narrative approach whereby the thesis itself becomes a narrative of explanation.

As Langley (2009), however, points out, a great deal of the systematic analysis and verification in processual research takes place behind the scenes. As a result, a narrative approach to writing the thesis can appear to be over-simplified when compared to more discursive methodologies: the 'nuts and bolts' of the processes of induction and deduction being hidden from view in the final written form. The critical moment in writing up the research was, however, finding the right level of abstraction to link the primary questions and conclusions with the heuristic frameworks. Articulating the narrative of explanation was further complicated by the dualism of process: firstly as objectively defined phenomena, '*what is this?*' the NCP and the yoghurt contract, and secondly as an abstract mechanism or '*what is this a case of?*

Thus writing the thesis became a task of breaking down the narrative of change according to the context, content and process, the latter being the processual explanation of change. The empirical section of the thesis follows this sequencing, with the historical narrative leading to the description of the present structures, firstly for the context, the higher layer representing governance for sustainable development and value for money in Wales and the second as healthcare governance. These layers are distinct and separate structures as a result of devolution, and were assessed individually so that potential explanatory material, as hypothecated mechanisms, could be tested in context to demonstrate embeddedness for validation of the final thesis. The content of the thesis relates to the embedded case studies as the process structures of the NCP and the sourcing and contracting of yoghurt, the latter a process embedded within the NCP. Thus Chapters 3 to 6 were aligned with structures, as embedded processes.

The final section of the written thesis relates to explanation. Chapter 7 considers governance as the primary mechanism of strategic change, or 'what is this a case of?' This Chapter is framed around a discussion of the emergent mechanisms of change for each of the constitutional and process governance frameworks, and how those empirically observed conditions of change relate to theory. Thus standardisation, simplification, devolution, integration and differentiation are key mechanisms within the constitutional governance framework, with the process structure the critical condition, and leadership, learning and collaboration mutually

dependent conditions of process. The final Chapter concludes with summaries of the answers to the specific research questions, for clarity as well as construct and internal validity, and includes the thesis that the causal mechanism of change at an individual level is a concept of capabilities, where structural empowerment is a critical pre-condition of change.

Looking forward, as well as to the present and the past, is also a feature of critical realist retroduction, the final research question placing the research within the moment, the present providing the antecedent structures from which the outcomes of the actions of agency will emerge. The Chapter concludes with reflections on the research project, in particular the academic and policy relevance and some potential future research avenues.

2.8   External Validity

Tsoukas discusses four overlapping approaches to ensure external validity in single or small number case studies. He compares the experimental method logic in comparative designs, the need for regularity of occurrence in studies seeking causal mechanisms at an individual level, the way in which results are generalised to a broader theory with analytical generalisation and the methodological collectivism of necessary relations in structures inherent in a critical realist approach (2009, p.292).

Generalisation, concludes Tsoukas (ibid, p.298) is a matter of refinement as a heuristic device, the general being a matter of abstraction, rather than enumeration. The dialogical relationship between the empirical and theoretical in a cyclical relationship is therefore critical to explanation from this perspective and whilst this process of refinement enriches understanding it also challenges the way we think about phenomena in a more general, open-ended way.

In developing a heuristic framework from the literature, to guide the data collection and analysis, the design of this research meets the criteria for external validity by virtue of its inherent replication logic within a hierarchy of theoretical layers as well as across differing bodies of literature, supported and strengthened by refinement by the use of the existing literature school food procurement case studies.   Thus validity is provided by the synergy between research questions, heuristic representation and the presence of the conditions of change in different contexts within the study.

Nevertheless, the heuristic itself is not an abstraction of the mechanism, but remains a general theoretical proposition that can be refined or used to study

alternative, particular processes, either in variance studies or in the search for mechanisms in different contexts. Thus it could be argued that external validity of the thesis is demonstrated through governance as process: primarily as nutritional care, but also as a critical realist framework for sustainability governance, or when linked to alternative outcomes, more generally as governance.

The adoption of an institutional perspective on governance is also one which transcends the deeply contextual contingency of other approaches, such as those based upon structuration theory and in more confined contexts, such as the organisation.

Yin (2009) also suggests that construct validity for the composition of the thesis can be achieved through review by key informants of the written report. Draft narratives were provided for key informants to review, only those minor amendments referred to in 2.6.3 arising as a result. Drafts of Chapters 5 and 6 were sent to appropriate key informants, and one key informant reviewed the final draft of the thesis. No amendments were suggested or made as a result of these reviews.

2.9   Research Ethics

The NHS Research Ethics Service (NRES) provide assistance in identifying whether research constitutes, in their terms, research or an evaluation, the outcome of which determines the body from which research ethics approval is required. In view of the possibility that full NHS Research Ethics Committee (REC) approval might be required, and the consequential delays that might ensue, potential research ethics issues were addressed at an early stage of the design.

The general guidance provided by the NRES was unclear as to whether this research project fell into the category of research or evaluation, and so an outline of the proposal was submitted to them for advice. The submission made to the NRES and the resultant determination, that the study was an evaluation, was presented to the Research Ethics Committee of the School of City and Regional Planning (now Planning and Geography), who gave consent for the research to proceed. The application for consent is attached at Appendix 6, and was approved by the School Research Ethics Committee on 15 August 2011.

There were a number of research ethics issues that had to be considered in the initial design. In view of the prevailing sensitivity over nutritional care and hospital food in the NHS, it was decided that both individual and organisational anonymity had to be designed into the research. Although not a performance evaluation, the

influences identified in the literature review suggest that there were potentially different and possibly conflicting perspectives that might emerge and therefore individual identities and roles would need to be protected. Likewise, the political nature of the external environment to the organisation could make the identity of the organisation a sensitive issue, as well as providing a key means by which the informants could be identified. Such issues were pertinent to the formulation of the research aims and questions, the selection of case studies, approaches to the potential case study organisations, the design of the research methods and of particular importance in the reporting of the research findings.

Langley (2009) addresses these issues as particularly pertinent to the study of organisational processes, suggesting that the dilemma is most likely to be in the reporting of the research findings, and that by developing a strategy in the research design, these ethical dilemmas can be resolved. The independence of the researcher, using open interview techniques to study change as the lived and living experiences of informants and writing narratives as accounts of events and interactions, rather than seeking meanings, were all intended to overcome the need to identify informants, either by role, or by organisation.

The theoretical framework for the process under study has identified perhaps the most contentious, but contested concept - that of the influence of political behaviour, albeit not as the primary focus of the research. By using aliases for the organisation and informants, multiple units of analysis as context, and considering the organisation as embedded in an open system, rather than bounded entity, 'politics' takes on a contextual meaning beyond the legal boundary of the organisation, and thereby mitigates potential ethical concerns of confidentiality, protection of the participant's interests, or indeed political bias on behalf of the researcher.

The initial approach to the informants provided them with information on the research topic, the nature of their voluntary participation and offered copies of interview transcripts as well as material from the final draft report as a means of validating the data and the way it was represented. Key passages from the draft dissertation were provided to informants to ensure validity and that there were no concerns regarding their anonymity.

Two notable ethical issues arose during the study. The first was in connection with the study of the NCP in the third LHB. Whilst a number of informants who were approached were happy with the NRES confirmation that the study was an evaluation, thereby not needing a full REC hearing, one key informant was unwilling

to participate until the LHB's own REC had approved the study. As a consequence, the interview schedule was suspended. However, as informants within the other two LHBs provided evidence of significant differences between the organisational structures and processes, it was decided not to proceed with the third LHB, as neither the project as a whole, nor the validity of any conclusions, was prejudiced by restricting the number of LHBs within which the NCP could be studied.

The second ethical issue was in the use of the data from some of the interviews. One particular informant related narratives of the practice care they has witnessed or been party to. Some of those narratives included data which, although would not identify the patient to those not present, were intensely personal and emotional as well as relating to a medical condition. Although excellent evidence of some of the arguments being proposed in the thesis, the researcher had concerns that the patient's permission should have been sought to include such detail, and consequently that particular narrative was not used in the final dissertation.

PART 2
CONTEXT: GOVERNANCE, PUBLIC SERVICES AND HEALTHCARE IN WALES

PUBLIC SERVICE DELIVERY IN WALES

HEALTHCARE GOVERNANCE

CHAPTER 3
Public Service Delivery in Wales

3.1   Introduction

Organisation theories emphasise the influence of the external environment as the political, economic and cultural conditions within which multiple processes take place. Process theory also requires consideration of the historical context, the ordering of events being crucial in arriving at causal explanations (Langley, 2007). Whilst this study is primarily concerned with the process of nutritional governance, nutritional care is embedded within an institutional context of healthcare, the structures, cultures and politics of which are nationally contingent. The governance of public services in Wales therefore represents the external context for this study.

Wales has approximately 3 million citizens, 66% of whom live in urban areas, occupying just 13% of the total land area (ONS, 2011), concentrated in the south. This population reflects a wide disparity in wealth, health and wellbeing, containing some of the most deprived communities in the UK, with high concentrations of persistent multiple-deprivation, especially in former industrial areas. Public administration in Wales is arranged locally through 22 unitary authorities strategically linked to other public, private and third sector organisations through the six regions of the Wales Spatial Plan. The seven LHBs which provide or arrange healthcare services for their respective populations are spatially aligned with the unitary authority boundaries and collectively comprise NHS Wales, the relevant ministerial portfolio being Health, Social Services and Children (DHSSC).

Wales is, however, presently dependent upon the UK Government for its funding. In 2010-11 this amounted to £15bn, 89% of which is allocated for revenue spending and which is expected to fall in real terms by 9% by 2014-15 (WAO, 2011), thereby placing an unprecedented pressure to deliver cost savings over and above improved efficiency measures across the public services. £4bn, or 30% of this revenue funding, is spent annually in purchasing goods and services from third parties and this procurement budget is viewed as a principal means of supporting the Welsh economy.

This thesis is, however, that sustainable public procurement is not only concerned with the external spending power of public bodies, but also those activities that precede sourcing and contracting from third parties. Sustainable public procurement

is, therefore, a matter of the way in which public services are designed, delivered and accounted for, as governance.

WG organise and frame their aspirations for public service delivery according to the principles of solidarity and subsidiarity, devolving resources, responsibility and accountability for front-line service delivery, mainly to publicly owned bodies for the general good, rather than adopting the principles of privatisation and marketization. Government promotes a learning, or systems thinking, approach that seeks to challenge traditional ways of public sector working, to place the citizen and wellbeing at the heart of service delivery. The aspiration is that services should be structured as process, rather than function, and linked to outcomes to achieve a whole that is greater than, but not necessarily attributable to any particular part of, the system. The 70% of revenue that is retained within the public sector in Wales can, therefore, also be used to demonstrate best value through the quality, and thereby effectiveness, of services delivered directly to citizens.

At the interface with the market, as in the case of food procurement, public bodies are nevertheless guided and steered by Government through the use of policy and strategy instruments, towards using their spending power to support local producers and SMEs, within the perceived constraints of UK legislation. WG have, in this role, developed a set of supporting structures intended to overcome gaps in procurement knowledge and skills, to bring local producers, independent service providers and public buyers together. The success of these initiatives has, however, been shown to be patchy (McClelland, 2012), evidence suggesting higher levels of achievement within the NHS rather than within local government.

Increasing and immediate economic pressures, however, create tougher future challenges for public bodies, the aim of improving the wellbeing of such a diverse population becoming more reliant upon finding innovative ways of working for the longer term, founded upon the need to challenge existing behaviours, to bring about cultural change. In the interim, however, Government has the option of using its political powers in the way it structures public services, in addition to its guiding, steering and supporting role.

This Chapter therefore considers this overarching governance framework, shaped by the historical development of policy, changing priorities and structures which aim to embed sustainable development as the primary organising principle of all of the economic activities of the state, the outcome of which is intended to be best value as socio-economic wellbeing and public health.

3.1.1 Service Delivery and Sustainable Development in Wales

The Welsh Office (WO), established in 1964, held responsibility for the delivery of certain UK policy objectives in Wales until 1999 when devolution and the formation of the National Assembly for Wales (NAW) started a new era of policy and strategy making to reflect the particular needs and culture of the Welsh population.

The 1998 Government of Wales Act (GOWA) imposed a duty on the NAW to set out how it proposed to promote sustainable development and equality in the exercise of its functions (GOWA, 1998, s.121), including a requirement for consultation, review and reporting of the sustainable development scheme (SDS). The 2006 GOWA essentially transferred those NAW responsibilities to Ministers, requiring them to keep the scheme under review and to report annually on its effectiveness (GOWA, 2006, s.79). This new era of Welsh policy and strategy making nevertheless came into being within a broader multi-layered legal, political and strategic arena, where global, European, and UK influences affect governments' activities, in particular how the contested issue of sustainable development can be reflected in governance. In practice, the activities of WG are delivered through strategic plans for the delivery of public services, which are guided by the SDS. In both instances, the process by which these have come about reflect and follow periods of public consultation and discussion.

3.1.2 Programmes for Government

Although the early post-devolution 10 year plan for Government was produced by WG in 2000 (WAG, 2000), 2003 saw the start of a cycle of more in-depth strategic plans from successive governments. *"Wales, A Better Country"* (WAG, 2003b) set out the Government's aims and an enduring vision for the future direction of a public sector committed to people centred services, social justice, sustainable development, fairness and well-being. The key priorities in *"Wales, A Better Country"* embraced employment, skills, health improvement and communities, in a vision that focused on equality of outcomes underpinned by principles of transparency, partnership and participation. The ambitious vision for a radically changed Wales was followed by one of delivery of world class public services in "*Making the Connections*" (WAG, 2004a), which rejected outright the competitive model of public service delivery that focuses solely on cost efficiency, in favour of a quality agenda based on improvements in service delivery in order to meet multiple needs, evidence of which would be based on outcomes and value for money. These twin aims were intended to be achieved through co-ordination, co-operation and

collaboration across the functional silos of government, using partnerships with the private sector, voluntary groups and citizens to reflect the collectivist tradition and culture of Wales.

A key enabler of these radical changes was perceived to be collaboration, which would enable individual organisations to utilise specialist resources, overcome problems of limited capacity and provide integrated and joined-up services for the benefit of citizens. Whilst the belief was that this approach would bring about efficiency and value for money, the complexity of public sector structures, involving numerous Assembly Sponsored Public Bodies (ASPBs), was seen to be a genuine barrier to change, despite their often specialist knowledge and capabilities. The abolition or dispersal of many of the ASPBs, and the return of responsibility to the National Assembly did, however, bring some simplification and clarity.

These themes of simplification, integration, collaboration and efficiency underpinned the frameworks subsequently set up to ensure the accountability of public bodies, based upon concordat agreements, particularly in respect of external inspection, evaluation and audit, and to enable mutual benefits to arise from the sharing of information.

The second key driver of change in public service delivery was maximising value for money, initially through the use of monetary savings targets, with the intention that these would be redirected to improved outcomes. Smarter procurement, as added value both in terms of sustainable development and financial benefits for Wales, has remained the central pillar of the better value for money agenda. In addition to smarter purchasing, improvements in service delivery were perceived to be able to deliver efficiency savings, whether through shared and streamlined back office functions, reshaped service delivery or improved workforce capacity. The subsequent Beecham Review (WAG, 2006) made specific recommendations for developing enhanced capacity, reducing complexity and fostering innovation and ambition across the public sector in Wales. Rather than seeking to drive change from structural reform, the review recommended that needs should determine and drive change. The Assembly Government's response was a delivery strategy (WAG, 2006a) which set out a 5 year programme of delivery.

The quality of life aims of the devolved administration were re-affirmed in 2007 when the succeeding coalition published "*One Wales*", their programme for government (WAG, 2007), which continued to emphasise the underlying principles of social justice, sustainability and equity, whilst setting aims across a number of

areas of government and how they proposed to achieve those aims. The ensuing delivery plan contained 225 specific commitments, published in line with broader commitments to transparency and democracy (Morgan R, 2008). By the final quarterly report on the progress in April 2011, 90% of those commitments are reported to have been delivered (Jones, 2011).

The current ambitious and comprehensive Programme for Government (WG, 2011a) continues to claim to embed sustainable development, equity, social justice and well-being across policy areas, centred on bettering outcomes for the all the people of Wales. The plan acknowledges the deep short term challenges imposed by economic recession, particularly in the context of WG funding from the UK Government and the limited ability of WG to raise investment capital from taxation or borrowing. The programme prioritises growth and jobs, with public procurement viewed as providing a key opportunity to support this economic agenda. The need for strengthened democracy, accountability and partnership working are emphasised for long term sustainability.

The stated aims, shown in Figure 15, are supported by statements setting out how government intend to achieve and be accountable for them. The commitment to the programme being a living document is based upon annual reviews and reports, the first of which, at 666 pages, was produced in 2012 (WG, 2012c). Although that review suggests progress is being made, success stories are fragmented with little evidence of either concrete long term achievements or radical change, despite the enduring nature of the underlying needs and core objectives in place since devolution.

Nevertheless, some key achievements are noted, in particular the simplification of structures for statutory partnerships, with a consequential reduction in duplication and improved resource savings; some progress in the move towards collaboration as the norm, illustrated by spatial and sectoral alignment between regions, local authorities and LHBs, with the latter represented on the Public Services Leadership Group (PSLG) and development of leadership and procurement capability across the public sector through finance networks and education.

The core aim throughout the post-devolution period has been to drive better value for money to ensure the long term sustainability of citizen centred public services, with an increasing reliance on the strategic role of procurement as the means of doing so.

	AIM	KEY ACTIONS
GROWTH & SUSTAINABLE JOBS	To strengthen the conditions that will enable business to create jobs and sustainable economic growth	Support economy and business Improve employment skills Improve infrastructure Create sustainable low carbon economy
PUBLIC SERVICES IN WALES	To support the delivery of effective and efficient public services that meet the needs of people in Wales	Strengthen local democracy Support continuous improvement Ensure that our funding supports stronger and more effective service delivery Securing effective collaboration between public services
EDUCATION	Help everyone reach their potential, reduce inequality, and improve economic and social well-being.	Improving early years' experiences Improving school attainment Developing Welsh Medium Education Improving Further and Higher Education
21st CENTURY HEALTHCARE	Better health for all with reduced health inequalities.	Improving health outcomes by ensuring the quality and safety of services is enhanced Improving access and patient experience Preventing poor health and reducing health inequalities
SUPPORTING PEOPLE	High quality, integrated, sustainable, safe and effective people-centred services that build on people's strengths and promote their well-being.	Providing users and carers with a stronger voice and greater control over the services they receive Ensuring people receive the help they need to live fulfilled lives
WELSH HOMES	To ensure that people have a high quality, warm, secure and energy efficient home to live in.	Increasing supply and choice Improving quality Improving housing services and support
SAFER COMMUNITIES FOR ALL	Make our communities safer through reductions in anti-social behaviour, crime (including the fear of crime), substance misuse and the incidence and impact of fires as well as effective co-ordination of emergencies	Reducing the level of crime and fear of crime Reducing the harm associated with substance misuse Reduction and prevention of young offending Reducing rates of domestic abuse and violence against women Improving safety in communities Improving the resilience of communities
EQUALITY	Create a fair society free from discrimination, harassment and victimisation with cohesive and inclusive communities.	Advance equality of opportunity and tackle discrimination More inclusive and cohesive communities
TACKLING POVERTY	Reducing poverty, especially persistent poverty amongst some of our poorest people and communities, and reducing the likelihood that people will become poor.	Poverty and material deprivation Tackling worklessness and raising household income Improving the skills of young people and families Improving the health and educational outcomes of children, young people and families living in poverty
RURAL COMMUNITIES	Ensure that rural communities remain vibrant and able to offer people an excellent quality of life with access to high quality employment, affordable housing and public services and sustained by reliable and effective infrastructure in terms of broadband, public transport and utilities.	A thriving rural economy Ensuring rural communities have access to faster broadband speeds and new digital services Improving public services for rural communities
ENVIRONMENT & SUSTAINABILITY	To become a "one planet nation", putting sustainable development at the heart of government.	Living within environmental limits and acting on climate change Protecting healthy eco-systems Creating sustainable places for people
CULTURE & HERITAGE	Enrich the lives of individuals and communities through our culture and heritage.	Widening access to our culture, heritage and sport, and encouraging greater participation Strengthen the place of the Welsh language in everyday life

Figure 15: Aims and Key Actions from Programme for Government (adapted from WG, 2011)

The steering capacity within Wales does not, however, solely rest with WG. Whilst traditionally the role of audit has been that of scrutiny, there has been a trend in Wales to more collaborative approaches, with the independent WAO demonstrating a longer term, interactive and proactive approach towards public sector efficiency. Their work has developed from a traditional scrutiny role to one of collaboration. They have, for instance, commissioned academic studies in order to provide sound evidence of good practice, and supported dissemination through a public sector forum, learning seminars and a web based Good Practice Exchange.

As an example of their leadership role, the WAO commissioned a report on lean and systems thinking from Cardiff University (Zokaei et al, 2010) which outlined the principles and benefits of systems thinking to the public sector as:

- process relevant standardisation for effectiveness and quality rather than efficiency
- the need to think differently and enable a continuous process of learning through stakeholders and their interrelationships with and within the system
- empowering front line workers to achieve optimisation

Positive changes in service effectiveness were demonstrated by Zokaei et al (ibid), in particular how the use of systems thinking could overcome the box-ticking inevitability of performance management based upon target setting and compliance reporting. Although the report used local authorities as case studies, WG and the National Leadership and Innovation Agency in Healthcare (NLIAH) have also advocated the use of systems thinking approaches within healthcare.

As part of organisational design or as a management tool, systems thinking is a process based methodology and as such is a set of principles that can be adapted to the needs of particular processes. Based upon a best practice standards established through consultation with stakeholders, performance is managed through identification of variance in outcomes and process compliance using both qualitative and quantitative techniques to ensure validity. Improvement is brought about through learning from raising awareness and appropriate training. As such the approach uses benchmarking rather than targets as a means of assessing progress, but is heavily reliant on co-operation and collaboration, and is open to the claim that actors in government have no mandate over subordinate bodies.

3.1.3 Sustainable Development Schemes

Whilst better value for money, efficiency and effectiveness are deeply embedded aims in policy and strategy for the delivery of public services across WG, sustainable development has been dealt with separately in three successive SDSs: "*Learning to Live Differently*" (WAG, 2000a); "*Starting to Live Differently*" (WAG, 2004b) and "*One Wales: One Planet*" (WAG, 2009c). Each SDS has built from previous experiences in a cycle that has involved statutory reviews as well as public consultation. The overarching and ambitious aim is for WG is to become an exemplar by embedding sustainable development in practice across the Welsh public sector, leading and guiding society through shared values, whilst also setting an example of good practice beyond the spatial boundaries of Wales.

The most recent SDS (WAG, 2009c), intended to supplement rather than replace the programme for government, seeks to embed the process of sustainable development as a core organising principle across WG. The scheme acknowledges the multiple levels within governance by taking into consideration international coalitions for sustainable development such as the European Union's (EU) sustainable development strategy (EU, 2006) and the UK governments' shared framework for sustainable development (Defra, 2005). These strategies emphasise integration, innovation and economic activity; a just society with sustainable communities and personal well-being; environmental enhancement and protection and the efficient use of resources. Defra (2005) also provide a set of agreed indicators to enable progress to be monitored.

In line with the desire to deliver services appropriate to the needs and culture of Wales, WAG published a Welsh vision of sustainable development as a process which enhances

> "*the economic, social and environmental wellbeing of people and communities, achieving a better quality of life for our own and future generations:*
>
> – *in ways which promote social justice and equality of opportunity; and*
> – *in ways which enhance the natural and cultural environment and respect its limits*
>
> *- using only our fair share of the earth's resources and sustaining our cultural legacy. Sustainable development is the process by which we reach the goal of sustainability.*" (WAG, 2009c, p.8).

"*One Wales: One Planet*" (WAG, 2009c) stresses that participation and integration are essential in decision making processes that should be supported by six, environmentally biased, principles that

- seek to reduce the ecological footprint of Wales
- reflect whole-life costing in its broadest sense
- adopt an evidence-based approach whilst using the precautionary principle
- ensure the polluter pays
- solve local problems locally whilst ensuring that diverse local needs are met.

The scheme therefore provides a framework within which sustainable development is intended to be embedded in all government processes opposed to the weaker, previously adopted approach that set sustainable development as a separate but cross-cutting theme. The intention behind this change was to remove the likelihood of politicisation of the principle of sustainable development and the consequential vulnerability to differential prioritisation with the attendant risk that it could be totally ignored. The 2009 SDS attempts to integrate policy and a strategy for implementation by setting out the vision with underlying principles and the expected outcomes and indicators to enable progress to be monitored, summarised in Figure 16.

Core themes include responsibility, accountability and transparency, responsibility residing within a new Directorate of Sustainable Futures, the Director General of which is accountable to the Permanent Secretary. The commitment to annual reporting, debate and independent scrutiny from the Commissioner of Sustainable Futures, supported by Cynnal Cymru, also promotes transparency and accountability to citizens.

This latest SDS shifts the emphasis toward longer term considerations, ostensibly as a response to the short term economic climate and the limited powers devolved to WG to enable them to invest directly, considerations that feature strongly in the latest Programme for Government (WG, 2011).

External, independent reports on actual progress made with the SDS have since been undertaken by the Auditor General for Wales (WAO, 2010), Netherwood (2011) and Price Waterhouse Coopers (PWC, 2011a). These reports, respectively into whether WG were making progress in their goal to embed sustainable development and 'One Planet' in government, and the effectiveness of the

	AIM	HEADLINE INDICATORS
		Figure 16. Summary of Main Aims and indicators, One Wales, One Planet (WAG, 2009c)
SUSTAINABLE RESOURCE USE	Within the lifetime of a generation we want to see Wales using only its fair share of the earth's resources	Reduced energy use and increased energy efficiency through community and renewable energy generation Better local environments which contribute to health and wellbeing, where local people are involved to promote low carbon, low waste living Low carbon accessible transport network , ensuring less need for single occupancy car travel An exemplar NHS that leads on low carbon and sustainable development best practice through outcomes focused health services
SUSTAINING THE ENVIRONMENT	Wales has healthy, functioning ecosystems that are biologically diverse and productive and managed sustainably	Managed land, freshwater and marine environment to provide food, wood, water, soil, habitats and recreation
SUSTAINING THE ECONOMY	A resilient and sustainable economy for Wales that is able to develop whilst establishing, then reducing, its use of natural resources and reducing its contribution to climate change	Resilience to changes in the global economy Secure a long term economic future through a transition to a low carbon, low waste economy Encourage businesses to locate, start up, grow and prosper Communities based regeneration based on sustainability principles, creating an infrastructure for the future that favours sustainable ways of living and working
SUSTAINABLE SOCIETY	Safe, sustainable, attractive communities in which people live and work, have access to services, and enjoy good health and can play their full roles as citizens	One that values and promotes healthy living and improves the quality of life for all Access to better homes and community facilities sited in sustainable locations, free from the risk of flooding Improved global impact through being an international exemplar of sustainable development Promote Fair Trade, and deliver strong community partnerships with sub-Saharan Africa
WELLBEING OF WALES	A fair, just and bilingual Wales, in which citizens of all ages and backgrounds are empowered to determine their own lives, shape their communities and achieve their full potential	Equality for all is a core value promoting themes of age, gender, race, disability, sexual orientation Embedding sustainable development and global citizenship in education programmes and ways of working, underpinning all our work including Human Rights and the UN Convention on the Rights of the Child. Encourage active citizenship, with everyone meeting their personal and community responsibilities, both as a national and global citizen. Eradicating child poverty and ensuring a real translation of wealth and power in our poorest Celebrate and promote Wales' rich culture, values and traditions including the Welsh language; Place based regeneration informed by heritage, local character, a sense of place and a potent heritage and cultural tourism offer.

sustainable development scheme, recognise that some progress is being made in certain areas, but that there has been more limited success in others, casting doubt on the scale and depth of the Government's achievements in leading radical cultural change by example and sharing innovation and good practice as enablers of learning.

Whilst the aforementioned reports cite notable cross sector successes, such as the Food Strategy for Wales (WG, 2011a), the Economic Renewal Programme (WAG, 2010c) and Our Healthy Future (WAG, 2009d), they also highlight numerous inconsistencies across government, a lack of capability, and a focus on compliance over progress which fails to challenge existing behaviour. The latter is viewed as essential to enable transition from prioritising environmental sustainability to sustainable development. WAO did, however, note some progress in a transition towards an outcomes focus, and emphasised the strategic association between sustainable development and good governance. Nevertheless, evaluation and performance management remains heavily reliant on narrative reporting and compliance recording as box-ticking, rather than recording action (WAO 2010).

3.2   Achieving Best Value

Successive programmes for government have stressed the need for effective delivery, with particular emphasis on quality of service and outcomes, where improvements through efficiency savings are intended to sustain and improve front line services, but also in respect of supporting the Welsh economy by purchasing goods and services, wherever possible within the legislative framework, from Welsh SMEs.

Whilst the UK Government retains overall economic control over Wales through a devolved budget, WG nevertheless has the power to determine how that devolved budget is distributed within the public service framework, and does so according to political priorities informed by the needs of Welsh communities, a commitment to keeping public services within public ownership and the benefits of keeping the Welsh £ within the Welsh economy. As a consequence, the delivery of public services relies heavily upon partnerships with the private and third sectors rather than outsourcing or privatisation. The present economic climate has, however, imposed short term financial pressures on Welsh public services in the form of real time budget cuts at a time when social and technical conditions mean that demand for public services will not only increase, but the need for financial savings, of the order of £1.6bn before 2013/14, are likely to compromise service delivery (WAO, 2011).

The political emphasis on quality and outcomes, rather than cost, as a driver of improvements in public service delivery consequently places dual importance on the need to eliminate systemic waste in organisational processes and the transactional role of back-office functions to deliver monetary savings. As the latter, sourcing and purchasing roles, are unlikely to bridge the short term funding gap (MacArthur et al, 2012), the strategic role of procurement needs to be demonstrated through smarter working practices. Strong leadership, good governance and workforce planning are stressed as key ways in bringing about this transformation. In the absence of a complete restructuring of public service delivery, the potential of collaboration needs to be realised *between* public sector departments, to challenge the culturally embedded silo mentality, and *across* the devolved and partner organisations to deliver effective and efficient front line services.

The policy statement "*Better Outcomes for Tougher Times*" (WAG, 2009, p.11) concluded that in order to achieve this, the following need be prioritised:

– joining up government and public services around common goals and through local collaborative ventures

– strengthening the citizen voice in shaping and delivering services; using innovation in design and process; empowering staff to focus on citizens' needs and providing better and shared information and stronger accountability

– redirecting resources to the front line through efficiency, better procurement, smarter business processes, collaboration and making better use of public assets

– transferring good practice, and more effective support for public services to improve performance, efficiency and effectiveness

– taking the long term view by using investment for the future to bring about a more sustainable economy

The creation of the Welsh Procurement Initiative (WPI) in 2002 was a direct response to the public sector review of procurement in 'Better Value Wales' (WAG, 2001) and not only set the agenda for collaboration across the Welsh public sector, but was lauded as an international exemplar as the first specialist public sector body in Europe to be established solely to address the procurement activity of a country. Membership of the WPI was drawn from central and local government, the NHS, higher education, arms-length public bodies and NGOs representing environmental groups.

The WPI was replaced by the Efficiency and Innovation Board (EIB) in 2009, and its 2011 successor, the Public Services Leadership Group (PSLG) is the current strategic stakeholder body leading collaboration in procurement across Wales. Managed by Value Wales (VW), a division within the Directorate of Strategic Planning, Finance and Performance of WG, the PSLG has been given the task of ensuring coherence and implementation of public service reform; sponsoring and mandating action for effectiveness and efficiency, and development of regional leadership for collaboration with designated regions coterminous with Local Health Board boundaries. The three work streams of the PSLG are:

- asset management and procurement, the emphasis for procurement being on developing collaborative agreements, e-procurement, simplification and standardisation of contracting practices and proposals for a national procurement service

- organisational development with emphasis on the strategic role of innovation and 'lean' and 'systems thinking' approaches as a route to efficiency and effectiveness

- effective services for vulnerable groups.

3.2.1 The Role of Value Wales

VW provides the operational purchasing service for government but also holds a strategic role in leading and guiding the Welsh public sector as a whole through training, facilitating innovation, collaboration and dissemination of best practice, whilst ensuring that sustainable development is embedded in purchasing practice. Nevertheless, it has no mandate over devolved organisations, instead promoting smarter procurement as providing best value for the Welsh £ and the people of Wales, thereby linking to economic, social and environmental benefits (EIB, 2011).

This lack of mandate persists in actors' perceptions as the primary barrier to changing practice in subordinate organisations, but as an informant suggested in relation to the food group:

> "there are 30 odd people – it's a forum – it can't be a group because it can't possibly deliver anything because it is too big".

Setting the standard and leading by example through its own procurement practice, VW works within a WG procurement policy reproduced in Figure 17.

Figure 17: Welsh Government Procurement Policy

- Look for the best overall outcomes from our procurement activities awarding contracts on the basis of value for money to the most economically advantageous tender, taking into account cost and quality.
- Define 'value for money' as ' the optimum combination of whole-life costs and quality to meet the user's requirement' and thereby use appropriate criteria to consider value for money in the widest sense.
- Conduct our procurement activity in an ethical, fair and transparent manner, in accordance with the Professional Code of Ethics of the Chartered Institute of Purchasing and Supply.

    Uphold the Welsh Government's principles of equality and diversity in all aspects of its operation, and we expect our suppliers and contractors to adopt a similar approach to this issue. Continue to embrace all the principles in the 'Opening Doors' the Charter for Small and Medium sized Enterprises (SME's) and therefore:

    - consider the potential impact of procurement strategies on SMEs prior to making decisions through use of the Sustainable Risk Assessment tool on all tenders over £25k in value;
    - identify and remove barriers to business with SMEs, including taking a risk based approach to financial assessment, simplifying our documents, and providing useful tender de-briefing to help suppliers improve;
    - ensure our processes create a level playing field for all suppliers';
    - make it easier for suppliers to talk to us, including publishing guidance, providing briefings and contact information;
    - where appropriate packaging large contracts into separate elements or using regional lots, or encouraging larger first tier suppliers to provide opportunities for SMEs to deliver elements of our contracts';
    - becoming more familiar with Small and Medium Sized Enterprises in Wales (SMEs) and the services provided;
    - publishing all contracts above £25k on www.sell2wales.co.uk; and
    - treat all suppliers fairly and pay within 30 days from receipt of a correct invoice.

- Embrace Sustainable Development principles to influence all aspects of procurement to ensure that environmental, social and economic factors are considered within the framework of value for money, and to encourage all our suppliers to adopt a similar approach through:

    - application of the Sustainable Risk Assessment (SRA) tool to all contracts over £25k and through our contract management processes
    - Utilisation of the Sustainable Procurement Assessment Framework (SPAF), tool to measure and monitor performance and drive on-going improvement to achieve and maintain level 5 by 2011
    - In particular support retention of Green Dragon Level 5 in all our buildings through encouraging the reduction of negative environmental impact, through a procurement process that specifies or encourages the elimination of hazardous materials, utilisation of recycled and biodegradable material, and a reduction in waste, emissions, and unnecessary packaging.

- Support 'Delivering Beyond Boundaries' policy by taking a collaborative approach to procurement, working across Departments and where appropriate with other sectors to improve outcomes. Work in accordance with the all-Wales Sourcing Strategy to maximise opportunities from collaboration.
- Improve processes for both ourselves and our suppliers, maximising the benefits to the business from the introduction of a new Welsh Government strategic finance programme IDEAS (Information Delivering Excellence, Accountability and Success) and the xchangewales supplier portal, which will provide electronic procurement connectivity and enable us to access e-procurement tools. Increasingly we will make use of electronic supplier catalogues.
- Work in partnership with the business community, developing good channels of communication to improve our understanding of the market and managing our contracts effectively.

Source: http://wales.gov.uk/topics/improvingservices/bettervfm/wob/wagpolicy/?lang=en [accessed 11.7.12]

Between the PSLG and VW (and its predecessor, the WPI) a number of innovative projects have been undertaken with the aim of improving purchasing practice in terms of value for money, process efficiency and sustainability:

3.2.1.1 Sustainable Procurement Programme (SPP)

The SPP was developed to provide training and workforce development across the public sector. '*Buy Now Don't Pay Later*' (WPI, 2004) presented the business case for joining with the WPI and supporting the SME sector.

3.2.1.2 Opening Doors (WAG, 2008b)

This Charter provided the vision for modernising public procurement within the context of the guidance in '*Food for Thought*' (WAG, 2004) and focuses on communication and business development with SMEs.

3.2.1.3 Xchangewales (http://www.xchangewales.co.uk/)

This integrated e-procurement service aims to simplify processes and procedures, reduce duplication and increase efficiency by bringing together buyers and sellers in a single online system. The service also provides links with WG's business development organisation, Supplier Development Service. Although £59m of benefits are reported to have been achieved since 2008, the lack of a systematic across the public sector has been noted (PSLG, 2012).

Within Xchangewales, dedicated web portals have been developed for buyers and sellers of goods and services to the public sector. The Buy4Wales portal (www.buy4wales.co.uk) hosts a free, comprehensive guide to procurement in Wales, which brings together information, guidance and documentation on legislation, policy, supply chains, sustainability, markets and best practice. The innovative procurement route planner also provides a systematic step by step 'how to' best practice guide for the procurement process, specifically tailored in respect of key specialist areas, of which food is one. There is strong emphasis on standardisation and simplification through the use of technology in e-procurement, but also on sustainable purchasing, for which the sustainability risk assessment (SRA [EA, 2007]) and sustainable procurement assessment framework (SPAF) tools are provided, the former in relation to the goods and services being purchased and the latter on the procuring organisation.

Figure 18: Value Wales Sustainable Procurement Template	
Action	Considerations
Planning in partnership with stakeholders	establish needs
	possible procurement routes
	method for project management
	specification (including market research and sustainability risk assessment)
	estimating demand
	process strategy
	evaluation, selection and award criteria
	contract management
	key performance indicators
Tendering and Evaluation	supplier engagement
	procedural options
	use of e-procurement
	SQuid
Contract Award	structured evaluation in line with contract notice
	clarification with suppliers
	compliance
	interviews
	debriefing
	award
	notices
	implementation
Contract Management	ensuring best value through relationship management, supplier development and key performance indicators
Source: Author based upon information at http://buy4wales.deployment.sequence.co.uk/PRP/prp/strategy/procstrat/strategytemplate.html	

The primary advice from VW is that organisations should have a procurement strategy that is aligned with the main WG policies and strategies. The route map suggests that sustainable procurement needs to be cyclical, reflect upon previous

experience and practice and sets out a process that encompass those issues set out in Figure 18.

Sell2Wales (www.sell2wales.co.uk) enables potential suppliers to access and keep up to date on tender opportunities and notices in Wales. Users can register their profile, which will then be available to registered buyers. The intention is to link this portal with SQuID, the simplified, risk management based, 'once only' pre-tender qualification service aimed to help and encourage SME's to participate. Nevertheless, the format and accessibility of Sell2Wales are viewed as a barrier to engagement with SMEs (WAG, 2009), a claim easily confirmed by trying to access the site as part of this research.

3.2.1.4   Invest to Save

The Invest to Save Fund provides interest free, flexible loan finance to organisations funded by WG who otherwise have no powers to borrow. The aim is to release cash savings to support the efficiency and improvement agenda by encouraging innovation. The scheme has successfully supported 50 projects to the sum of £52m (Hutt, 2012).

3.2.1.5   National Procurement Service (PSLG, 2012a)

Proposals for a National Procurement Service, as a centralised collaboration for common and repetitive purchases, are being considered. The EIB procurement taskforce have proposed having a basket of common goods, with initial suggestions of 16 categories and 63 sub-categories, equivalent to 20% of public sector spend. The aim will be to seek leverage of scale, focus on demand management and implementing best practice.

3.2.1.6   Home-Grown-Talent

Funded by the EU Social Fund, the Home-Grown-Talent project, cited as an outstanding initiative by Sir John McClelland in his 2012 review, is intended to transform procurement by improving existing skills and capacity of the procurement workforce as well as identifying and promoting innovation and raising the professional status of procurement through executive trainee programmes. Although noted for its potential, its success in attracting participants was noted as falling far short of expectations (McClelland, 2012).

3.2.1.7   Open for Business Events

More strategic than the 'Meet the Buyer' events for specific procurement processes, 'Open for Business' events provide opportunities for all stakeholders to engage, identify and discuss a range of issues relating to public purchasing, the purpose being to overcome perceived and actual barriers in collaboration.

3.2.1.8   Sharing Good Practice

The dissemination of best practice is viewed within the Welsh public sector as a vital part of a process of learning and has already been illustrated through the work of the WAO. Publication of case studies supports dissemination (WAG, 2005b; 2010; 2011c).

3.2.1.9   Buying Safe Food for the 'Public Plate' (WAG, 2010a)

This guidance was developed through the VW collaborative 'All Wales' Food Group and prioritises food safety and food quality over cost (ibid p.5) and advocates the use of the standardised procurement route planner as best practice. It is, however, the last significant food related project co-ordinated by VW, although they retain responsibility for coordinating the national contract with STS, the food safety accreditation body.

Despite these strengths of VW and the progress that McClelland identifies in his review of public procurement in Wales (McClelland, 2012), some informants were critical of the lack of progress in the 'hard to do' areas:

> *"We're arguing that it [fresh food] should be in there because we have done fresh food as an 'All Wales' contract – so if we can do it for the Welsh NHS then why can't it be done for the Welsh public sector, so we have got a – not a debate, but a discussion about the rights and wrongs of all that."*

3.2.2 Practice Evaluation and Recommendations for the Future

The McClelland Review into the impact of public procurement in Wales recognises that significant progress has been made in recent years, but also identifies scope for further improvements, particularly in the local authority sector. Reasons for successes are suggested to be strong political leadership, complemented by some good examples of centrally developed tools, programmes and services through VW, although conversely, the lack of centrally imposed sanctions for non-compliance is also highlighted, along with a recommendation for conditional funding.

This way of using the coercive powers of government provides an opportunity to overcome the lack of mandate inherent in governance frameworks, mandating behaviour in devolved organisations being associated with resistance to change and stifling innovation. There is also an argument that, as local authorities are directly and financially responsible to the local electorate, from whom they raise part of their income, financial sanctions are the most powerful tool available. Imposing financial sanctions has, however, been both impractical and politically unacceptable in Wales, demonstrated aptly by the persistent annual bailout of overspent LHBs, as previously highlighted by Sir Derek Wanless (WAG, 2003a).

Nevertheless, the continuing lack of capability, resources, and low adoption of collaborative arrangements, evidenced through variations in the percentage of locally procured goods and services, suggests weak leadership in some of the devolved public bodies, especially in the local authority sector. The 28 review recommendations are framed around policy and implementation; capability; impact; collaboration and Value Wales Programmes.

3.2.2.1 Policy and Implementation

The recommendations steer WG towards securing a higher level of implementation through consolidation of existing policy and guidance; mandating implementation; formalising and adopting recommendations from '*Buying Smarter in Tougher Times'* (EIB, 2011) and providing clarity around targets.

3.2.2.2 Capability

Good governance and the strategic importance of procurement form the core principles underpinning the recommendations under this heading, which emphasise adequate resourcing and skills, evaluation and development.

3.2.2.3 Impact

Mandating local adoption of national policy, the need to measure and report on levels of spending within the Welsh economy, developing stronger links between procurement, SDS and suppliers are seen as paramount to the future development of positive impact of procurement activity.

3.2.2.4 Aggregation through Collaboration

20% of public procurement in Wales is conducted through collaborative arrangements, with wide variations across the public sector: 63% through collaborative arrangements in the NHS, but only 11% in local government

(McClelland 2012, p.13). The report recommends the strengthening of existing structures through a corporate procurement service for WG; aggregation for common and repetitive spending areas through a national procurement service; improved governance through a procurement board, and the development of data management capability.

3.2.2.5   VW Programmes

The capacity of VW has been heavily restricted by the proportionate lack of human resources, but also by the lack of mandate. Participation in any schemes created and managed by VW is discretionary, and this lack of involvement and commitment from certain public sector organisations is viewed as hampering the development of any 'All Wales' approach to the standardisation of processes and achieving economies of scale in purchasing and contracting activities.

Although the McClelland Review looked at collaboration and communication within Wales, WG is also a stakeholder in the EU, and has actively engaged with the consultation on the modernisation of EU procurement Directives (WAG, 2011d). Their response to the EU consultation highlights the need for public procurement to meet multiple objectives such as sustainable development and wellbeing, the latter through support to local economies.

The representations suggest that this can be done through simplification and engagement: realignment of the default basis towards the open procedure, e-procurement and framework agreements, accompanied by a less prescriptive approach which would enable innovation and supply chain relationship development. The suggestion is, however, that leadership should come from the EU, with member states empowered to develop appropriate but transparent and fair procurement practice that can reflect local social and economic needs, as a consequence of which competition should not just be on price, but have a greater emphasis on qualitative measures, as long as the processes and award criteria are applied equitably.

3.3   Supporting Strategies

3.3.1 Our Healthy Future: A Public Health Strategy for Wales

The concept of public health recognises that the determinants of health are economic, social and environmental, put into practice in Wales through the three strands of health protection, health improvement and health service quality.

Improved quality and length of life, and fairer outcomes for all are the main aims of the public health strategy (WAG, 2009d).

In a cross-cutting approach, the strategy takes a medium term view and aimed to build from existing strategies, policies and action plans that focused on health improvement and reducing health inequities. The focus of the strategy is on the health of individuals along a life course, recognising not just the costs to individuals and society of ill-health, but the benefits to individuals, families and communities of good health outcomes.

3.3.2 Policy and Strategy for Food

The aims of the Welsh Food Strategy (WG, 2012b) are to provide safe, affordable, and healthy food from a system that minimises environmental impacts and provides social benefits. This is founded upon the need to enhance capacity to increase competitive advantage and thereby develop a resilient food system. Re-localising supply chains is the primary focus of the earlier Local Sourcing Action Plan (WAG, 2009b), and public procurement is seen as pivotal in that re-localisation agenda.

3.4 Governance for Sustainable Development: Public Services in Wales

Although central common themes recur in the historical development of public service delivery in Wales, successive programmes for government and sustainable development strategies have progressed separately. Apparently conflicting objectives remain. The interplay between politics, economics and the moral claims for social justice is apparent from the drive for efficiency savings as a means of sustaining publicly owned services and creating jobs for economic development, fairness and economic wellbeing, but the overall approach has been that of making sustainable development a social, rather than specifically environmental or economic policy matter. Changes throughout the temporal development of successive strategies and programmes have built upon experiences gained, but have nevertheless been slow, fragmented and have concentrated on the easy targets and measurement, rather than the difficult qualitative, enduring and deeply embedded social policy issues.

The Sustainable Development Bill, in the Assembly's current legislative programme, suggests a shift to a more directive approach. Whilst it may, in principle, strengthen the current position and become a key tool for leadership, in practice its effectiveness will be highly dependent upon the ability to identify the responsible

party against whom to take action, the sanctions that can realistically and proportionately be imposed, and the resources and mechanisms for enforcement. Sustainable development is overtly framed as a process within this Welsh governance framework, and as such the danger with tighter regulation is that it will promote compliance with process, leaving sustainable development a rhetorical device rather than stimulating innovation and behavioural change. Accountability through public reporting also remains weak without a tried and tested means of measuring action as well as outcomes. Embedding sustainable development in everyday practice therefore remains a cultural, rather than just a political, challenge.

Whilst sustainable development is intended to be the primary organising principle of the Welsh public sector, delivering services is guided by the principles of value for money. WG retain their leadership role within this best value agenda by guiding and steering by example. Despite research and expert advice that the structures for public service delivery need to be aligned with processes, the constitutional structures of WG largely remain divided by department and function, governance thereby relying on cross-cutting thematic strategies within the political frameworks, underpinned by core values, to guide, rather than regulate for change. The fragmented approach is further demonstrated by the way in which procurement has been framed as the external spending power of public bodies, with an emphasis on the outcomes of that spending in terms of local sourcing, rather than any holistic view that challenges both need and needs within the purchasing organisation.

The transition to a more strategic view of the role of procurement, as part of service planning and design, is, however, demonstrated by its situation within the Strategic Planning, Finance and Performance Division, led by a joint head of finance and procurement. Nevertheless, the continuing emphasis on aggregation, standardisation, simplification and partnership working, in practice, suggests perceptions remain within the narrow functional conception of procurement as purchasing.

The political emphasis is on partnerships[10] as a structure for service delivery can avoid procurement regulations where delivered entirely within the public sector, although the underlying principles of fairness and transparency remain. The particular benefits of partnership structures are, however, the constitutional link with Government. Rather than devolve responsibility and accountability to corporate

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[10] In this context partnerships are considered to be both in respect of hierarchy, as between government and devolved organisations, and as networked structures between public and/or private organisations.

entities, partnerships enable a more reflexive and adaptable structure where responsibility and accountability can be assigned to individual roles, arguably a more robust and accountable approach than legislation. Whilst the use of partnership structures does not necessarily retain service delivery within the public sector it does achieve the political aim of keeping public services in public ownership. Thus constitutional structures, opposed to regulation, are potentially critical instruments of governing. Partnerships, opposed to sub-contracting or absolute devolution, also enable shared values and assumptions, such as equity, to guide behaviour towards cultural change.

The way in which public services are structured demonstrates the state's commitment to citizens, rather than markets. Retaining effective and efficient public services can reduce systemic waste, whether by the elimination of duplication, as in co-ordination and co-operation, or as the retention of economic activity within the region, perhaps as a form of economic resilience or of sustaining public services. Where the delivery of public services is devolved to subordinate bodies, Government can lead by example, but can also provide supporting structures to steer behaviour towards desired outcomes.

The supporting role of Government for procurement practice, at the interface of the market, is undertaken by VW, the connection to the wider political agenda apparent from their involvement with organisational development, the promotion of procurement policy and strategically by their engagement with European partners in procurement reform. Policy promotes the use of the SPAF to assess organisational performance on sustainability, and the SRA for individual projects. In both cases, collaboration with external sustainability NGOs in their development legitimises the respective processes in respect of the sustainable development agenda. The policy focus on collaboration and procurement outcomes is also directly related to local economic development and keeping the Welsh £ within Wales.

At the point where public bodies are exposed to markets for goods and services in the procurement of food provisions, the powers of public bodies are not only constrained by market structures, but by conflicting political objectives. Market structures for locally produced food, for instance, constrain to the ability of public bodies to meet local objectives in their purchasing activities, but also demonstrate structural and political conflicts between economy and health. Welsh agricultural production is dominated by the red meat and dairy industries, areas targeted for reduced consumption as part of a healthy diet, and by SMEs and micro-producers. Hybu Cig Cymru (Meat Promotion Wales), for instance, emphasises the need to

export in order to sustain the industry, and thereby prioritises profitability and competitiveness over localisation, resilience and environmental sustainability (Jones, 2012).

Such conflicts are particularly apparent in the absence of Welsh lamb on the 'Public Plate'. Demand from outside Wales, for both lamb meat and breeding stock, supports those who argue for regional and international competitiveness and bringing money into the Welsh economy, whilst the risks attached to market demand suggests that re-localisation can produce a more resilient domestic food system and retain the Welsh £ within Wales. Market structures, in terms of competition from other consumers, were cited as barriers:

> *"the trouble with Welsh local food is that it's always pitched at a premium product and it's never going sell to the masses …. but there must be some way of doing it. We can't all have the best meat in the world at the high level – it's unsustainable."*

Both Welsh lamb and beef enjoy PGI status, but beef is generally cheaper in comparison, although enjoys equal nutritional status. There is, therefore, no health claim, economic incentive or rational logic in budgetary constrained public sector for organisations to purchase Welsh lamb when the alternative, beef, is a quality local product, particularly in the case of hospital food, where the costs cannot be recovered from the patient.

With 67% Welsh lamb and 93% Welsh beef (WG, 2012b, p.25) consumed within the UK, there is also an argument that WG should prioritise capacity development in other sectors, such as fruit and vegetable production, where the story is one of potential rather than achievement. The Welsh fruit and vegetable industry only represents about 2% of the Welsh agricultural economy (WAG, 2010e), and as such cannot meet the range and demand from the public sector, despite calls for public procurement to purchase Welsh produce.

The narrative of change within the context of public service delivery is therefore one of aspiration, adaptation and transition. The aspiration is that public services should be structured around process, rather than hierarchy and bureaucracy, which will structurally link citizens' individual and collective needs with outcomes, for sustainable development and best value. This external context of public service delivery demonstrates the potential mechanisms of change as integration rather than economic rationalisation; differentiation; leadership, constrained by external

markets, and the devolution of powers to Local Authorities and the NHS, and perhaps double, but not triple, loop learning (Argyris and Schön,1978).

The future challenges for WG are to continue to make progress within diminishing financial resources, strengthening the need to retain the broad economic and social benefits created by public services as a whole, rather than just expenditure at the interface with markets, within the Welsh economy. Where market transactions, as sourcing and contracting, do take place, Government support through the procurement route planner not only guides best practice, but legitimises planning and specification based upon quality criteria as part of best value.

The relatively good practice in the NHS, acknowledged by McClelland (2012), suggests that structural or constitutional integration might be necessary to achieve best practice across the public sector, the poor example of Local Authority purchasing perhaps a result of greater financial devolution, including raising revenue direct from council taxpayers, and more localised political behaviour through directly elected representatives.

These issues are explored further in the following Chapter which considers the specific area of healthcare governance as the immediate context within which nutritional care takes place. The DHSSC does, however, provide an example where formerly separate government departments have been integrated, providing constitutional ties between separate bodies with devolved responsibility for the delivery of health, social care and public health services, further reinforced by joint senior roles with the NHS.

CHAPTER 4
Healthcare Governance

4.1 Introduction

Chapter 3 set out the framework within which Welsh public sector bodies, including the NHS, are expected to operate in order to simultaneously attain best value and sustainable value objectives. The NHS is a publicly funded health system, delivery of services within Wales being devolved to WG. LHBs and NHS Trusts have further devolved responsibility and resources to deliver healthcare services and to be accountable to Government and citizens. As the internal context for this study, this Chapter outlines the way in which healthcare services, relating to hospital care, have evolved and how they are planned and structured to achieve aims which have increasingly been structured around principles of public health and care, rather than the treatment of illness.

The early foundations of the wider NHS in England and Wales are, however, contextually significant to the current NHS in Wales. Focusing on the historical development of NHS Wales since Devolution covers the period from when WG was able to direct and steer a pathway towards sustainable development and citizen centred services. The historical narrative is therefore intended to provide the material from which the underlying reasons for change can be drawn as well as the background for a description of the present governance structures within healthcare.

The provision of hospital services is now planned and delivered by the 7 LHBs, supported by NHS Trusts for 'All Wales' services, an arrangement that came about through a major restructuring of healthcare provision that integrated the vertical divisions between primary and secondary care, and reduced the number of organisations providing localised care. These have been supported by 'All Wales' clinical and operational bodies, structured as partnerships. The resultant streamlined structures were intended to improve efficiency, by reducing duplication and waste, but also removed the inter-organisational boundaries perceived as barriers to delivering patient centred care.

These healthcare bodies, despite having devolved authority, responsibility and accountability, are structurally tied to Government, senior roles, and thereby accountability, shared between NHS Wales and WG. Within the healthcare governance framework, the constitution of the LHBs and key roles of Board members are also centrally defined, whilst sustainable development and best value

are instrumentally embedded in the respective constitutions. Healthcare governance is also arranged around a constitutional framework of strategies, standards and values, with evidence of emerging innovation in the use of process based structures as 'care pathways'.

The principles of sustainable development, framed as equity for social justice, are embedded in healthcare standards with values of dignity and respect promoting equity as well as guiding behaviour. The standards demonstrate leadership from the nursing profession in setting best practice, and emphasise care at the core activity of hospital based activities, but also stress the role of patients, the experiences of whom are incorporated into accountability. The framework of accountability, internal and external audit, inspection and self-reporting, is designed to capture the quality of patient experience and patient safety and ensure that clinical concerns drive efficiency rather than cost.   Accountability is, however, undergoing transition, from periodic sampled inspections to one of continuous performance management, with action, rather than compliance, playing an increasingly important role.

The Chapter begins with an account of the structuring of healthcare governance since Devolution, followed by a description of the political, ethical and accountability frameworks of healthcare governance and concludes with discussion of the emerging themes within this healthcare context. The Chapter provides the immediate context for the focus of this study, the governance of nutritional care in hospital settings.

4.2   Post Devolution Development: The Political Framework

The NHS across the UK has, since its inception, been subjected to continuous reform, largely in an attempt to cope with rising demand, medical and technological advances and spiralling costs. Nevertheless, major reforms have been perceived and promoted as politically, rather than economically motivated (Klein, 2010).

Founded in 1948 by the Minster for Health, Aneurin Bevan, the NHS was intended to be " *a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness*" (1946 NHS Act). These aims were to be delivered according to principles of equity and quality and free at the point of delivery. The Government of Wales Act (1998) transferred the powers of the Secretary of State for Wales to the National Assembly of Wales (NAW), and conferred on the NAW the ability to reform the structures of the NHS in Wales. The

complex legal and policy patchwork of healthcare provision for England and Wales was neither consolidated nor fully devolved until 2006, when the NHS Act and the NHS (Wales) Act were introduced as a response to the divergent nature of healthcare provision between England and Wales. Thus the stronger communitarian values of Wales were able to steer the direction of NHS Wales away from the competitive structures favoured by Westminster. Despite devolution of health policy and administration, however, NHS bodies hold no powers to borrow in order to deliver the service, which remains funded via a block grant from the UK government.

The importance of wellbeing as a core aim across policy and practice in Wales was stressed in "*Better Health: Better Wales*" (WO, 1998), with collaboration seen as the key mechanism that would enable change. This was complimented by the white paper "*Putting Patients First*" (NHS Wales, 1998) which set a post devolution vision for the NHS in Wales. The subsequent 2001 strategy for the future of the NHS in Wales (NAW, 2001) sought to bring about radical change through a process of renewal that also set out a vision for a pluralistic and participative governance framework to guide practice delivered through collaborative partnerships, underpinned by the fundamental aim to achieve a qualitative state of wellbeing for all. Although the strategy retained the distinction between primary (GPs), secondary (hospitals) and tertiary care, it stressed the need for the former to have a strengthened role in delivering patient centred care in the community and in public health through health promotion and protection.

Furthermore, the need to reduce the reliance and sentimental attachment to in-patient care was essential to make the service sustainable. The vision that the future should be based upon the principles of a planned 'natural health economy', was based upon collaboration through "*natural relationships between hospital services, reflecting existing practices and known patient flows*" (NHS Wales, 2000; NAW, 2001, p.14). The strategic transition was towards a process rather than functionally structured service, with specialist secondary care delivered in centres of excellence. Such structures enable a patient focus through flexible, needs based integrated care pathways, rather than determined by which services are provided and where. Thus structural reform was envisaged through integration and collaboration across all three spheres of healthcare as well as the multiple organisations that collectively formed the NHS.

The subsequent 2003 restructuring simplified the organisational configuration. The strategic planning role of the five Health Authorities passed to WG's three regional

bodies, and the local planning and commissioning role devolved to the LHBs, strengthening local influence and opportunities for collaboration with Local Authorities through coterminous geographical boundaries. The post April 2003 configuration was nevertheless criticised as being overly expensive and bureaucratic, the 22 LHBs and 14 NHS Trusts requiring separate senior managers and executive officers. (Lane and Jenkins, 2007, p.15). Lack of WG control over the devolved budgets and organisational spending were also highlighted by Wanless WAG, 2003a), successive ministers having repeatedly bailed out overspent subordinate organisations.

A review of health and social care (WAG, 2003a) reported in the light of the then proposed changes, but emphasised the need for vertical integration of health and social care, not through structural changes that would merge organisations, but through governance and integrated national service frameworks within which health and social care bodies could work collaboratively and evaluate performance against standards set by evidence based best practice. The use of care pathways, adoption of shared values, clarity in roles and responsibilities, and accountability provided the means to bring about change and efficiency within the planned configuration. The Wanless recommendations were incorporated into strategy (WAG, 2005b) and proposed service integration through regional networks which were reliant upon voluntary co-operation and co-ordination between health care providers, within and external to the NHS.

The NHS (Wales) Act 2006 provided additional direction through the imposition of a legal duty on all health bodies to cooperate between themselves and with local authorities, aligning with the enabling authority conferred for the purpose of Local Health and Wellbeing Strategies.

The subsequent programme for Government (WAG, 2007) set out a clear health agenda which focused not only on the quality of the service delivery and patient experience but, contrary to Wanless and perhaps in response to the lack of voluntary progress, proposed a review of the constitutional configuration of NHS Wales, primarily to reduce bureaucracy, overheads and transaction costs by reducing the number of health organisations. The health commitments in '*One Wales'* continued to emphasise other Wanless recommendations, but also expressed an intention to remove competition, ruled out private finance initiative funding, removed private sector commissioning, in particular compulsory competitive tendering for cleaning. The strategic aims were for a transition to a

wellness, rather than illness service and to keep the NHS in public ownership (WAG, 2009, p.3).

Integration of NHS Trusts also came about through collaboration, with a number of successful voluntary mergers taking place in 2008. The most significant restructuring of the Welsh NHS, however, took place in 2009, the proposals for which followed academic research into health service governance commissioned by the NLIAH. The resultant review of evidence by Dickinson and Ham (2008) identified particular features of alternative health service systems but stressed the need for new structures to be tailored to Welsh needs, culture, and funding structures.

The subsequent changes saw the organisational distinction between primary and secondary care removed and seven new bodies, to be called LHBs, were created, coterminous with the former seven NHS Trusts. Whilst the consultation process generated many responses, the majority were concerns about the names of the new bodies, particularly in North Wales. One change brought about following consultation was, however, the direction that there should be a Therapies Director at Board level, elevating the status of the constituent allied health professions such as dietitians and speech therapists. The new LHBs were ostensibly better able to focus on local planning and public health, engage with clinicians, and collaborate with partners through a more process, rather than functional, mode of service delivery.

The LHBs providing patient care are supported by three 'All Wales' specialist service NHS Trusts. Figure 19 illustrates the new 'simplified' spatial and horizontal configuration of LHBs, whilst Figure 20 illustrates the constitutional relationships between healthcare organisations, from 2012 onwards.

The reorganisation was also intended to address the governance deficits identified by Wanless (WAG, 2003a) by simplifying and standardising of the internal structures of the LHBs and Trusts to enable planning and ensure accountability by comparing performance. Efficiency savings through this systemic approach were, therefore, intended to come about through governance rather than either centralised control or absolute devolution.

Within WG the Minister for Health, Social Services and Children (HSSC) holds responsibility for the NHS. The role is supported by statutory powers which enable the direction of LHBs in the exercise of any of their functions and that such functions might be exercised by local authorities or through joint committees (ss.12-13, 2006

Fiigure 19: Post 2009 Spatial configuration of Local Health Boards

Betsi Cadwaladr
Hospital Sites: 35
Beds: 2567
Population:658417
Local Authority Areas: 6

Powys Local Teaching
Hospital Sites: 10
Beds: 213
Population:133071
Local Authority Areas: 1

Hywel Dda
Hospital Sites: 10
Beds: 1216
Population:381867
Local Authority Areas: 3

Aneurin Bevan
Hospital Sites: 16
Beds: 1859
Population:577077
Local Authority Areas: 5

Abertawe Bro Morgannwg
Hospital Sites: 16
Beds: 2510
Population:517981
Local Authority Areas: 3

Cwm Taf
Hospital Sites: 8
Beds: 1404
Population:293224
Local Authority Areas: 2

Cardiff and Vale
Hospital Sites: 8
Beds: 2134
Population:472121
Local Authority Areas: 2

© Crown copyright and database 2012 – contains ordnance survey data

Data Source: Source: EFPMS data 2010-11 (NHSSSP-FS, 2012); https://statswales.wales.gov.uk

Figure 20: Post 2012 Organisational Configuration

Adapted from http://www.nhswalesgovernance.com
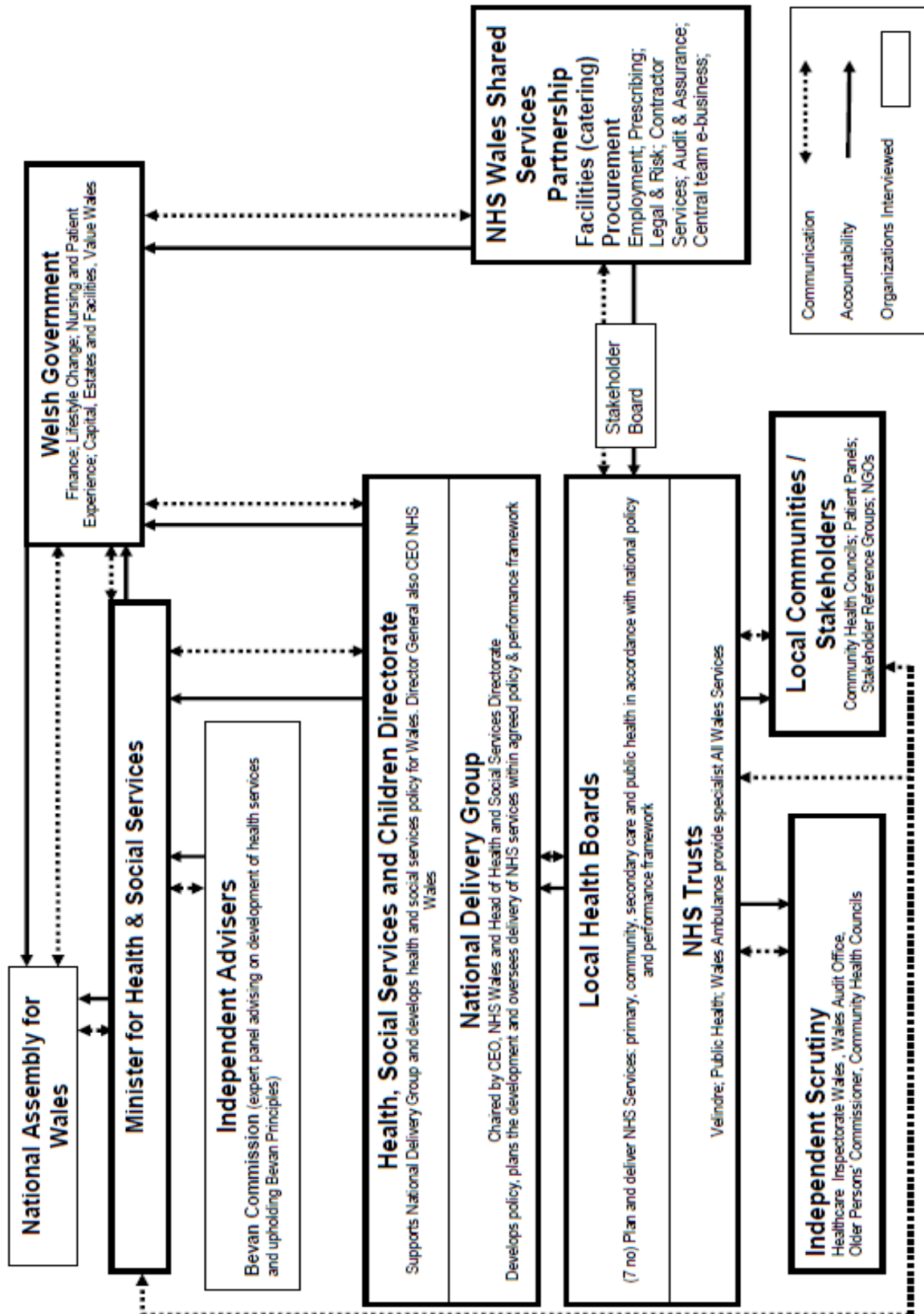
Act). Operational guidance is also issued through Ministerial direction. The Directorate of HSSC and the National Delivery Group are responsible for the delivery of NHS services, for which there are a number of strategies.

Successive strategies for service delivery have been supplemented by strategies for public health and wellbeing to address inequalities, for the provision of primary and community care (WAG, 2009d; 2010d; 2011b) and nutrition (FSA/WAG, 2003). Local strategies also provide the statutory requirement for citizen engagement in their development (NHS Reform and Health Care Professions Act 2002; SI 2003 No.154). The most recent strategy for the NHS in Wales (WAG, 2011) came into being in a period of extreme financial pressure on public services, and places particular emphasis how on equity in health can be achieved by tackling poor health, localising and integrating healthcare provision through partnerships and safety and quality of healthcare services as drivers of excellence and improved outcomes. Workforce development through leadership, engagement and empowerment are also highlighted, but the underlying message with regard to value for money was the imperative to drive efficiency through effectiveness by improving financial management, innovation and cutting waste as harm and variance from best practice.

4.2.1 The Role of Local Health Boards in Current Healthcare Governance

In operational terms, LHBs have statutory devolved responsibility to plan and arrange health services for patients within their spatial boundaries, but are supported in delivery by NHS Trusts and shared services partnerships, and work in collaboration with local communities and stakeholder groups.

The constitution of LHBs is set by statutory instrument, (SI 2009 No.779) which is supplemented by Model Standing Financial Instructions [SFI] (NHS Wales, 2010) and Model Standing Orders [SO] (NHS Wales 2010a), with the expectation that LHBs will adopt them as a minimum, from which they will adapt and enhance to meet local needs.

Key roles, responsibilities of the Boards and in some cases job descriptions of their members are thus determined jointly by WG and NHS Wales as part of NHS governance, with minimum requirements for Board membership and committee structures, as set out in Figure 21.

Whilst the Board sets the vision and strategic direction of the organisation, it also holds the Executive to account for the LHBs day to day activities, through the CEO.

The Chair of the Board is ultimately responsible to the Minister for the good governance of the LHB supported by non-executive members, who hold a scrutiny role.

Within the Executive team, the Medical, Nursing and Therapies Directors are jointly responsible for the patient experience, including catering and nutrition, as part of quality and patient safety. The Director of Finance has responsibility for performance measurement and management, accountability, value for money and procurement, whilst the Director of Planning is primarily responsible for planning, change, and resource use, including sustainability thereof, but also for ensuring local delivery and operating plans align with the national frameworks.

Figure 21: Minimum constitutional requirements for Local Health Board Members and Committee Structure					
BOARD					

Executive Members:
 CEO (Accountable to Board)
 Medical Director
 Nursing Director
 Therapies Director
 Public Health Director
 Primary Care, Community, Mental Health
 Finance Director
 Planning Director
 Workforce and Organisational Development
			Non-Executive:
			 Chair (Accountable to Minister)
			 Vice-Chair
			 Independent Members
			     Local Authority
			     Trade Union
			     University
			     + 5 others
			 Associate Members (4)
			     Director Social Services
			     Chair Stakeholder Forum
			     Chair Healthcare Professions Group			

COMMITTEES (Minimum Requirement)					
Quality & Safety	Audit	Information Governance	Charitable Funds	Remuneration & Terms Service	Mental Health Act Requirements
Source: Author					

The Local Stakeholder Group and Partnership Forum represent the local population and workforce respectively, with a representative of the former holding a Board position as an Associate. The purpose of these bodies, model terms of reference for which are standardised across Wales, is to advise the LHB on matters that affect

local citizens and the workforce, whilst the Local Professional Forum advises the Board on clinical, professional or medical issues.

The operational activities of the LHBs takes place through committees, which are "*powerful tools of good governance*" (NHS Wales, 2010a, p.5), provide advice, management and assurance to the Board through delegated functions and responsibilities. Central joint WG and NHS guidance for standard terms of reference and operating arrangements is provided, for example for the Quality and Patient Safety and Audit Committees (NHS Wales, 2010c; 2012b).

The SFIs are explicit in directing that LHBs must carry out their procurement practice according to legal principles of transparency, fairness and non-discrimination, but also direct that procurement activities must meet both effectiveness and efficiency objectives stated as " *the commercial, regulatory and socio-economic goals of government in a balanced manner appropriate to the procurement requirement*", and cost effectively so as to secure value for money (NHS Wales, 2010 p.32). The SFIs are also explicit in that the LHBs must support and align their own sustainable development strategies with '*One Wales, One Planet'* (WAG, 2009).

LHBs also have a number of their own policies, supplemented by annual operating plans. Key roles in relation to nutritional care are the nursing profession (including healthcare assistants); the therapies professions (in particular dietetics and speech therapy) and catering services (within estates/facilities divisions). The relationships of these actors in NHS governance are underpinned by the existence of 'All Wales' and LHB wide collaborative groups, examples of which include nutrition and catering groups, professional groups for ward sisters/charge nurses, senior nurses and dietitians, and in some LHBs multi-disciplinary food interest groups. These groups are supported by intranet based tools and resources provided by WG and NHS Wales.

4.3   Political Frameworks for Healthcare Provision

4.3.1 Service Frameworks for Continuous Improvement

The political framework for healthcare delivery Wales has undergone a transition from one which has devolved and fragmented responsibility to one of governance, with a focus on the equity in meeting individual needs, and quality and patient safety as outcomes.   Although local planning and provision of healthcare is devolved to LHBs to ensure local needs are met, this takes place within a national service

framework founded on principles of quality with common, evidence based, operational standards (WAG, 2010b). Governance outcomes are judged on principles of added value: quality improvement and quality assurance (WG, 2012a). Whilst standards set out expectations for service delivery, accountability is needed to show that the NHS is "*doing the right thing, in the right way, at the right time, and with the right staff*" (WG, 2012g, p.6).

'Together for Health' (WAG, 2011e) forms the five year umbrella strategy for the Delivery Plan (WG, 2012g) and is supported by annual operational frameworks and six cross-cutting specialist service frameworks. In addition, the annual national quality framework sets out a collective vision for, and expectations of, subsidiary healthcare organisations. The five year '*Service, Workforce and Financial Strategic Framework for the NHS*' (NHS Wales, 2010b) also prioritises health outcomes, system performance and financial sustainability and proposes action that improves performance, quality and financial stability.

Annual operating, replaced in 2011 by quality frameworks, were intended to bring about incremental, but lasting, improvement in the quality of care through prioritisation, target setting and largely quantitative measures of performance with assessment and accountability reliant upon internal governance, and values of transparency, openness, proportionality with a desire to minimise duplication and bureaucracy. Performance indicators were directly related to service quality assessed as timeliness, safety, effectiveness, experience and efficiency, financial performance and good governance.

The expectations were that the strategic outcomes of integrated care and stability in quality and finances could be achieved by adopting an approach that would reduce waste, harm and variation, in line with the five year strategic framework. In essence the aims could be achieved by embedding healthcare standards, using tested evidence-based approaches such as 1000 Lives methodologies to reduce avoidable harm; adopt care pathways to integrate and improve the patient experience, and make systems and processes reliable through clinical governance, innovation and collaboration. Thus the emphasis in this process thinking approach is on addressing systemic as well as material waste.

In 2011-12, however, the approach was adapted to embrace a more qualitative and less target driven philosophy that envisaged that transformation would come from subsidiarity, with an explicit emphasis on values as drivers of improvement. Retaining the underlying systems thinking methodology, it is envisaged that this can

be achieved through both innovation and collaboration. Although the emphasis remains upon cost control above all else, rather than focus on targets the measurement of performance is now based on quality of service, patient experience, and health outcomes.

The six themed National Service Frameworks supplement the quality framework and deal with specific healthcare issues or vulnerable groups, such as the elderly. The National Service Framework for Older People in Wales (WAG, 2006b), adapted from the English NHS version, forms part of the Welsh Older Persons Strategy (WAG, 2008c), and contains a standard relating to hospital care which specifically covers the non-clinical areas of environment and nutrition, and bases care provision around principles of dignity and respect for the patient, rather than organisational need. This strategy preceded the creation of the Commissioner for Older People in Wales, whose evidence in '*Dignified Care*' (OPC, 2011) has been attributed as a driver for a number of subsequent initiatives to improve the quality of care (OPC, 2012).

These frameworks provide the structure for how service should be delivered, with standards determining expected quality and accountability to the NHS and the public.

4.3.2 Healthcare Standards

Healthcare Standards (WAG, 2005, 2010b) set out the main areas against which LHBs performance is monitored are integrated into the frameworks for public service delivery to *do "the right thing, at the right time, for the right patient in the right place with the right staff" (WAG, 2010b, p.4)*.

The standards explicitly refer to the key aims of WG including sustainable development and equality and attempt to integrate all existing guidance, including the Fundamentals of Care [FOC] (WAG, 2003). There are 26 separate standards, each of which is centred on the patient experience, summarised in Figure 22 and mapped against other standards and frameworks within the NHS governance e-manual.

Figure 22: Doing Well, Doing Better: Healthcare Summary of Standards Framework (WAG, 2010b)

<table>
<tr><th></th><th>Standard and Description</th><th>Area of Practice</th></tr>
<tr><td rowspan="6">PATIENT EXPERIENCE</td><td>1. Governance and accountability framework
4. Civil Contingency and Emergency Planning Arrangements
8. Care Planning and Provision
23. Dealing with concerns and managing incidents
3. Health Promotion, Protection and Improvement</td><td>Governance</td></tr>
<tr><td>2. Equality, Diversity and Human Rights
7. Safe and Clinically Effective Care
11. Safeguarding Children and Safeguarding Vulnerable Adults
10. Dignity and Respect</td><td>Values</td></tr>
<tr><td>5. Citizen Engagement and Feedback
6. Participating in Quality Improvement Activities
9. Patient Information and Consent</td><td>Participation</td></tr>
<tr><td>12. Environment
13. Infection Prevention and Control (IPC) and Decontamination
14. Nutrition</td><td>Facilities Management</td></tr>
<tr><td>15. Medicines Management
16. Medical Devices, Equipment and Diagnostic Systems
17. Blood Management
18. Communicating Effectively
19. Information Management and Communications Technology
20. Records Management
22. Managing Risk and Health and Safety</td><td>Clinical Management</td></tr>
<tr><td>21. Research, Development and Innovation
24. Workforce Planning
25. Workforce Recruitment and Employment Practices
26. Workforce Training and Organisational Development</td><td>Improving Performance</td></tr>
<tr><td colspan="3">Source: Author</td></tr>
</table>

4.3.3 The Pathways Approach: Systems Thinking and 1000 Lives Plus

The transition from treatment to integrated care, through a process, or patient pathways approach, was first mentioned in '*Putting Patients First'* (WAG, 1998) but recurs throughout subsequent policies and strategies, was a significant feature of

the Wanless Report (WAG, 2003a) and underpins the Healthcare Standards and improvement programmes such as 1000 Lives Plus.

This pathways approach to care adopts a systems thinking methodology to link clinical governance and the efficiency agenda by enabling real time continuous performance management that is based upon common standards set by peer reviewed evidence of best practice. The underlying concept of a patient journey integrates treatment into healthcare and enables multiple, relevant, clinical pathways to be embedded into an individual pathway dependent upon an individual patient's needs as equity in both needs and outcomes.

There are a number of pathways which have been developed in the NHS in Wales under the umbrella of '1000 Lives', within which there are a number of specific care 'bundles' aimed at reducing harm and improving the patient experience and within which many have explicitly embedded the principles of good nutrition. The '1000 Lives' methodology has been subsequently adopted as best practice for improving process efficiency, healthcare effectiveness through improved patient outcomes, as well as promoting innovation.

The process based methodology originated in the US in the 1980s and has been successfully adapted and adopted elsewhere (NLIAH, 2005). The development process requires a multi-disciplinary practitioner and patient team to identify the area of practice with scope for improvement at a local scale. Evidence that the intervention will result in actual improvements is gathered through pilot schemes and development of appropriate metrics to provide data that will enable performance management. Rather than direct that the scheme is applied elsewhere, good practice is disseminated through coaching: communication of experience in case studies by peers.

The '1000 Lives' programme contains specific but standardised 'bundles' of care which that are attached to individual care pathways according to need. Although specific, there is evidence that individual programmes are, where possible, being adapted and as a consequence, more widely adopted. Enhanced Recovery After Surgery (ERAS) provides a good example where the underlying principles relating to the patient's nutritional and psychological wellbeing before, during and after hospital admission have been scaled-up by adoption within alternative elective surgical functions, process effectiveness and cost efficiencies arising from shorter patient stays and quicker recovery times.

The change philosophy is therefore one of starting small and ensuring efficacy before adapting or expanding. Evidence of effectiveness and efficiency is critical to its wider success, requiring a collaborative approach across task-based departmental boundaries, but the use of case studies and peer coaching is viewed by informants as critical to its wider adoption in practice. Informants also stressed the need to start small and the benefits or raising awareness over mandating behaviour change.

4.4   Embedding Values in Healthcare Governance

In addition to the political framework, healthcare governance structures and service delivery are underpinned by a framework that brings together a number of related values to guide both strategy and action.

4.4.1 Principles and Values of NHS Wales

The NHS in Wales has consistently aimed to uphold the original objectives of the Bevan Principles and the need to put the citizen, rather than competition, at the centre of service delivery. The Bevan Commission (BC) was set up by WG in 2008 expressly to advise the Minster on health related matters, but particularly to advise how the NHS in Wales is performing against those principles and how it might achieve the aim of a world class health service, which they define as:

> " *A system that performs well against the Bevan Commission Principles;*
>
> *A care system that is balanced and integrated across all levels and functionally and effectively links health and social services;*
>
> *A care system that achieves an excellent level of quality that is as good as or better than that demonstrable in comparable systems elsewhere;*
>
> *The quest for health care that best suits the needs of Wales, matched by concurrent efforts to realise a step change in population health, which requires government taking a crucial leadership role; and*
>
> *Readily available high quality, pertinent, and comprehensive information to analyse, compare, evaluate and develop services."*   (BC, 2011, p.6)

The Commission also acknowledged the need for modernisation and their deliberations resulted in eight revised Bevan principles:

> "*A shared responsibility for health between the people of Wales and the NHS;*

A service that values people;

Getting the best from the resources available;

A need to ensure health is reflected in all policies;

Minimising the effects of disadvantage on access and outcome;

A high quality service that maximises patient safety;

Patient and public accountability; and

Achieving continuous performance improvement across all dimensions of healthcare." (BC, 2011 p.7)

The emphasis is on caring for the patient in a more holistic manner than simply treating illness, with patient experience based upon principles of respect and dignity. The recommendations nevertheless acknowledge the need for cost considerations, but are explicit that these should be framed as cost-effectiveness rather than purely economy (BC, 2011, p.7).

In addition to the values of healthcare, principles that define standards of behaviour in public office, the Nolan principles, are paramount. These embody sentiments of selflessness, objectivity, accountability, openness, honesty and leadership, and core values that promote quality and safety, continuous improvement, partnership working and workforce empowerment. Key enabling mechanisms to bring about these conditions are evidence-based care, the elimination of variation and harm, the reduction of systemic waste and capacity building.

There is, therefore, a plurality of sources of guidance on the values that need to become embedded in healthcare processes, and on how actors should conduct themselves. The emphasis is on the qualitative outcomes of effectiveness as the driving force for efficiency and the need for culture change so that caring values become not just an accepted norm, but are embedded as taken for granted behaviour.

4.4.2 Sustainable Development Principles in Healthcare Governance

WG adopts a principled approach to sustainable development, and those principles are structurally embedded in the constitutions and model standing orders of NHS bodies. Sustainable development in this context reflects the WG view that it is a public health concern relating to the long-term wellness and wellbeing of people and communities. Within LHBs, the role of aligning organisational and national policy objectives lies at Board level with the Director of Planning, as part of the standardised role.

The nature of guidance on how to put sustainable development into practice has developed from guidance in the Sustainable Development Toolkit (NHS Wales, 2007 which attempted to operationalize higher level principles. Although mandated, there is little evidence of it being used to monitor respective organisations' progress.

The present position is that the principles of sustainable development are integrated into the strategic framework for public health (WAG, 2011e) and a process methodology, now in favour in NHS governance, has replaced the previous functionalist approach. The 4 'E' model for behaviour change brings together 57 action points within a framework guided by the process principles of enable, engage, exemplify and encourage (Figure 23). In operational terms, sustainable development is viewed as the pinnacle of the public health inspired Corporate Health Standard (CHS) and sits alongside corporate social responsibility as the qualifying standard for the platinum award which LHBs are required to achieve in 2013.

Figure 23: The 4 ' E' s Approach to integrating values in healthcare (WAG, 2011e, p. 30)
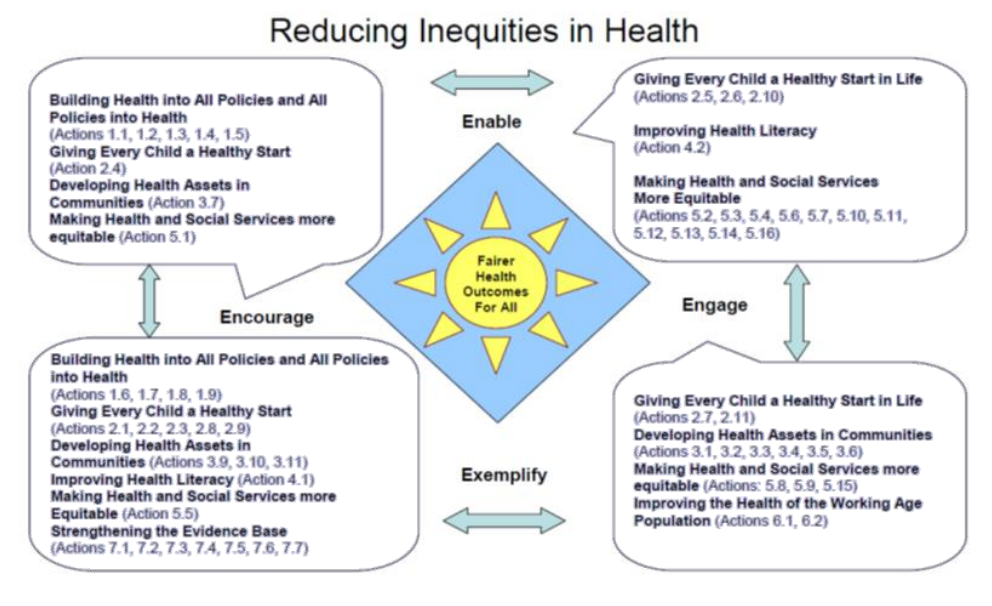
4.5   Ensuring Public Accountability: Assurance Frameworks

Governance frameworks within the NHS in Wales are based upon the principle of 'adopt or justify' and rely heavily upon self-assessment to demonstrate effectiveness and efficiency. The 2012 delivery plan (WG, 2012g) strengthens NHS governance

through a new framework where public accountability will move from a mainly internal system of LHB control relating to operational standards, to one which broadens accountability for institutional governance through greater transparency. The transition is intended to be one towards continuous accountability through performance management, although existing internal audits will still be used to measure progress against the healthcare standards.

4.5.1 From Self-Regulation to Public Accountability through Governance

Achieving Excellence (WG, 2012g) attempts to overcome the shortcomings of internal periodic and sampled audits through setting twin goals of improving quality of service and quality assurance. The improvement of quality is envisaged to arise from subsidiarity to front line staff, in line with concern for re-localisation in the 1000 Lives methodology. The intention is also that public involvement will be improved through a nationally coordinated approach to enable user experience to drive quality where clinical audit and outcome reviews will provide tests of the quality of care, and research and innovation will drive continuous improvement.

The quality assurance framework proposes to adopt common outcome standards and metrics to enable performance to be measured and compared within and across LHBs, as well as publicly reported to widen the external scrutiny role. The proposed outcomes framework, Figure 24 relates to 8 specific areas of care practice, with qualitative measurement against patient centeredness, effectiveness, safety, equity, timeliness and efficiency (WG, 2012g, p.1), the assessment of which is supported by population outcomes indicators.

The development of the indicators is to be in partnership between WG, NHS and devolved organisations. Within this quality assurance framework, operational outcomes measured against the Healthcare Standards will remain within the domain of internal audit, supported by external validation by HIW.

Key bodies with an external scrutiny role in relation to LHBs are the Wales Audit Office (WAO), Healthcare Inspectorate Wales (HIW), the Community Health Councils (CHC) and the Older People's Commissioner for Wales (OPC). There is a concordat agreement between these bodies that they will collaborate over planned inspections, but CHCs and HIW also hold powers for unannounced inspections.

Figure 24 Delivering Quality: Proposed Outcomes Framework (WG, 2012g)

© Crown copyright 2012
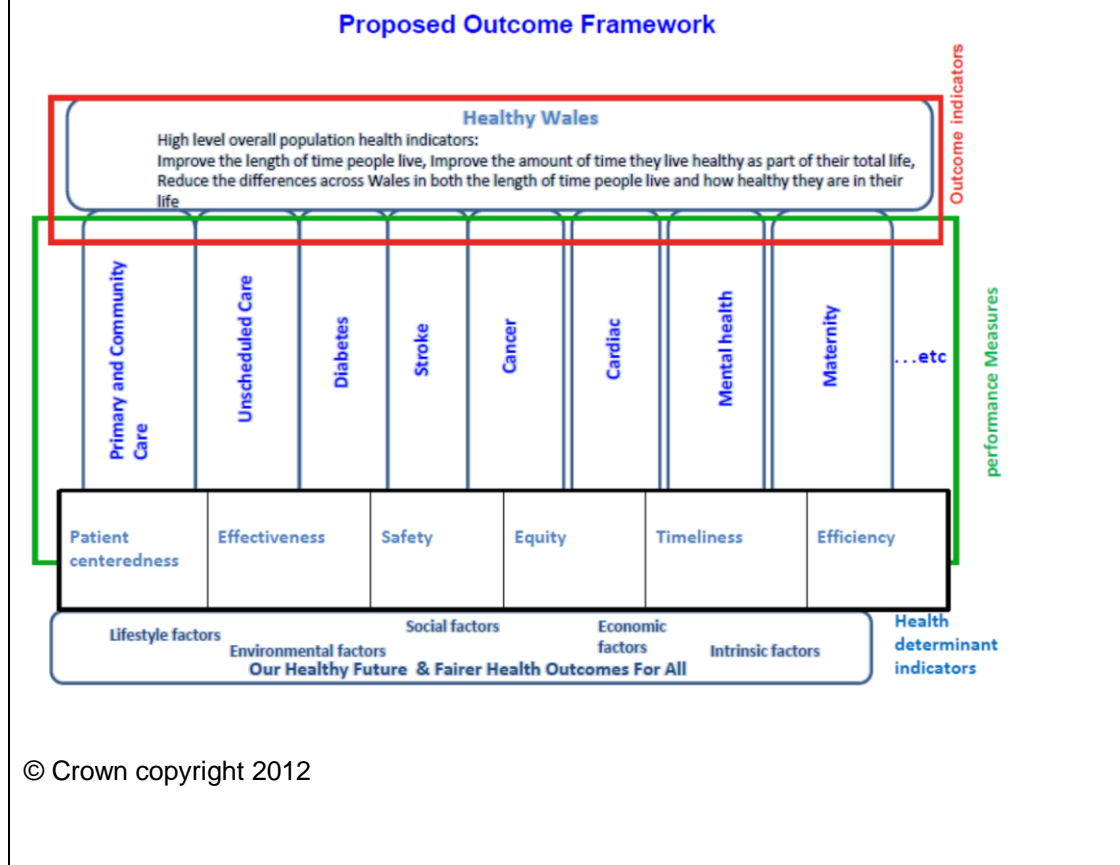
The WAO has a role in annual audit of the NHS and LHBs as a whole in connection with their use of public money, but also carries out periodic audits on selected themes, such as nutrition and catering. Although those themed reports are not solely concerned with efficiency, the other independent bodies have a primary concern with the quality of patient experience and patient safety.

LHB responses to external inspection reports take the form of action plans, and as such the external audit process is an attempt to highlight areas of concern, with no remedy available through sanctions. Reports by the Auditor General are, however, scrutinised by the Public Accounts Committee (PAC) who hold WG to account for value for money. The PAC recommendations are therefore from the highest authority within governance.

4.6   Setting the Scene for Nutritional Care: Healthcare Governance

The interaction between economics, cultures and politics within healthcare governance is most apparent since 2003, the explicit aim of the restructuring programme at that time being to reduce systemic waste by eliminating duplication and internal competition through integration.

The 2006 National Health Service (Wales) Act enabled political action to further distance the NHS in Wales from the changing NHS structures in England, achieved primarily through integration and standardisation, rather than fragmentation and greater devolution of power to healthcare organisations. The final elimination of the internal market for commissioning services, for which WG resumed control, also reinforced the political aim of keeping NHS Wales in public ownership, but simplified further the structures and removed a bureaucratic layer within hierarchical governance.

The pattern of political action and structural reorganisation preceding cultural change is apparent from the consultation responses in respect of the 2009 integration of healthcare bodies. This was most evident in terms of the spatial re-organisation in the rural north and west of the country, locally defined concerns ultimately ignored by politicians. Nevertheless, concerns for cultural resistance to structural change in the vertical integration of primary and secondary care, as expressed by Wanless (WAG, 2003a) were not apparent from the consultation responses. The voluntary Trust mergers in 2008 also suggest the genus of a culture of collaboration and demonstrate a shared vision for a publicly owned and funded health service based upon the principles of public health. Structural integration, as a political action, appears to have been founded upon synergies in local needs and cultures, but was arguably driven by the economic need to reduce duplicated costs, the outcomes in terms of public health equally, as Wanless (2003a) suggested, achievable through collaboration.

Although easily attributed to political action driven by external economic conditions, evidence of prior political commitment to radically restructuring healthcare delivery within NHS Wales is firstly provided by the earlier formation of the NLIAH, a specialist innovation agency within the NHS and secondly by the adoption of the first comprehensive set of healthcare standards (WAG, 2005a), both of which took place before the 2008 consultations on structure.

The NLIAH provided leadership and support for innovation, learning and collaboration across the NHS and they have been critical in terms of the adoption of the care pathways approach and subsequently the 1000 Lives programme. The success of the latter in this broader healthcare context is also evidence, in contrast to the actions of WG outlined in Chapter 3, of triple loop learning (Argyris and Schön, 1978): transformation through a radical approach that challenges the rationale behind existing practice. The dispersal of the NLIAH in 2013 between WG, Public Health Wales and NWSSP, nevertheless highlights the present emphasis on efficiency, the dispersal being part of a rationalisation of a number of agencies supporting organisational development. 1000 Lives Plus continues, however, to promote innovation in healthcare and so the dispersal of NLIAH does not necessarily signify an abandonment of innovation within the broader healthcare context.

The first comprehensive set of healthcare standards (WAG, 2005a), although building on the earlier FOC, was introduced in 2005 to integrate the four domains of patient experience, clinical outcomes, healthcare governance and public health with existing clinical governance guidance. These standards were effectively a stepping stone towards the updated 2010 version (WAG, 2010b), which although not fundamentally different, demonstrates commitment to continuous improvement, learning and the movement away from a treatment service to one based upon care. Although important, therefore, progress in terms of improvement, by structuring around the qualitative experience of care, was already being made before the 2006 legislation and the 2009 reorganisation.

The post 2009 NHS structural reforms, however, demonstrate the interplay between the political commitment to reducing systemic waste, by eliminating duplication and harm, and to a health service based upon qualitative experience. The core principles of sustainable development have, for instance, been embedded into the constitution of LHBs and the regulatory and ethical frameworks of healthcare governance, whilst best value is being structurally embedded by integrating common shared and specialist services across NHS Wales.

The biggest innovation over the period since Devolution has been the adoption of process structures, the NCP being the prime example of a political and cultural commitment to principles of equity and care being put into practice. Care pathways have been an aspiration since before Devolution, but actually putting them into practice has been a relatively recent achievement, dependent upon clinical leadership, learning and collaboration. Pathway structures embed values to guide

action, place patient needs and outcomes as drivers of quality, as effectiveness and promote best value as reduced waste, transaction costs and unnecessary interventions. Although a bottom up, clinical led innovation there has been considerable political support for restructuring treatment as function to care as process, which has in turn enabled a collective aspiration to be put into practice.

Accountability frameworks have developed alongside the changing healthcare delivery structures, towards a more reflexive performance management regime. Although targets remain for some clinical areas, patient experience and safety, as the domain within which nutritional care is practised, is of paramount concern. Common standards, audit, inspection, performance management and transparency, through public reporting, define the accountability framework, with accountability increasingly measured against action in respect of effectiveness as quality of experience, equity for dignity and respect, and efficiency for best value. The accountability framework is supported by clearly defined roles where, ultimately, accountability of the Board, through the Chair, is to the Minister.

The holistic review of the health system from 2007 is an example of radical strategic top down change supported by bottom up, or incremental, change, as leadership and learning. Effective change has, however, been brought about through collaboration, the planned, radical constitutional changes being complimented by adaptive changes based upon the expertise and on-going experience of professionals and patient representatives. Key themes emerging within this healthcare governance context, in addition to devolution and integration, are the standardisation and simplification of structures across NHS Wales, to enable performance management at an institutional level; innovation in the development and adoption of new structures for healthcare delivery at national and localised[11] level, and democracy, demonstrated by the way in which collaboration has shaped the processes of healthcare provision.

The more recent political narrative nevertheless demonstrates a transition from healthcare governed by qualitative drivers of needs, outcomes and accountability, albeit constrained by an imperative to constrain costs, to one where the political imperative is economic, not only framed as cost reduction, but in the form of reduced budgets for planning. Such economic pressures will inevitably challenge the aims of quality and effectiveness as drivers of change.

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[11] Localised refers not only to the spatial and organisational dimension, but is also associated with patients' individual and collective care needs.

The future challenge is, perhaps, to ensure that core principles, currently becoming embedded in structures, are also embedded in behaviour, so that actions become tacit knowledge, embedded in culture and therefore more resistant to change. The continuing move to rationalise specialist operational support for the delivery of healthcare services perhaps indicates a political and structural commitment to efficiency as a driver of change, with the danger that quality and effectiveness are reduced to a symbolic representation of care.

Although process efficiency has been the main objective, steered by standards set by effectiveness, the future challenge is therefore to demonstrate cost efficiency aligned with new process structures. Whilst this may be possible in some clinical areas, others, such as nutrition, are likely to be more problematic. Aggregated statistics, for some specific elective procedures, might show some efficiency improvements attached to average length of stay, but the complex health conditions and needs of many of the most vulnerable patients are likely to mask the direct effects of nutritional care in hospital settings. This need to consider nutrition as part of patient experience therefore leaves the quality and provenance of the food to politics and as a consequence, vulnerable to competing demands.

Innovation, collaboration and learning are apparent from the analysis of the historical and contemporary evidence, whilst structural integration, simplification and standardisation have enabled a more robust accountability framework to be put in place. This context of healthcare governance therefore sets the political, structural and cultural scene for the particular focus of the research, the governance of nutritional care in hospital settings.

PART 3
THE GOVERNANCE OF NUTRITIONAL CARE IN HOSPITAL SETTINGS

FOOD AND NUTRITION IN HOSPITALS

HOSPITAL FOOD: SOURCING AND CONTRACTING

CHAPTER 5
Food and Nutrition in Hospitals

5.1   Introduction

The provision of hospital food in Wales takes place within the seven LHBs and Velindre -NHS Trust[12], supported by the NWSSP, within which Facilities Services (NWSSP-FS) and Procurement Services (NWSSP-PS) are the divisions relevant to this study. Nutrition within this healthcare context is the provision of both food and fluids.

£54m was spent on hospital catering operations within Wales in 2011-12, with just over 36%, or £19.5m, spent directly on food provisions. This represents 1% of LHB income, or approximately 3% of non-pay expenditure. 11.6 million meals were produced for patients across 104 hospital sites in Wales that year, reported to be at an average cost of £3.34, an increase of 22% over the previous year. At a cost of £38.9m, the cost of providing meals to patients therefore represents a very small part of the overall NHS delivery budget of £5.4bn (NWSSP-FS, 2012; NWSSP-PS 2, 2012).

Chapters 3 and 4 outlined the historical and present context within which hospital based nutritional care takes place, and the way in which there has been steady, if slow, transition towards patient centred care, enabled by restructuring clinical care around process and the patient, rather than function, and by integrating structures on an 'All Wales' basis. This framework sets the scene for the focus of this study, the way that nutritional care is planned, designed and delivered in order to achieve the dual outcomes of sustainable development and best value, as nutritional governance. As part of this process, pre-sourcing and purchasing activities take place within hospitals, whilst outcomes are also part of hospital based nutritional care.[13] Thus the hospital setting links needs and outcomes, and sourcing and purchasing becomes a process embedded within nutritional governance, dependent upon both qualitative needs and quantitative need, which is carried out within a constitutionally separate, 'All Wales' supporting organisation, the NWSSP. Chapter 6 therefore considers the embedded procurement process carried out by NWSSP-

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[12] Further references to LHBs include reference to Velindre NHS Trust
[13] This research excludes elements of nutritional care in community settings and public health related nutritional care, both of which are also the responsibility of LHBs and within the context of healthcare governance.

PS and this Chapter food service and catering, which includes the activities of NWSSP-FS.

The changing role of hospital food demonstrates transition, with food, as nutrition, becoming integrated within care beyond the provision of hospital meals. This is demonstrated in practice outside of the NCP, through the development of specific care bundles within which food and fluids are a critical element of care processes. The structural embeddedness of nutrition is therefore a major concern of this study, in order to provide empirical evidence of political commitment to positive change.

The Chapter is largely descriptive, and represents the content in Pettigrew's triangle (1997). Although a post-structuralist approach, retroduction is based upon a more positivist than social constructivist position, with the interactions between structures and agency providing the material to enable explanation. The approach does not, however, reject discourse and language, as these are necessary considerations for the study of cultures, but does question the dependence on discourse in interpretive perspectives that rely upon structuration theory. Rather than relying upon direct quotations as indications of meaning, this Chapter presents vignettes, as narratives drawn by the researcher from qualitative interviews and documentary evidence, selected to demonstrate practical examples of informants' actual experiences of good and differing practices. Attribution to role is not therefore felt to be necessary, and protects the anonymity of informants and their employing organisations.

In order to provide more detail to the description in this Chapter, supplementary details on the formal structures of the NCP process, guide to the nutritional standards and 'All Wales' catering data are included at Appendices 3, 4 and 5.

The structure of the Chapter aligns with the functional divisions within the NCP, firstly as nutritional care and secondly food service and catering practice. Although traditionally separated by clinical and operational governance, the NCP, as a radically new structural form, has been a key means of overcoming existing cultural and professional differences. Those differences remain within the internal accountability framework, although have enabled professional leadership in the development of relevant performance management tools. Collectively, however, these changes have taken place within a framework of prior structural integration, standardisation and simplification.

As a whole, the activities within the governance of nutritional care described in this Chapter represents demand, as in 'needs' or effectiveness, which informs the embedded procurement process of sourcing and contracting. The changes that

have been brought about, planned, or are in progress, continue to demonstrate the collective aim of reducing waste for operational efficiency, which in turn determines need for purchasing.

5.2   Hospital Food as Nutritional Care in Hospital Settings

Although the most significant change within Welsh healthcare governance has been the transition to the NCP, nutrition has become a major concern within other areas of clinical practice, and is governed by the principle of equity and technical minimum standards. This section therefore describes the present and emerging changes that have, and continue, to take place in hospital settings.

5.2.1 The Nutritional Care Pathway

Patients and carers views and priorities provided the rationale for and substance of the FOC (WAG, 2003), which provided guidance on principles and good practice indicators of the practice of nutritional care for all public and private health and social care settings in Wales. The FOC integrated existing standards and regulations rather than replacing them and Standard 9 relates specifically to eating and drinking, emphasising availability, choice, presentation and assistance in respect of food.

FOC guidance came about in the same year of the Council of Europe (CoE 2003) directive that member states should draw up and implement national recommendations on food and nutritional care in hospitals. The essence of the EU resolution was that food is nutrition, and consequently part of the care of patients, rather than an ancillary hotel service. The 10 key recommendations, shown in Figure 25, emphasise the importance of nutritional screening of vulnerable patients upon admission to hospitals and the value of protecting mealtimes by ensuring patients are free from interruption by medical interventions. Both of these concerns have, historically, been addressed in principle, but using different methodologies and not always consistently across or within LHBs. In practice, the principles have been put into practice in the adoption of nutritional risk assessments, protected mealtimes[14], and red tray schemes to identify patients at particular risk of malnutrition. These were supported and subsequently mandated by both WG and the NHS (WHC, 2006.67), although subsequent audits suggest limited compliance with these directions.

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[14] Protected mealtimes is an initiative intended to ensure that patients' mealtimes are not interrupted by non-essential medical activities.

Figure 25: Council of Europe 10 key Characteristics of Good Nutritional Care in Hospitals

All patients are screened on admission to identify the patients who are malnourished or at risk of becoming malnourished. All patients are re-screened weekly.

All patients have a care plan which identifies their nutritional care needs and how they are to be met.

The hospital includes specific guidance on food services and nutritional care in its Clinical Governance arrangements.

Patients are involved in the planning and monitoring arrangements for food service provision.

The ward implements Protected Mealtimes to provide an environment conducive to patients enjoying and being able to eat their food.

All staff have the appropriate skills and competencies needed to ensure that patient's nutritional needs are met. All staff receive regular training on nutritional care and management.

Hospital facilities are designed to be flexible and patient centred with the aim of providing and delivering an excellent experience of food service and nutritional care 24 hours a day, every day.

The hospital has a policy for food service and nutritional care which is patient centred and performance managed in line with home country governance frameworks.

Food service and nutritional care is delivered to the patient safely.

The hospital supports a multi-disciplinary approach to nutritional care and values the contribution of all staff groups working in partnership with patients and users.

Source: http://www.bapen.org.uk/pdfs/coe_leaflet.pdf

The FOC provided the building blocks from which the nursing profession has developed its own best practice standards for care within the NHS in Wales. '*Free to Lead Free to Care*' (WAG, 2008) was the outcome of an 'All Wales' Task and Finish Group set up in 2007 by the Minister for Health and Social Services to consider how patient experience and the environment of care could be improved within hospitals.

The group were asked to consider whether ward sisters/charge nurses had sufficient authority and capability to manage care effectively and examined a number of areas of practice. The Task and Finish Group itself had a multi-disciplinary membership, including civil servants and union representatives, whilst the subsidiary working groups had professional membership appropriate to the task. The FOC working group was led by the nursing profession, but included representatives from patient, medical, nursing and therapies professions, facilities management, chief executives and human resources. Whilst there was no representation from procurement (sourcing and contracting) they were represented

on the overarching Task and Finish Group, and within other workgroups, such as that dealing with the 'All Wales' nurses uniform.

The resultant expansion of the nursing role gave ward managers explicit authority and responsibility to lead and manage their wards in respect of the particular areas of cleanliness, nutrition and patient experience. Recommendations for nutrition emphasised the importance of protected mealtimes, but also prioritised the need for the development of a NCP, within which food and fluid charts should be used to measure and manage nutrition. The need for nutritional skills development for all ward staff, for nutritional supplements to be afforded equal status to medicines, and to actively promote food and fluid as nutrition were highlighted, led to the recommended for a nursing led awareness campaign. The '*Improving Nutritional Care*' training programme and awareness campaign followed, developed between the Royal College of Nursing (RCN), National Patient Safety Agency (NPSA) and British Association of Parenteral and Enteral Nutrition (BAPEN).

Although some nutritional screening was put in place in hospitals before the FOC and Free to Lead Free to Care, the significance of the NCP is that the expectation is that *every* patient is screened within 24 hours of admission and that appropriate action is taken and recorded. The action based metric was developed and prioritised by the nursing profession as part of their nursing dashboard performance management system and was specified to overcome the potential box-ticking problem of compliance recording.

The food and fluid charts, developed following Free to Lead Free to Care (WAG, 2008), are an essential management tool within the NCP, and in keeping with the pathways requirement for a single care document, have been designed to align with medication records. The purpose of the charts is to record the approximate and proportional food intake of patients, using a uniform methodology supported by picture guides to simplify and standardise measurement and enhance communication. Patients and their relatives are encouraged, where able to do so, to be actively involved in measuring their own nutritional intake, although nurses retain responsibility for completion of the record charts and ensuring adequate nutrition. The standard documentation used across Wales is reproduced at Appendix 3. The record charts have now been adapted for use in the community, extending the nutritional pathway beyond the hospital and into primary care, but also to encourage and facilitate patient participation in their own care pathway.

The NCP, including food sourcing and contracting, also defined the 2010 audit inspections by the WAO, who deferred their planned Hospital Nutrition and Catering audits to give an opportunity for the initiative to become established. It was also a significant element of the Dignity in Care inspections of the HIW unannounced inspections in 2012.

5.2.2 Nutrition in Clinical Practice

The significance of nutrition to patient care is also evident across the 1000 Lives Plus programme, which is underpinned by the principle that by improving the quality in care, and reducing harm, hospital stays will be minimised, resulting in both better patient outcomes and greater efficiency. The process based 'bundles' within the programme demonstrate how nutrition is becoming structurally embedded in care beyond the NCP. Examples include the '*skin bundle'*, the '*stroke bundle'* and the '*mouth bundle'* which are attached to care pathways according to patients care needs, form part of the patient record, and in many cases are highlighted on the ward bed plan. Other more general schemes, such as ERAS, use aggregated bundles to ensure continuity of pre and post-operative care, emphasising the particular significance of nutritional wellbeing, with malnutrition addressed before admission for surgery, and the intentional use of food as an integral part of post-operative recovery, itself a medical innovation for certain conditions. This particular innovation received a healthcare award in 2012.

Of more general applicability, '*Transforming Care'* and the associated '*Intentional Rounding*' provide structured opportunities for nursing staff to directly and personally address issues relating to care rather than treatment, such as comfort, psychological concerns and nutritional wellbeing. As an indication of the efficacy of the scheme, the amount of time spent on direct care in one ward of a major hospital has been increased from 40% to 80%. As a programme initially piloted on a few wards, it is now in place in over 300 wards across Wales, and has been adapted to emergency areas as '*Transforming Care at the Trolley'* and in the '*Community*' (1000 Lives plus, 2012).

The practice of individual care, displaying the qualities of attentiveness, responsiveness and respect was also present in interview narratives, most particularly those related by a Board member and key adviser to the Minister. The informant related a number of stories of individual caring practice and offered the opinion that the driver of change from hospital food to nutritional care was the transition to a care based healthcare system. The experiences described were

largely from the position of an impartial observer, with experiences originating not just within their own LHB, but across the whole of Wales.

One particular narrative described observations during a main mealtime on a particularly challenging ward where many patients suffer with dementia. As part of their rehabilitation and a process or re-learning skills diminished as a result of their illnesses, patients are encouraged to sit at a communal table in a dining area to eat. The inspection team observed and challenged a care assistant entering the ward with a shopping bag containing bottles of vinegar and sauce. The care assistant highlighted to the inspection team the particular needs of that group of patients in particular their reluctance to eat food that appeared unfamiliar, in this case sausages, without sauce. Although the LHB provided sachets of condiments, as the cheapest, safest and least wasteful alternative, the patients neither recognised nor trusted sachets, and equally importantly did not have the physical dexterity to open them. Bottles were both familiar to the patients and enabled them to re-gain skills that enabled independence and promoted recovery and patients were more likely to eat all of their food. Apart from the clear demonstration of care in action, the issue for the informant was a concern about lack of leadership from the board, that the potential problem had not been anticipated. The example demonstrates attentiveness, responsiveness and respect by the immediate care team, dignity and respect for that particular patient community, but also leadership from the ward and organisational learning.

The senior management response was to raise and address the issue within their LHB, the result of which was the issue of a policy aligned to what was considered to be better practice. The mutual dependency of caring as a relationship is also illustrated in the following informant's narrative.

The informant described a ward with predominantly elderly stroke patients some of whom were unable to eat a normal meal. Meal substitutes were described by another informant as unpalatable, both because of their texture and consistency, and likened the experience to that of drinking tea with the consistency of ice-cream. The informant observed a food technologist with a patient, looking at a large print picture menu, trying to generate some interest from the patient to move onto 'proper food', by asking him what he really fancied to eat. The patient suggested steak and chips by pointing at the menu and laughed, thinking that there was no chance he would be able to, and that the technologist was being totally unrealistic because of the patient's swallowing ability. The re-formed meal presented as 'steak and chips' was brought by the technologist within a few minutes and given to the patient. The

technologist stayed with the patient and encouraged him to try the food, which he did, with great delight from the patient when he tasted 'steak and chips' as real food.

5.2.3 Healthcare Standards for Nutritional Care

Whilst there is an increasing body of evidence of nutritional care being embedded in care practice, Healthcare Standards (WAG, 2010b) form part the regulatory framework, and are therefore embedded in the constitutional structures of governance. Although patient care is at the heart of all of the Healthcare Standards, Standard 14 (WAG, 2010; WG, 2012f) relates specifically to nutrition:

> *"Organisations and services will comply with legislation and guidance to ensure that:*
>
> *a) patients' and service users' individual nutritional and fluid needs are assessed, recorded and addressed;*
> *b) any necessary support with eating, drinking or feeding and swallowing is identified and provided;*
> *c) breastfeeding is promoted and supported.*
>
> *Where food and drink are provided:*
>
> *d) a choice of food is offered, which is prepared safely and meets the nutritional, therapeutic, religious and cultural needs of all; and*
>
> *e) is accessible 24 hours a day."* (WAG, 2010b, p.11)

5.2.4 Technical Standards for Nutrition

In addition to the drive to improve care, there has been a longstanding political and societal drive to improve the quality and sustainability of hospital food, and a commitment to ensure that evidence of good practice in hospital catering was shared across Wales:

> "*Patients have the right to expect well-presented, dietetically sound and nutritious meals. They should be offered a reasonable choice of menu and flexibility of meal times and meal choice according to their condition and appetite as they progress through their stay. Patients needing help while eating their meals must be identified and given that support and encouragement according to their individual needs and condition. Staff catering arrangements will also offer a range of healthy nutritious food contributing to a healthy balanced diet.*" (NAW, 2001, p.56)

The subsequent Audit Commission report into Hospital Food in 2001 (AC, 2001: ACW, 2002), prompted WG to develop guidance through an 'All Wales' multi-

disciplinary group. The 2002 Nutrition and Catering Framework (WAG, 2002a), set standards for nutritional assessment as well as nutritional content. Although the standards provided a framework for self-assessment, they were supported by the Welsh Risk Management Standard 23; with compliance monitored by the Welsh Risk Pool.

The imperative for the then hospital trusts to adopt nutritional screening standards was also embedded within the National Service Framework for Older People, however the lack of significant improvement in the quality of the food and nutritional care, brought to light through the number of adverse comments and complaints, led the CMO and CNO to jointly issue a Welsh Health Circular to Trusts stressing the need for compliance with the framework (WHC, 2006.67). Nevertheless, there is no evidence that the Trusts and subsequently LHBs used the framework as a standard or for monitoring performance, other than compliance with standards such as the Hazards Analysis and Critical Control Points (HACCP) within ISO 2000.

The 2002 framework was superseded by new nutritional guidelines and technical standards, in 2011 (WAG, 2011), the implementation plan for which is attached at Appendix 4. Developed largely by dietitians, the multi-disciplinary steering group included civil servants, hospital caterers, nursing and procurement staff. The standards are acknowledged as being largely informed by NHS Scotland's nutritional standards, but have been simplified and tailored to the specific needs of NHS Wales for the Welsh population. The standards are perceived by many as vital to the improvement of nutritional and general quality perceptions of hospital food, and although some LHBs were already using nutritionally assessed dishes, or moving towards nutritional assessment, these new standards provide a minimal technical specification for all patients' nutritional intake, and have been wholeheartedly supported by WG and the Minister.

The technical guidance for in-patient nutrition was also accompanied by a staged implementation plan, acknowledging potential resource problems that might engender resistance in implementation. A key informant from WG with experience of developing nutritional standards in other settings remarked, during the course of this study, upon how comparatively straightforward and timely development of the NHS standards had been.

WG guidance was subsequently published for standards for non-patient food in hospitals (WG, 2011b) which provided advice on healthy eating, healthy vending and the Corporate Health Standard [CHS] (WAG, 2010f) a public health initiative

promoting workplace wellbeing across Wales. The centrally set goal is for LHBs to achieve platinum standard by 2013.

5.3 Meal Production and Food Service in LHBs

Although each LHB has responsibility for feeding its patients, how they organise the production and provision of hospital meals is at, present, discretionary as part of their devolved authority to design and deliver services to meet local needs in line with the principle of equity. Combined with a historical legacy of the facilities physically available to produce meals, there are, in practice, different models for catering and food service between and within LHBs. Despite this historical legacy, there have been recent moves towards standardisation across all hospital sites, with the introduction of a standard menu framework of nutritionally assessed recipes, and work continues on a recommended best practice catering model.

Registered nurses are responsible to the ward sister or manager for ensuring that the patients they care for receive the right nutrition, whilst catering managers are concerned about the general quality of the meals that are produced. Food production and service on the wards involves caterers, housekeepers, hotel service staff facilities managers as well as nurses.

Meals are produced using a variety of cooking technologies, 54% of patient meals reported across NHS Wales to have been produced and served using conventional plated service, 35% cook-freeze with bulk trolley service and 30% conventional with bulk trolley service. A minority of LHBs use cook-chill and other technologies (NWSSP-FS, 2012). The details of the All Wales 2011-12 catering data analysed and collated by LHB to include cost data, meal production technology and reported waste, are provided at Appendix 5.

5.3.1 Structures within LHBs

Clinical nutrition steering groups, as multi-disciplinary teams within LHBs, work collaboratively in order to meet nutritional care standards and ensure that the design and delivery of nutrition to patients is of sufficient standard to meet their care needs. Part of this process has been the development of localised LHB specifications for food service, which set out the expectations of those involved in catering and food service, their respective roles and responsibilities, and to whom they are accountable. Whilst ward sisters and charge nurses have ultimate operational and professional responsibility for ensuring each patient's nutritional needs are met, this is delegated to registered nurses, supported by healthcare assistants, on the ward.

Catering managers have clear lines of responsibility within facilities and operational management and collectively these groups are responsible to the Boards through patient experience and safety committees, headed by the respective nurse directors. The respective internal nursing, dietetic and food quality audit results are brought together through this structural pathway.

These hierarchical and divisional structures are supported by LHB and NHS wide networks with local and national groups for nurses (at various levels of responsibility and experience), dietitians, caterers and facilities managers. Collaboration also takes place between catering managers, dietitians and procurement through the 'All Wales' Foodstuffs Commodities Advisory Group (CAG) which is embedded in the sourcing and contracting processes of the NWSSP-PS.

The two LHBs considered in detail within this study demonstrate different internal structures for catering and food service, in each case taking a different approach to improving patient experience. Both have major acute hospitals supported by community based hospitals, and care collectively for just under one third of the population of Wales, including some of the most deprived areas of the UK.

The respective LHBs have retained their separate catering technologies and food service models, in each case replicating their respective food service models in their newly constructed hospital premises.

5.3.1.1   LHB Z

LHB Z adopts a conventional catering model, with either plated or bulk trolley service to the wards from central kitchens within the respective hospitals. Some smaller hospitals do, however, use a cook freeze and regeneration system. Meals are either plated in the kitchen and served by housekeeping staff, or plated from the trolley by catering or housekeeping staff and served to patients by nurses. The drawback of this approach is that the conventional system requires patients to complete their menus the evening before so that the kitchen can have the order early the next morning, deemed to be a contributory factor in over-catered waste. Menus rotate over a 14 day cycle and are changed seasonally or when food prices exceed the available daily allowance

This LHB has a particularly good reputation for sound business management of catering operations, the WAO (2011) recommending that other LHBs consider them as best practice. There is a dedicated business team led by a catering manager and supported by a lead dietitian, food safety adviser and administrative assistance. The business manager provides a direct and dedicated strategic link between

procurement and catering. Computerised catering management systems have been put in place to enable the catering manager to set and continuously manage the catering budget through a patient daily meal allowance. The system also enables prompt identification, at ward level, of excessive over-ordered or over-catered waste, meals returned to the kitchen being recorded by catering staff. The dedicated link dietitian is present on Food Interest Groups (FIGs) at each locality, where staff involved in nutrition are brought together to collectively deal with any issues arising specific to that location. Within this LHB there are formal structural and operational links between key actors in procurement, catering, dietetics and nursing.

Criticisms from within the LHB have been that the effectiveness of these local groups is dependent upon the active involvement of senior nurses, but the increasing awareness of nutrition has, in some locations, broadened their membership beyond nurse-dietetics-catering. The purpose of these groups is to enable communication but also to facilitate multi-disciplinary and mutual learning, a process also enabled by disciplinary based networks within the LHB.

Although praised for its financial management in the 2010 individual WAO report, the LHB was criticised for the levels of waste, poor performance in terms of meal ordering, and lack of robust approach to the nutritional assessment of recipes. Its financial management of non-patient catering operations has been praised, but this has been attributed locally to the unique level of demand in one hospital that is unlikely to transfer elsewhere. The patient and non-patient catering are, however, accounted for as separate catering operations, a system only in operation in this and one other LHB.

The new hospitals within this LHB have been designed to retain the existing models for the hospitals being replaced, with conventional centrally cooked meals. The design of the kitchen and restaurant facilities in one of the new hospitals has come under a lot of criticism, attributed by several informants within and external to the LHB, to a failure to take account of the requirements specified by the facilities and catering staff in the design process. Repeated requests for additional space to accommodate a conventional catering service were rejected on the grounds that this was not available within the overall design footprint. The catering equipment supplied was not in accordance with the type and models specified by the in house caterers. A change 'control request' was considered by the Project Board but rejected on the grounds of cost. As a result substantial expenditure has subsequently been incurred in replacing much of the equipment that failed in the early days of operation. The restaurant was subsequently extended, but it has also

been necessary to construct an additional deep freeze building in the grounds external to the catering department. Another new hospital within the LHB did experience similar difficulties but it was possible to make the changes, which included replacing specified equipment and the kitchen flooring, before the building opened.

The strategic plan for future catering services will assess the option of changing to a regeneration model in any new-build hospitals, although the particular meal production technology has not been defined.

Food service models in the new hospitals reflect existing local arrangements, although there have been some significant innovations at ward level which has improved both efficiency and patient experience. Following an example from a different hospital within the LHB, communicated through the FIG, the ward structure has been changed, initially on one, but now two, wards within this hospital. A nursing assistant has been re-assigned as a ward hostess, whose role is to look after the patient environment, a large part of which relates to food.

Although there is a formal job specification, the role has evolved as opportunities to improve aspects of patient care have become apparent. There are many nutrition related activities which form part of the housekeeper's responsibilities. He/she will take meal orders direct from patients on the preceding day, discussing options and ensuring appropriate choices are made. Those beds which are due to become vacant also are identified on the bed plan and the collective order that is sent to the kitchen. The orders are then checked the following day, and amendments communicated to the kitchen. Despite the need for previous day ordering with this catering technology, the potential for waste is thereby minimised. The managerial role of the head chef is significant within this system, as he/she is in contact with the respective wards on a daily basis in connection with patient, rather than catering needs.

Meal service has been redesigned on this ward, and further changes are being discussed between the hostess and the ward sister/charge nurse. The hostess prepares the trolley with trays, identifying those who need assistance by use of red trays. Nursing staff are allocated patients by room, and working as pairs they will collect the trays, ensures that food served by the ward housekeeper from the trolley is as ordered by the patient, taking into account portion sizes, and deliver the food to the patient. The plated main courses are covered to retain heat, and those patients who need assistance eating are helped once all patients have received

their food. Prior to the change, the trolley was moved along the ward during service, but the changes that have been brought about mean that the nursing staff, rather than the food trolley, is mobile to maintain optimum temperature and quality; meal service time has halved, so that patients receive their meals as quickly as possible.

The ward sister, in collaboration with the hostess, is considering trying further changes to the order of meal service to try to optimise the quality, in particular the temperature, of the main courses at the bedside. Deemed a huge success, the LHB is promoting this 'model' as good practice across the LHB. Although successful, implementation is at the discretion of the ward sister/charge nurse. The nursing assistant was not a newly created role, and the lack of staff capacity on other wards is seen as a barrier to universal adoption by practitioners.

LHB Z has also been working for some time on standardising recipes across their catering sites to ensure quality, as consistency in nutritional content and organoleptic qualities, and efficiency through simplification and standardisation with a consequential reduction in transaction and administrative costs.

The LHB has used and continues to develop the role of volunteers, who assist with mealtimes in hospitals catering, particularly for elderly patients. Although limited to preparing the patient and their surroundings for mealtimes, the role is being developed and training provided to enable volunteers to provide more direct assistance with feeding.

5.3.1.2   LHB X

LHB X, on the other hand, has taken the strategic decision to standardise the catering and food service operations across the LHB and uses a central production unit to supply cook-freeze main meals to each of their hospitals for regeneration at ward level. Orders are taken an hour or two before lunchtime service by ward based catering staff, and meals are served to patients by nursing staff. Provisions other than the frozen meals are delivered direct to hospitals.

This standardisation of the meal production and service models across LHB X included significant capital expenditure to build new ward based regeneration kitchens in an existing hospital as well as expanding the capacity of the existing central production facility (CPU). The rationale behind the standardisation of patient catering and food service across the LHB was that that particular catering and food service model provides the best patient experience, through consistency, organoleptic quality and mealtime experience, but also that it was more efficient, enabled economies of scale and ensured the highest standards of quality

management. Critical to its success is the fact that meals can be ordered the same day, with catering staff being able to build relationships with patients due to their continual presence on the ward. This was reported by a key informant as having a very positive effect on the morale of catering staff as well as having had a dramatic effect in reducing waste. The existing bulk cook-freeze model was also amended so that meals are available in smaller two-portion size trays, overcoming previous problems with over-catered for waste in the bulk delivery system.

Financial management of catering operations has followed need, with the use of nutritionally assessed recipes dictating cost. There has been a recent introduction of a seasonal menu, providing a wider range of options than in other LHBs, but with fewer menu changes. The strategic management of catering expenditure also follows a different model to LHB Z, and to date annual budgets have followed the previous year's expenditure, the underlying rationale that efficient processes ensure that quality can be met at minimum cost.

Although the restructuring within the LHB was largely based upon the best practice catering model in one of the major hospitals, it also provided an opportunity to adopt more strategic and commercial approach to catering operations within and beyond the LHB. This involved the otherwise redundant kitchen and chefs being used to develop new nutritionally assessed recipes, with a view to then using the catering facility on a commercial basis to supply other LHBs and public sector bodies. This development work has been extended to the supply chain, the catering services manager working in collaboration with a Welsh SME to establish whether their product can be provided to the correct nutritional standards, organoleptic qualities such as taste, sight and smell, portion size and quantity for the NHS and whether the cost can be reduced, for instance by altering the packaging. The creative use of the ability for LHBs to purchase off contract is thereby enabling supply chain innovation.

The use of volunteers within this LHB has been developed and directed towards assessing performance, with volunteers spending time talking to patients to get feedback as part of the FOC audit. Responses given to the volunteers are reported to have demonstrated slightly lower levels of patient satisfaction than those given to nursing staff, and have been viewed as a more realistic and helpful basis from which to work on improving the patient experience.

Future plans, currently under trial, are to introduce a professional style laminated and printed seasonal menu, which has fewer changes, but more choice. The menu

cards will be available permanently at the bedside so that patients can think about food choices in advance, but also to enable patients, relatives and carers to engage with nutritional care through the food choices on offer.

5.3.1.3 Improving Patient Experience within LHBs

Despite differing internal structures, both LHBs have demonstrated innovations that are considered to have driven improvements in demand efficiency through addressing the quality of the food service, catering operations and patient experience in a holistic manner.

Experiences of these two LHBs have had a significant influence on the model being recommended as best practice through the 'All Wales' Catering Group. The benefits of the model food service being recommended were cited by an informant as "*good communication with nurses; we can sort out minor problems straight away. If there's a problem then we produce action plans, so there is no misconception of who is either at fault or has something to do as corrective action*."

In addition to these two case studies, examples of innovations shared as part of the WAO Good Practice Exchange demonstrate how specific needs are being dealt with within care, reflecting dignity and respect for differentiated needs. The introduction of a milkshake round in Cardiff and Vale LHB is one good example which also demonstrates the 1000 Lives methodology in practice. A local audit of a ward with predominantly elderly patients revealed that they were at particular risk of malnutrition and consuming 70%-80% of their nutritional requirements. Although 70% of the patients required nutritional support through oral supplements, only 40% were consumed. A pilot was undertaken to replace the fortified drinks with milkshakes, increasing the uptake from 32% to 60%. Following further refinement, which included addressing technical issues relating to nutrition, promoting awareness and collaborating on how to integrate the round into ward schedules, the scheme was tested further. 70% of the patients offered the milkshake took it in place of the alternative fortified supplement, and 64% finished the whole drink. Further adapted to include a biscuit, the development team were able to show that patients were receiving up to 20% more calorific intake. The success of the implementation on one ward was shared with two other elderly wards within the LHB (C&V, 2011).

From catering practice, the development of a texture modified menu for patients who require puree meals in Cwm Taf LHB was extended across the LHB in 2011. The need was identified as traditionally puree meals were perceived to be of poor

nutritional quality and unpalatable appearance. The meals are freshly prepared by chefs, frozen and delivered to hospital sites. Patients have a choice of three meals a day and to assist with communication can choose from pictorial menus. The meals are presented in a form that is as close as possible to a standard hospital meal rather than as a response to special needs. The range of items for the menu continues to be expanded (CTLHB, 2011).

In addition to different models of food service and meal production technologies, menus and recipes within LHBs were not always co-ordinated, nor nutritionally assessed. An informant in one LHB remarked that when they looked at standardising and assessing their recipes, they found 23 different recipes were being used for porridge, each with their own 'special' ingredient. Standardisation and nutritional assessment therefore reduced the number of ingredients, and enabled co-ordination with the central procurement contracts.

5.3.2 The 'All Wales' Menu Framework

Proposals for an 'All Wales' Menu had been discussed for some time as a collaboration across Wales, mainly through the CAG, firstly in WHS and then in NWSSP-PS. The inefficiencies and differences apparent across Wales were also highlighted by the WAO (2011), and along with the introduction of new nutritional standards, an "All Wales", nutritionally assessed, menu framework has been developed. A multi-disciplinary Menu Planning Task and Finish Group was set up by the joint CEO of NHS Wales and Director General of the DHSSC, initially to produce a single standard menu from nutritionally assessed recipes to accord with the new nutritional guidelines. Initial feedback from the Group was, however, that a standard menu across the LHB was not always appropriate due to different demographic and cultural preferences across Wales and variations in the catering and food service models within LHBs. This is aptly illustrated by a quotation from one informant:

> "one of our non-officer members did a review in [hospital x] about a
> fortnight ago, and she was asking patients about what they thought of
> the food – the senior nurse and sister on that ward at that time, she did
> feedback that she had concerns that the meals weren't perhaps 'old
> age' friendly, and bearing in mind that hospital is for predominantly
> elderly people, and some patients with dementia, the senior nurse rang
> me the next day to give me feedback on what he non-officer said, and
> we've discussed that and already set up a menu planning group – multi-

disciplinary group – including the volunteers group, for that particular hospital"

The main objective of a standard menu framework was to lead improvements in patient food related experience by prioritising quality, as taste, presentation, ingredients as well as the technical nutritional content. There was also an explicit desire to achieve consistency across Wales, to ensure food safety and enable proper performance management, but also to achieve economic efficiency through maximising economies of scale in food purchasing and the reduction of transaction costs. Procurement frameworks, for instance, could be developed around the menu framework. The potential was also identified to increase the purchase of local and seasonal produce. Significantly, however, the group were adamant in their recommendations that nutritional standards should be met over and above any budgetary constraints (WG, 2012a).

The ministerial response to the initial report was to stress the need to align the framework with the policy aim of supporting Welsh businesses in procurement, but also emphasised the need to demonstrate timely action in implementation, setting a target date of December 2012. The Steering Group, however, felt that there was a need to improve on the existing ad-hoc arrangements for dietetic advice in the purchasing process and proposed that funding be sought for a dedicated dietitian. Despite an initial response from NWSSP-PS that there was no funding for a dietetic adviser, an initial twelve months funding for a dedicated dietitian has been found. The dietetic expertise, within that timeframe, will be used to review the nutritional content for products that will be part of future contracts so that they can be aligned with the menu framework. The Group is also now being chaired by Public Health Wales, and are seeking to include patient representation on through the CHC.

Whilst a lot of the detail in the nutritional guidelines is drawn from the experiences of NHS Scotland and their nutritional guidelines, the Scottish version is much more detailed, akin to a manual (NHS Scotland, 2008). Lessons have also been learned from previous nutritionally led attempts to improve UK hospital food. The failure of the earlier Better Hospital Food Programme led by the DoH and BAPEN is partially attributed to the number of recipes it contained as well as the fact that many were too expensive, too fancy or modern for patients' tastes, or too complicated to be accommodated in hospital catering (Cross and Macdonald, 2009, p.146). The objective of the Welsh framework is to accommodate differentiated needs, and thereby equity, through a relatively simple matrix of recipes based upon patients' favourite dishes and within catering budgets.

Key proposals within the menu framework reflect simplification, led by seasonal menus, a maximum number of dishes for each of the three courses required to be provided for main meals, and standardised nutritionally compliant recipes. Ready meals and snacks, bought only when cost effective to do so, also need to be evaluated according to nutritional content and portion size.

The menu framework is available to the public, and is hosted by NWSSP-PS, the organisation that source and contract food provisions on behalf of LHBs.

5.3.3 The Future Direction: An 'All Wales' Catering Model

An 'All Wales' Catering Group was set up in response to the 2011 WAO report and subsequent PAC recommendations and has considered whether there is evidence of a best practice catering model that considers patient experience, quality of food and overall efficiency, with cost savings coming directly from economies of scale, greater productivity, improved power of purchase and reduced food waste.

The Group's deliberations have been made by looking at existing cost and patient satisfaction data from LHBs that data provided to NWSSP-FS through the Estates Performance Management System (EFPMS). Their recommendation to Boards is that a best practice model should be based upon combining practices currently in use in two LHBs. This model is based upon a cook-freeze technology for caterers operating a ward-based regeneration service to meet orders taken on the day of consumption, combined with the need for nurses to serve meals and monitor nutritional intake. The use of a computerised catering cost management system, is also recommended, the single LHB that uses it at present having been praised in the WAO report (WAO 2011)

A further recommendation has been made for regionally based central production facilities across Wales (CPU) to produce cook-freeze meals, but structured within the existing NHS, rather than any independent facility that would, within procurement rules, have to submit to competitive processes in order to provide meals to other NHS bodies.

Critically, the cost of the alternative catering and food service models was only considered in terms of available data, itself subject to concerns about validity. The quality and safety of the food, food security from the organisational perspective, and the patient experience were primary concerns.

5.4 Demonstrating Accountability

The accountability framework for nutritional care within LHBs combines internal and audit and performance management, each structured around function or profession, with external audit, structured by the HIW and CHCs on care, or in the case of the WAO, the NCP.

MacArthur et al (2012) highlight the lack of whole life costing capacity within NHS Wales, and suggest this as a potential reason for the lack of more widespread use of process methodologies. Their argument is that, although there is consensus that effectiveness and cost efficiencies have been brought about through restructuring practice from function to process, evidence of cost efficiency relating to the pathway is the only means of demonstrating monetary savings in a demand led healthcare system. The alternative fragmented and functional approach not only steers cost accounting towards reinforcing existing sub-cultures and political behaviour, but is unable to demonstrate actual savings due to the way in which costs are aggregated and the fact that demand for hospital care will, at any one point in time, exceed supply.

Accountability is therefore fragmented, rather than aligned with the care pathway, but has nevertheless undergone a transition towards management of performance, the emphasis being on outcomes relating to quality and patient safety, with actions guided by principles of dignity and respect.

5.4.1 Internal Scrutiny: Nutritional Care

Internal LHB governance for nutrition is managed according to profession, with nurses leading on nutritional care and facilities managers on catering, converging within the reporting structure through nutrition and catering steering groups to statutory patient safety and quality committees. Patient experience and progress is measured against the Healthcare Standards, managed through the internal FOC audit. These audits employ multiple methods of observation, documentary checks, staff interviews and

Figure 26: Health Standard 9, Annual Fundamentals of Care Audit 2011 (WG, 2012)

Standard 9 Eating & Drinking
Standards for Health Service in Wales: Standards 5; 8; 14

Principle: You will be offered a choice of food and drink that meets your nutritional and personal requirements and provided with any assistance that you need to eat and drink.

Sdt 9 Compliance within each area
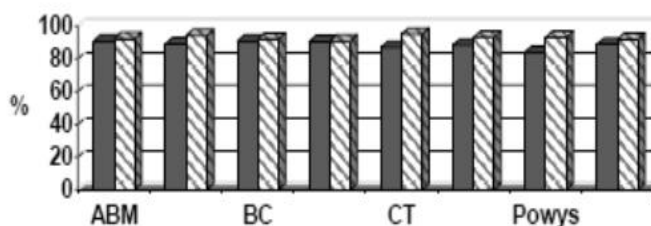
■ Operational 2011   ▢ User Experience 2011

Summary of Common Issues/Key Themes
- Variations in the standard of documentation e.g. not always complete.
- Lack of access to Speech and Language Therapy.
- Inconsistencies in routine weighing of patients.
- Lack of availability of snacks.
- Lack of availability of day rooms for patients to each their meals away from the bedside.
- Staff are experiencing difficulty in attend training on 'Food Handling'.

Good Practice with the following standards
- Improvement in the number of Patient Nutritional Risk assessments undertaken on admission.
- Improvement in the number Patient Nutritional Risk assessments evaluated.
- Protected Mealtimes, with the emphasis on allowing families and or carer to assist in feeding where necessary.
- Availability of snacks for patients who have missed meal times available in some areas.

Plans for Improvement
- Implementation of training packages to enable registered nurses to perform swallow assessments.
- Improvements in offering patient's hand washing prior to meals.
- Review frequency of 'beverage' rounds.
- Ensure regular audits of documentation is undertaken.
- Continue to work collaboratively with dietetic and catering staff.

patient surveys. The data, collected using a sampling methodology, is recorded at six monthly or annual intervals, with annual reports sent to the CNO. The publication of internal assessments was not, until 2011, a requirement, when the CNO produced a summary of the FOC results across Wales (WG, 2012) [Figure 26]. LHBs supplement the FOC audit with their own regular, multi-disciplinary quality audits and patient satisfaction surveys, and conduct regular inspections defined by the nutritional pathway.

Acknowledging the weakness of the FOC audit methodology the nursing profession has developed its own continuous performance management tool. The nursing dashboard provides for comprehensive continuous performance management. Data is available at ward level and can be compared within and across LHBs. Leading the way in the UK, the Welsh nursing profession decided to include nutrition as one of the four key priorities at the start of implementation of the dashboard, the metric adopted linking the nutritional assessment for all patients within 24 hours of admission to action, the metric being the written record of appropriate action, such as referral to dietitian, taken. Enthusiasm for the dashboard was apparent throughout an interview with a Deputy Director of Nursing, but that informant also felt that "*you are now comparing apples with apples – the first time this has happened across Health Boards in Wales, so I think this is something to be proud of from the nursing perspective.*"

The benefit of the new approach is that variations from best practice can be observed and appropriate managerial action taken in a timely fashion.

5.4.2 External Scrutiny and Inspection: The Nutritional Care Pathway

Key bodies with an external scrutiny role in relation to the organisation and hospital nutrition are the Wales Audit Office (WAO), Healthcare Inspectorate Wales (HIW), the Community Health Councils (CHC) and the Older People's Commissioner for Wales (OPC). There is a concordat agreement between these bodies that they will collaborate over planned inspections, but there are also powers for unannounced inspections.

The role of HIW is to validate the self-assessments of the individual LHBs against the Healthcare Standards. It has also undertaken a pilot of a review of governance arrangements in one LHB (HIW, 2012). In addition HIW has the power to carry out unannounced spot checks, and these took place for each LHB in 2012 in respect of Dignity and Essential Care, following which each LHB has produced and published an action plan.

In addition to these 'All Wales' bodies, each LHB has a CHC which has powers to carry out unannounced inspections relating to the quality of the patient experience and safety. In relation to nutritional care, the 2011 report recorded a 96% compliance with protected mealtimes, but a much less satisfactory level of pre-meal hand hygiene at 37%, an issue also picked up through the FOC Audits for that year. The availability of appropriate menu choices, 24 hour food access, food service itself, assistance with eating and clearing away are brought together in the CHC assessment. The ward environment assessment form used in inspections was reviewed and replaced in July 2012 and now aligns the PEARS considerations with the recommendations of the OPC (OPC, 2011, 2012).

The overall aim of the 2010/11 WAO Nutrition and Catering Audit was to find out if hospitals in Wales were providing efficient catering services to meet good practice through strategic planning, procurement, production management, ward delivery, food quality and patient recovery and engagement. The report was based upon a detailed methodology and inspection programme using a combination of tools that included existing data, inspections, surveys and observations (WAO, 2010b). In a departure from previous practice, the 2010 audits embraced the entire NCP. Their rationale was that "*Effective hospital catering services rely on sound planning and co-ordination of a range of processes involving menu planning, procurement, food production and distribution of meals to wards and patients.*" (WAO, 2011a, p.6). The components of their strategic view of the catering service are represented in Figure 27.

The outcome of the audit was an 'All Wales' report, but unlike previous occasions, reports for individual LHBs were published, those individual reports facilitating the development of action plans and instrumental in bringing about a number of changes in catering practice and performance management (WAO, 2010a; 2011a). Individual LHBs had received their respective WAO nutrition and catering reports in 2010, and action plans and improvements were underway before the 'All Wales' report was published in March 2011, and the PAC proceedings between July and November 2011.

The need to make changes was emphasised through scrutiny by the PAC, who noting that "*It is disappointing that a wide variation in the costs, planning and delivery of catering services across NHS organisations in Wales persists, especially when the importance of good nutrition in supporting patient' recovery is well accepted by the Welsh Government and reflected in its policy objectives*" (PAC (04) 08-12 (b), p.7).

Figure 27 The Hospital Catering Service (WAO, 2011a, p8)

Strategic plans – national and local
Operational policies and procedures
Financial planning
Leadership and accountability
– groups and individuals

Planning the service

Delivering the service

Catering services
• Procuring food
• Producing meals
• Controlling cost and wastage
• Menu planning

Ward services
• Delivering food to wards
• Preparing patients and wards
  for meal times
• Serving meals to the patients

Patient nutrition
• Nutritional analysis of menus
• Nutritional screening
• Nutritional care plans
  including:
  - Monitoring food and
    beverage intake
  - Helping patients with eating

Monitoring the service

Measuring patient satisfaction
Involving patients in quality reviews
Using information to improve planning
Monitoring costs and wastage

Source: Wales Audit Office

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The PAC took evidence from WG and NHS Wales (PAC (04) 07-11; PAC (04) 06-11 PAC (04) 08-12, PAC (04) 08-12 (a)) and questioned the Commissioner for Older People in Wales (PAC (04) 04-11), before making recommendations for change. They accepted the Auditor General's six recommendations and required WG to provide an action plan to demonstrate how those recommendations were to be met. At the subsequent hearing on 22 May 2012 the PAC accepted the responses from the Welsh Government, but that relating to WG role in ensuring accountability was only partially accepted (PAC (04) 08-12).

Recommended actions highlighted the variations in practice and at ward level as well as between hospitals and LHBs. Specific recommendations covered national policy and governance issues, including leadership by WG and within LHBs at Board and ward levels. The need for clarity surrounding protected mealtimes policies was a particular area of concern, as was the information communicated to patients on what they should expect of nutrition and food. Poor governance by Boards, as weak leadership in devolving authority and resources to ward managers,

lack of alignment between purchasing and the food strategy and sourcing plan (WAG, 2009b; WG, 2012b) and lack of scrutiny of catering data were highlighted. Concerns also related to levels of food waste and for food hygiene certificates to be made publicly available.

Evidence presented to the PAC by the Director General of the DHSSC (PAC (04) 08-12) demonstrated that some post audit progress was being made. The introduction of an e-learning package was cited as having been introduced, although a subsequent RCN Time to Care Policy Briefing has highlighted the apparent "*moratorium on nursing staff being allowed to undertake training*" (RCN, 2012). A Free to Lead Free to Care post implementation group was set up and given the task of reviewing and standardising documentation, and improvements were reported to have been recorded through the FOC audit. The nutritional standards (WAG, 2011) were also published during this period and work was reported to have commenced on the 'All Wales' Menu Framework and a best practice catering model by October 2011. A target of 10% or less for untouched meal waste has also been set, to be achieved by the end of 2012-13.

5.4.3 Performance Management: Catering and the EFPMS

The EFPMS is a performance management tool designed to enable performance management through benchmarking. The data set was initiated following the 2002 Catering and Nutrition Framework (WAG, 2002a) and collates information on a hospital by hospital basis regarding the number of beds, catering technologies used, the models of food service and the amount of over-catered waste.

Use of the data for performance management is, however, entirely at the discretion of individual Boards. An annual report is produced by the facilities directorate of the NHSSP-FS and has consistently raised concerns about the quality of the data being submitted by LHBs. Concern was also expressed by the Auditor General and the PAC that the system was not being used effectively for benchmarking and performance management. As the WAO identified only one LHB as having the operational systems and structures in place and to be actively planning and managing catering expenditure, and only two which separately account for non-patient food, lack of LHB capacity is one possible explanation. The original dataset did, however, include a measure for food waste, although the data was not always or consistently provided for the annual review.

Following the WAO inspections and reports in 2011, a review of the EFPMS commenced, although the review panel were unable to provide an explanation for

the wide variations in costs. As a result of the subsequent PAC, LHBs were directed to take specific action on levels of food waste, the costs of non-patient subsidy and cost per patient meal (Walker, 2012).

The review considered anomalies in the data and found that, for instance in relation to patient meal cost, the data was skewed by the inconsistent allocation of staff time allocated to food service on the wards. This was attributed to the costs apportioned for nursing time, which differed according to both food service model, but also varied between hospitals. There was also confusion over the definition of waste, and at what point food waste should be considered as avoidable as over-catered waste, avoidable as over-ordered waste or unavoidable as nutritional deficit. The measurement of the latter was, however, considered by several catering informants as unethical, and therefore undesirable.

The revised metric excludes on-ward staff and catering costs, thereby excluding the cost of regenerating centrally produced and frozen meals. The outcome of the review was that data definitions were clarified and the 2010-11 data reviewed, recalculated and re-submitted to provide baseline data for future comparisons. The outcome of the review is therefore a system that can be used for comparison, but not one which can be used to reliably monitor actual costs.

Despite the revision of the data, wide variations in cost within and across LHBs remain apparent. In line with calls for greater transparency, the data itself, rather than a summary, is included in the published 2011-12 EFPMS report (NWSSP-FS, 2012), but only in respect of the metrics required to comply with the PAC recommendations. It is not apparent from the published data, for instance, whether the provisions cost per patient meal are equivalent to those meals served in non-patient areas, nor is there any attempt to align the data with broader policy objectives such as local purchasing. Although the latter is now within the domain of NWSSP-PS, when LHBs buy, within their constitutional authority, other than from central framework contracts, or from NHS Supply Chain, such data is not readily available for scrutiny.

5.5   Effective Demand: Assessing Needs and Managing Need

The political aspiration to re-orientate healthcare provision so that the patient is genuinely at the heart of healthcare originated before Devolution and has, until relatively recently, remained an aspiration rather than an achievement. Continuing variations in the efficacy of hospital catering and food service, and the qualities of

the food produced have nevertheless endured, despite attempts to mandate processes and standards, which suggests that within governance, there are behavioural as well as structural conditions for change.

Although the process approach to healthcare delivery was seen to be the most effective and cost efficient means of improving the service (WAG, 2003a) it was not until the structural integration in 2009 that the necessary changes started to take practical effect. Empowering ward sisters to lead on ward management for patient experience, the introduction of the NCP and associated accountability frameworks have been instrumental in bringing about structural change by addressing needs, but, in isolation, only offers a partial explanation of reform within nutritional governance.

The 'All Wales' collaborative approach to the menu framework has begun to address some of those remaining structural deficiencies, both in relation to the assessment of need, and as a result of the mandated standards being structurally embedded, multiple needs. By structuring best practice within a flexible framework to meet differing clinical and cultural needs, the 'All Wales' menu structure reduces variation in meals, limits the number of ingredients that need to be purchased, and aggregates demand to enable economies of scale. Economies of scale are not, however, the sole consideration. With a standardised menu framework, the contracts for provisions can be optimised prior to publishing the tender, and contracts structured to meet stakeholder needs and maximise market opportunities. Certainty on the range and quantity of products within each framework reduces waste and minimises the risk and costs of suppliers, competition, in theory, ensuring the lowest price. Planning therefore needs to be an integral part of governance, the proposed alignment of catering and food service with regeneration technologies further evidence of a commitment to quality rather than lowest cost, and learning from experience.

Thus processual governance structures have enabled and supported the focus on sustainable development outcomes of effectiveness based upon equity, as differentiated individual needs, and best value as efficiency through the reduction of systemic waste as variation from qualitatively defined best practice. Programmes such as '*Transforming Care*', for instance, demonstrate how reducing systemic waste can release nursing time to provide care, suggesting time, rather than cost or staffing levels, is the material resource. Identifying best practice nevertheless requires leadership from front line practitioners, as a means of legitimising best practice and accountability models, and to enable ownership and encourage

compliance.   Collaboration is, however, critical for success. Best practice at ward level is evident where nurses, dietitians and catering staff work together and where cross-disciplinary clinical and management teams have developed programmes within the 1000Lives programme to embed food, as nutrition, in care.

The focus on food waste has also been reignited as part of the audit process, the emphasis being on the cost of avoidable waste arising from system failures, rather than lack of patient appetite. The labour cost of continuous detailed measurement and monitoring of physical waste, bearing in mind the relatively low cost of food provisions to the NHS, suggests, however, that physical food waste will remain a peripheral concern. The setting, and relatively easy and rapid attainment of maximum targets for food waste, irrespective of the correctness of the data, invites complacency unless the data relates to nutritional waste as part of effective service delivery to meet patient needs. The menu framework should, however, minimise waste in terms of quantitative need for purchasing, but only on the assumption that the underlying technical basis of the nutritional standards are fit for purpose. The perceived risk from practitioners is that the standards, although setting minimum quality levels, will increase overall costs without necessarily reducing food waste.

Within the process of healthcare governance, nutritional care activities within hospitals represent the assessment of nutritional needs and the management of demand that informs the sourcing and contracting role of NWSSP-PS. Actors continue to challenge current practice, with a continuing emphasis on an 'All Wales' approach that seeks to integrate best practice as a means of adding value, providing consistency and improving quality as the patient experience as well as the rigour in accountability through performance management.

Critically, however, inconsistency both in terms of the quality of the meals produced and the care provided on hospital wards, suggests a number of interrelated and contingent factors might be required to explain change, but that mandating is an ineffective mechanism of behavioural change. Collaboration, leadership and learning were suggested as interrelated conditions of change within the wider governance contexts. The policy narrative within nutritional governance is, however, that of empowerment, as devolution of responsibility, authority and resources to nurses, implying that structural empowerment alone will bring about change. Whilst structural empowerment enables leadership, adoption of best practice is arguably a matter of learning, which is conditional upon collaboration rather than technical skills. The development of best practice models has also been shown to be

conditional upon collaboration between stakeholders, rather than just a matter of professional or nursing leadership.

Although at a strategic level, the NCP demonstrates empirically a process structure dependent upon leadership, learning and collaboration, actual change cannot be explained solely by, but is arguably conditional upon, structural empowerment.

Following the thesis that processes are 'nested', the NCP, within healthcare governance, is te overarching process within which procurement takes place. Process effectiveness and efficiency therefore inform sourcing and contracting activities, which in NHS Wales take place within the NWSSP-PS.

CHAPTER 6
Hospital Food: Sourcing and Contracting

6.1 Introduction

Chapter 5 considered the NCP within hospitals, as the 'in-house' demand leading up to procurement, as the sourcing and contracting of food at the interface with the market, which is the focus of this Chapter. Sourcing and contracting, dependent upon the NCP, is therefore an embedded process within nutritional governance.

Whilst EU policy considers that best practice in procurement reflects fairness, transparency and competition, as the way in which purchasing contracts are planned, designed and delivered, best value within the NHS in Wales is defined by reference to a material conception of the "*optimum combination of whole life costs and quality (or fitness for purpose) to meet the user's requirements. This may not be the lowest price.*" This definition is supplemented by one of whole life costs as "*price, delivery date, running costs, cost effectiveness, quality, aesthetic and functional characteristics, technical merit, after sales services and technical assistance or clinical reasons*" (NHS Wales, 2012, p. 64).

Reframing this managerial conception to one of process thinking requires consideration of how things are done rather than what needs to be done. Best value is then the appropriate balance between quality outcomes, as effectiveness, and resultant process efficiency, which diminishes the need for material considerations of monetary cost where the aim is for qualitative outcomes. Efficiency in governance and embedded organisational processes can therefore be brought about by managing demand and removing waste and quality can be embedded through stakeholder involvement, setting a regulatory framework of standards and accountability, and aligning the overall aims of purchasing with core institutional values, which in NHS Wales are:

> *"Putting quality and safety above all else: providing high value evidence based care for our patients at all times*
>
> *Integrating improvement into everyday working and eliminating harm, variation and waste*
>
> *Focusing on prevention, health improvement and inequality as key to sustainable development, wellness and wellbeing for future generations of the people of Wales*

Working in true partnerships with partners and organisations and with our staff

Investing in our staff through training and development, enabling them to influence decisions and providing them with the tools, systems and environment to work safely and effectively."

[http://www.wales.nhs.uk/nhswalesaboutus/thevaluesofnhswales accessed 10.10.12]

This Chapter considers the sourcing and contracting activities of NWSSP-PS as their role within the governance of nutritional care in hospitals. This primary role aligns broadly with the 'procurement cycle' of Murray's policy framework (2009). Sourcing and contracting is a therefore strategic operational role, concerned with the purchase of goods appropriate to the nutrition care needs generated within LHBs and the needs of supply chain stakeholders in accordance with national policy objectives. Despite the constitutional separation of NWSSP-PS from the LHBs and Trusts, their activities are structurally integrated into the governance of hospital based nutritional care, constitutionally as an 'All Wales' partnership, as part of the NCP process. Their activities therefore need to align with the overall demands of best value, as effectiveness and efficiency, but success remains dependent upon collaboration, as a result of weak and potentially conflicting constitutional and stakeholder aims.

Qualitative concerns for sourcing and contracting are structurally embedded by the CAG, a long-standing collaboration between NWSSP-PS and LHBs and Trusts. The 2009-2012 changes strengthened the constitutional relationship between these organisations, in many ways making it more difficult for the LHBs to exercise their constitutional right to purchase directly from suppliers, rather than through the NWSSP-PS. Nevertheless, the concentration of professional expertise for sourcing and contracting within this structure is significant, successful innovations providing evidence of best practice within the McClelland Review (McClelland, 2012) and peer reviewed professional awards.

The procurement processes adopted are advocated as best practice by WG, the procurement route planner legitimising the use of the SRA, but also monitoring organisational improvement through the SPAF. The latter acknowledges that there is scope for further improvement, but the ability to achieve local sourcing outcomes is perceived to be hampered by market structures and high level political priorities. Aggregation of demand can, however, as shown in the procurement of yoghurt in

2012, achieve best value where planning and collaboration have ensured that qualitative and technical standards drive selection criteria, within the legislative framework. The activities of NWSSP-PS therefore demonstrate an innovative approach to procurement and how aligning their activities with national policy and guidance, as well as managing risk, can bring about positive outcomes for multiple stakeholders.

The structure of this Chapter follows the governance framework, firstly considering the regulatory regime within which procurement takes place, followed by the constitutional requirements of NWSSP and the particular part of the organisation for sourcing and contracting, the NWSSP-PS. The background to the embedded case study, the four stage procurement route planner, precedes detailed consideration of the 2012 Yoghurt contract.

The Chapter concludes with consideration of some of the evidence of the unintended consequences that have been identified during this research. The characteristics and necessary conditions of processual governance, planning for need and needs and accountability for action and outcomes, leadership, learning and collaboration are also shown to be present within this procurement process.

6.2   The Regulatory Framework for Public Contracts

The global market for goods and services is governed by agreements and regulations which affect public sector purchasing in member states. At a global level the Government Procurement Agreement (GPA) is a plurilateral agreement between member states of the World Trade Organisation (WTO), which include European Union (EU) member states and is the "*world's principle tool for facilitating trade in relation to government procurement markets*" (Lamy, 2012). Founded on a paradigm of competition, the agreement aims to promote transparency and eliminate discrimination to enable efficiency through value for money, but also to promote global development over and above national and regional policy goals. The global reach of domestic procurement activity within this framework is principally dependent upon a benevolent approach to non-domestic development, the dominant competitive, free-market values enabling and supporting international commercial interests to dominate global markets, with their perceived anti-development, anti-environment and anti-welfare values.

The EU operates within the WTO as a single market representing its member states with the aim of making the EU competitive in the global market for goods and

services. As such it provides the supra-national framework within which UK governments' purchasing practice operates. Regulation is intended to ensure transparency and fairness based upon founding values of human dignity, liberty, democracy, equality, the rule of law and respect for human rights. These values underpin objectives of peace, freedom and wellbeing, sustainable development, social inclusion, cohesion and solidarity. Although only contracts over specified limits need to comply with the regulations, these core principles apply to all public supply contracts. These rules are, however, persistently viewed by practitioners and potential suppliers as barriers to SME participation, such concerns relating to perceptions of overly bureaucratic procedures.

The EU Directive (EU 2004/18/EC) sets out the required procedures and time limits for the award of public supply contracts over the EU threshold, currently €130,000, and these have been enacted in England and Wales through the Public Contracts Regulations 2006. Those UK regulations were amended in 2009 following the EU Remedies Directive (EU 2007/66/EC), a response to the Alcatel case in respect of the remedies open to aggrieved parties, the sole means of markets ensuring compliance with regulation. The 2006 Regulations govern:

- the technical specification for the contract, which can be based on performance and function, but not make, source, process, origin or means of production

- notices and procedures, including notices, time limits, selection of procedure (open, restricted or negotiated)

- objectively justifiable selection criteria

- the award process

The effect of Alcatel was to improve transparency and fairness by forcing the contractor to promptly notify unsuccessful parties, providing due reasons including the scores and name(s) of the successful parties. Aggrieved parties' remedies are available solely through the domestic court system, with the attendant risks of immediate suspension of the ability to award the contract, costs in defending legal action and re-tendering, and damages for losses incurred.

The regulations do not, however, compel contracting bodies to award contracts to the lowest bidder, but enable most economically advantageous (MEAT) principles, and thereby qualitative criteria to be applied. Whilst the potential response is to

promote a risk-averse strategy within contracting organisations, tightening systems and processes and increasing professionalization offers an alternative approach to managing rather than avoiding risk. Ensuring sustainable development outcomes therefore becomes a matter of how the process is carried out.

In addition to the public contracts legislation there are many other legal considerations. The VW procurement route planner notes 14 separate pieces of legislation relevant to food purchasing in Wales, although there are notable omissions, such as the Human Rights Act 1998, Producer Responsibility Obligations (Packaging and Waste) Regulations, 2007 and Food Safety Hygiene Rating (Wales) Bill 2012. The former two are, however, included in the standard terms and conditions for purchasing used by NHS organisations in Wales. Although there is no UK wide legal requirement for sustainability criteria to be embedded in the sourcing and contracting process, sustainable procurement is considered, at the highest level, to be best practice. The Office of Government Commerce [OGC] and Defra have, for instance, promoted a joint approach through the Sustainable Procurement Action Plan (Defra, 2006), itself a response to the National Audit Office report '*Smarter Food Procurement in the Public Sector*' (NAO, 2006).

The Cabinet Office holds responsibility for ensuring that taxes collected are used effectively in order to provide value for money, as a consequence of which it has a primary concern with the efficiency agenda. Its predecessor, the OGC, has also been at the heart of claims that bureaucracy in directed procedures is a primary barrier to improving practice. The emphasis on value for money is reinforced by HM Treasury in The Green Book (HMT, 2007), but was reduced to cost in the review of government spending by Sir Philip Green (Green, 2010).

In 2002, the OGC commissioned Curry Report on the future of farming and food provided a response to the devastating effects on the UK food and farming industry of the foot and mouth outbreak the previous year (PC, 2002). The Report set an agenda to reconnect consumers with food producers and processors and to enable a safe, sustainable, healthy but profitable, competitive UK food industry within a collective role of environmental stewardship. A key means of doing this was to be through the £2bn spent each year on public food procurement. Supported by the OGC, Defra took up the challenge with the PSFPI, which aimed to help deliver the food and farming strategy by improving sustainability and efficiency in public food and catering, as well as:

- promoting food safety and hygiene

- increasing the consumption of healthy and nutritious food
- improving the sustainability and efficiency along the food chain
- increasing opportunities for small and local producers
- increasing co-operation throughout supply chains (Defra, 2003)

The ground-breaking and world-leading initiative (Morgan and Sonnino, 2008, p.27) comprised a plethora of guidance and toolkits, including practical assistance through sample specification and tender documents and was followed by advice on meeting the challenge of balancing cost, quality and sustainability from the NAO (NAO, 2006). The accompanying case studies and good practice guidance provided further resources to enable public purchasers to improve their practices, with the advice that *"Increasing efficiency can have a positive impact on sustainability and nutrition, by enabling organisations to use cost savings in some areas to help to finance improvements in other"* (NAO, 2006, p.4). The suggestion was that actual savings achieved through efficiency improvements could be redirected, for instance, to improve nutritional quality of ingredients purchased and thereby the effectiveness of catering within the purchasing organisation. The PSFPI was re-launched in 2007 (Defra, 2007) with '*Putting it into Practice'*, which brought together the previously published advice and information.

Within Wales, sustainable food purchasing guidance for public sector organisations was published in 2004 by the WPI. '*Food for Thought'* (WPI, 2004) also prioritised value for money through efficiency and "added value" through sustainable development, but advocated a more strategic approach to procurement as an on-going cycle of improvement, with a clear political priority for supply chain outcomes for Welsh public sector purchasing is supporting local micro-businesses, SMEs and the rural economy (WAG, 2009b; WG, 2012b).

> *"In the case of food provision in Wales we believe this means all of the following: providing nutritious meals, using quality ingredients, developing good reliable suppliers, minimising process costs, looking after the environment and natural resources and avoiding waste, contributing to the sustainable development agenda, demonstrating savings, achieving continuous improvement in public services"*
> (WPI, 2004, p.1)

The Sustainable Food Procurement Route Planner (SPRP) is advocated as the best practice process model for Welsh public sector organisations, existing socio-political structures precluding mandating adoption. VW have drawn together best practice

guidance from their own, NGO and public sector partners' experiences, to identify key components and stages of the purchasing process, as shown in Figure 28.

The emphasis within the guidance is on planning within an overarching organisational strategy which defines the vision, values and goals of the organisation and how the executive and board will ensure that both sustainable development and value for money are reflected in purchasing practice. Ensuring that values are embedded in governance structures therefore shapes the way in which public services are delivered. Within those structures, however, purchasing needs to be a strategic process where planning, evaluation and accountability differentiate sourcing and contracting from the transactional purchasing role.

Figure 28: Stages in Strategic Procurement Process (Source: Author)

Procurement Strategy
↓
Planning
↓
Needs Assessment
↓
Applicable EU, WG, Organisational Thresholds
↓
Proposed Project Management Structure
↓

Current Arrangements   Selection Criteria   Award Criteria
↓
Pre-procurement Research
↓
Sustainability Risk Assessment
↓
Specification

→ Preferred Strategy
↓
Tendering and Bidding
↓
Contract Award
↓
Contract Management
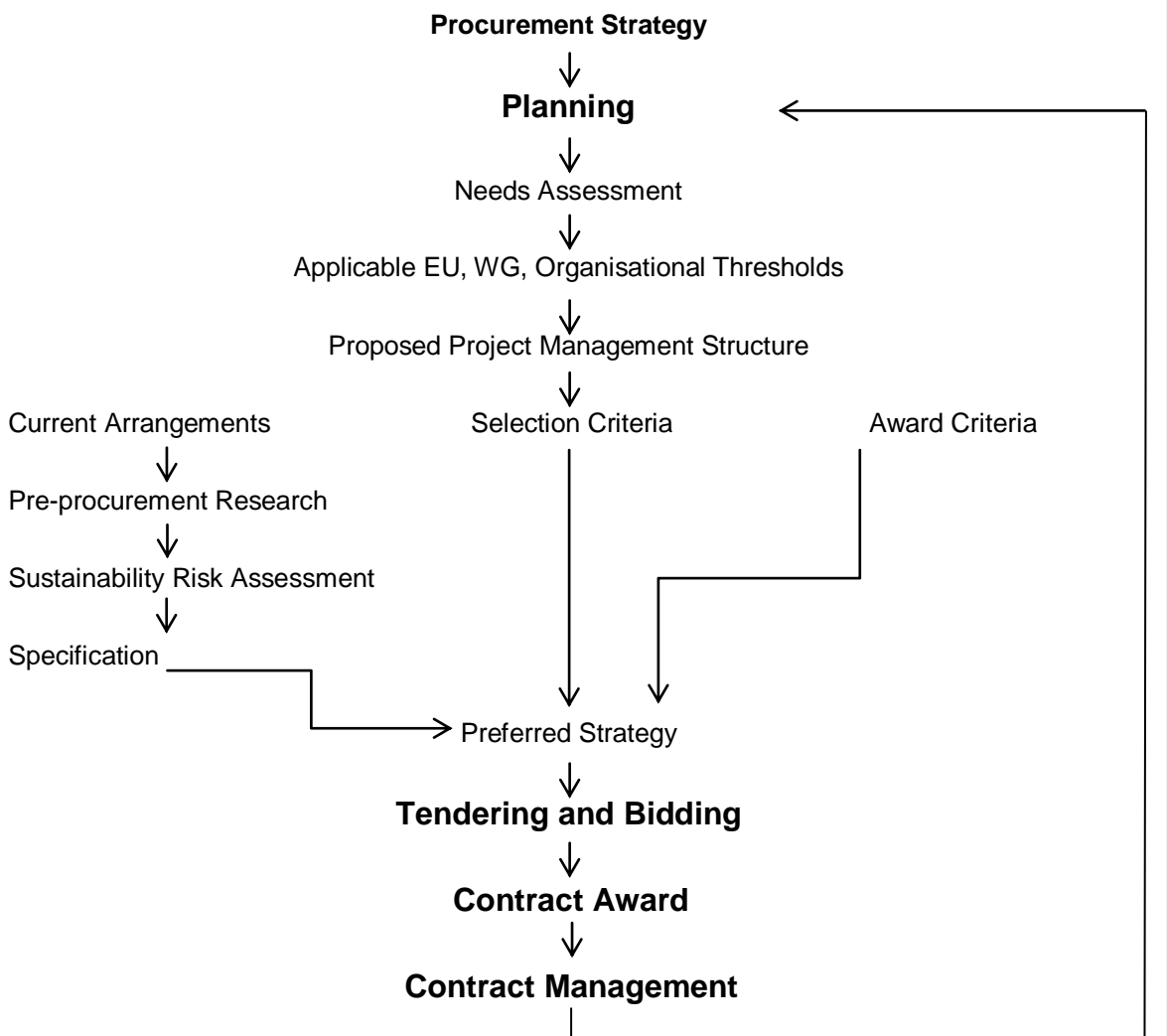
Within healthcare governance, the core principles of sustainable development and best value are a constitutional commitment of LHBs and Trusts. There is, therefore, an equitable and legitimate foundation for the inclusion of value based criteria in setting tender criteria and awards, the primary role of NWSSP-PS being to put these principles into practice.

6.2.1 The Shared Services Partnership

Originating in 1973 as the Welsh Health Technical Services Organisation, the Welsh Health Common Services Authority (WHCSA) came into being as a Special Health Authority in 1985 (SI1985/996). The constitution and functions were amended in 1990 (SI1990/2647), the latter comprising:

- capital works, procurement of supplies, provision of IT, wheelchairs, artificial limbs and appliances, invalid carriages and motor cars

- in relation to pharmaceutical services, examining, checking and pricing of prescriptions for drugs, listed drugs, medicines and listed appliances

- data collection, validation, processing and protection

- services relating to manpower, medical audit, planning, income generation and promotion of cost improvement

Although there were many interim changes, with parts of WHCSA being privatised (Griffiths, 1998) and the remainder being dispersed across the NHS when the Special Health Authority was dissolved, those shared operations continued to exist in varying forms across NHS Trusts and LHBs, with Welsh Health Estates (WHE) advising on facilities, hosted by one LHB, and Welsh Health Supplies (WHS) providing a sourcing and contracting service hosted by another. This hosted structure enables services to be provided for other organisations, independent to the main objectives of the Trust, but within the NHS.

In 2010 the Health Minister, following advice from academics at Bath University (Lewis et al, 2009), set out arguments behind the 2011 restructuring of the nine non-clinical support services into the NWSSP. The new body would enable LHBs and Trusts to concentrate on frontline service delivery without the distraction of running non-clinical functions. Retaining the service within the NHS was also intended to ensure any savings were redistributed speedily to frontline services within the NHS.

By working differently, the aim was to facilitate economies of scale, improve efficiency and bring about consistent quality (Hart, 2010).

The structural changes were brought about through statutory means and consolidated a number of non-operational functions and structural arrangements that had previously been fragmented across the NHS. The new partnership has a stakeholder board, with CEO representation from each LHB and Trust. In order to prevent political behaviour through self-interest, a memorandum of co-operation is in place to ensure the partnership is for the benefit of the NHS as a whole, restating the existing statutory duty to cooperate in the NHS (Wales) Act 2006. The enabling legislation is explicit that this principle of co-operation should underpin the activities of the NWSSP, with expectations that his would lead to:

- the optimal use of resources

- avoidance of duplication

- innovation in the delivery of shared services

- best practice through standardisation of processes, use of technology, economies of scale and better procurement

- effectiveness through openness and transparency

- cost efficiencies by adopting evidence based good practice models and clarity in service specifications

  equity through sharing risks and benefits   (SI 2011 no.13)

The constitution (SI 2011 No.13; NHS Wales 2011) sets out the purpose, role and responsibilities of the NWSSP committee, and enables delegation of the day to day executive functions to the Director. Responsibility for the services provided is to the National Delivery Group, thereby embedding these shared services within the constitutional structures of healthcare governance.

The NWSSP has an annual budget of £50m, and employs 1300 staff within its eight separate divisions, 468 of whom are within NWSSP-PS (2012). This particular division of the SSP has undergone a transition from a sourcing and contracting role for LHBs, which it retains in terms of hospital food, to holding a strategic role in healthcare governance as leader and adviser on cost saving programmes throughout the NHS.

6.2.2 NWSSP-PS

Welsh Health Supplies (WHS), now NWSSP-PS, was a separately hosted body providing a sourcing and contracting service to other NHS bodies. Those organisations were not compelled to use the service and so the success of WHS was reliant upon a positive professional reputation for good practice. At the time of the WHS transfer into Abertawe Bro Morgannwg NHS Trust in 2008, they held a portfolio of 47 contracts with an annual value of £27m (WHS, 2007).

Figure 29: Summary: NWSSP-PS Corporate Social Responsibility Policy (Complied by Author)		
AIMS	Social	Employee Quality of Life; Employee Health and Wellbeing; Organisational Ethics; Equality and Diversity; Human Rights
	Economic	Creating Added Value; Economic Development
	Environmental	Reducing Operational Impacts; Protecting Natural Resources
COMMITMENTS	SMEs	Engage and develop
	Climate Change	Minimise energy use and impact
	Packaging	Reduce, re-use, recycle
	Waste	
	Transport	Minimise impact
	Ethical Procurement	Use best practice: Ethical Trading Initiative
	Equality & Diversity	Compliance with policy and law
	Sustainable Procurement	Use SPAF and SRA
	Stakeholder Engagement	Encourage innovation
	Third/Voluntary Sector Collaboration	Engage and develop
	Employees, Values, Systems	Embed CSR principles in organisational culture
	Measure and Capture Results	Monitor progress, key targets and indicators, benchmarking

Quality in NWSSP-PS processes and management practice are demonstrated through technical industry standards accreditations (ISO 9001, 14001, 27001; OHSAS 18001) and for sustainability through the Sustainability Risk Assessment Framework (SPAF) developed by NWSSP-PS in collaboration with Forum for the Future, the independent not-for-profit sustainability organisation. The Corporate Social Responsibility Policy, summarised in Figure 29, is embedded in the SPAF, and contains broad commitments relating to sustainable development, framed as three separate pillars of social, economic and environment.

The outcomes of the most recent SPAF self-assessment reveal that NWSSP-PS achieved level 3 out of 5 in respect of food, assessed by reference to: "*Organisation knows how much food is locally sourced, and the benefits of procuring, fresh, seasonal and nutritious food are understood and healthy food choices are provided. Food procurement decisions are made on a cost/quality basis. Menus and food comply with set standards. In the NHS hospital catering services comply with the WAG Nutrition and Catering Framework*" (NWSSP-PS, 2013b).

Level 5 is assessed as having been achieved in respect of ethical trading. In addition to this self-assessment process, individuals and the organisation have been recognised in terms of their professional expertise through the Wales Quality Awards, Cabinet Office Customer Excellence Standard and Healthcare Supply Association Awards. Recognition of best practice for specific projects has also been achieved through professional awards, including the work undertaken with Forum for the Future in respect of the 2012 yoghurt contract, details of which are provided later in this Chapter.

Nevertheless, staff acknowledged that there is still progress to be made suggesting that putting new knowledge or difficult concepts into practice, as routine, remains a challenge:

> " *we have the SRA's in place and we use them and we understand the principles of what we are doing but making that leap from filling in a form and understanding it to doing something differently is quite a challenge".*

> *"Equality and diversity - what does that mean? How does that impact? What do we need to do? So that we can drive that through the organisation, so it becomes second nature to people – because at the moment it's a big scary topic – it's like . 'What does this mean – I'm not*

going to do anything with it'……... We are beginning to see some
improvement."

Governance principles of collaboration, with other public sector bodies, the third sector and along supply chains and integration, with UK and Welsh Government legal and policy frameworks, emphasise the need to follow and develop best practice, and are apparent in NWSSP-PS policy objectives. There is, however, no specific mention of the WG Food Strategy (WG 2012b).

As an indication of the increasing strategic importance of public purchasing and the role of NWSSP-PS, their current contract programme comprises about 3500 contracts, valued at about £1.2bn. Approximately 60 of those are food contracts, 38 of which are 'All Wales' collaborative food contracts, with 4-5 of those actively under consideration for renewal at any one time. The annual return for the Welsh Government Food Purchasing Survey in 2012 (NWSSP-PS1, 2012), however, showed that central framework contracts managed by PS accounted for £8.2m food provisions, 42% of the £19.7m of catering provisions reported as being purchased by LHBs (NWSSP-FS, 2012).   The main categories and amount of expenditure for food are shown in Figure 30.

Figure 30 : 2011-12 Main Categories of Expenditure on 'All Wales' Contracts (source NWSSP-PS1, 2012)	
Meat (includes, Lamb, Pork, Beef Poultry and Bacon and Sausage)	£2,775 m
Fresh milk	£1.25 m
Bread and Bakery	£744,833
Fresh fruit and vegetables	£441,739
Pre prepared vegetables	£366,736
Frozen vegetables	£269,133
Dairy Products (excluding milk)	£537,521
canned fruit and vegetables	£129,198

NWSSP-PS have achieved success in re-localising supply chains through their purchasing activities, with 69% of food and drink expenditure reported to be contracted through Wales based companies and 64% of that figure of Welsh origin. 100% milk[15] and soft drinks, 85% of bread, 59% meat and 13.25% of dairy products purchased in 2011-12 were of Welsh origin, whilst 77% of fruit and 58% vegetables were sourced through Welsh based suppliers (NWSSP-PS1, 2012). Welsh lamb, which like Welsh beef has PGI status, is also available on the framework contracts. The 2009 and 2012 meat contracts (EU2009/S 157-228605; EU2012/S 197-323120) were, however, awarded to two Welsh wholesalers as intermediaries in the supply chain, rather than direct to producers.

The remaining centralised contracts are managed by NHS Supply Chain, although individual LHBs retain the constitutional power to purchase goods and services, within specified limits, in their own right. Although many of those local LHB contracts are below the EU threshold, some of the suppliers already supply the NHS through central contracts, suggesting some opportunity for rationalisation to achieve greater integration and efficiency over and above the £34m financial savings that had been achieved on behalf of NHS organisations through NWSSP-PS activities (NWSSP-PS, 2012).

Although LHBs put their strategic role into practice through the stakeholder board, day to day practice involves approving both tender specification and contract award. The facilities section within NWSSP-PS is responsible for food and provides a planning, sourcing, contracting, central invoicing and payment service and works closely with caterers and dietitians on sourcing and contracting through the 'All Wales' Foodstuffs Commodity Advisory Group (CAG).

The role of these LHB stakeholders within the CAG is primarily to determine and assess quality criteria whilst NWSSP-PS ensure that process, practice and products comply with the regulatory framework. Informants from LHBs were generally very supportive of the effectiveness of the CAG:

> *"before the contracts are let they are discussing what is wanted. If the contract is then let, there will be adjudications for certain items and people will be involved in the whole contract process. That's all across Wales, so every health board has somebody going to those working*

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[15] Milk is however transported from producers in South Wales to England for pasteurisation and bottling, due to lack of suitable facilities in Wales.

parties… constantly… really influencing them trying to get what they want." (LHB informant)

There is, however, evidence of an increasing role of the CAG in terms of market development. A particularly enthusiastic catering manager described how relationships were being built through the CAG, with a potential SME producer-supplier:

"*They came to the meeting, took the advice on board from the catering managers there on the size they require – packaging, nutritional analysis and content, and they've gone away and are developing that and we are now looking at them being part of the contract process.*" (CAG member)

6.3   The Four Stage 'Procurement Cycle'

NWSSP-PS have been actively involved in the development of the procurement route planner through the WPI and subsequent 'All Wales' Food Groups, and use it as a template for their own procurement projects. As a strategic purchasing cycle, there are four stages: planning, tendering and bidding, contract award and contract management, of which planning is critical in terms of ensuring outcome criteria, such as the quality of the food, best value and sustainable development, are met within the regulatory framework.

Needs, action, outcomes and accountability are essential stages within governance and embedded organisational processes. Establishing needs for effectiveness and managing demand for efficiency informs purchasing and involves a collaborative approach between patients, nurses, caterers and dietitians within the LHBs. Thus the minimum qualitative and quantitative requirements are determined by stakeholders, and NWSSP-PS take responsibility for process compliance, thereby collectively ensuring best value outcomes for the purchasing organisations and their patients.

Achieving wider political objectives such as sustainable development, operationalized in this context as local purchasing for economic development, also needs a strategic approach to sourcing that is integrated with the needs of supply chain stakeholders. This strategic approach links demand to supply, broadening stakeholder involvement to nurture markets, rather than necessarily to let markets determine or control purchasing decisions. Collaboration with potential suppliers enables new ways of working, product innovation, efficiency and effectiveness

within the legal constraints of procurement law. The critical stage in enabling such creativity to be put into practice is in planning.

6.3.1 Stage 1: Planning

The planning stage of the procurement cycle is strategic, iterative and democratic and enables needs and objectives to be integrated prior to embarking on the legal tendering and contracting stages. Planning therefore needs to be seen as an opportunity to challenge existing practices through risk management rather than risk avoidance.

Structure and uniformity can be provided by setting minimum standards that can be incorporated into contract documentation, but also by adopting standardised procedures to enable best value outcomes to be tailored to specific needs. Figure 31 outlines the core elements of the standard planning template.

The existing contract programme is the trigger for action, which commences approximately one year before the contract expiry date to ensure the correct procedures are followed without risk of continuity of supply. The initial decision is whether to extend the existing contract or to go to market with a new tender and is based upon the outcomes of discussions between NWSSP-PS and existing contractors. Extending the existing contract can reduce transactional costs as well as the mutual risk and uncertainty of market exposure and whilst contractors are often keen to extend, extensions are dependent upon NWSSP-PS being able to negotiate a favourable market price. Engagement with the market, as well as existing contractors, is therefore essential when assessing options at the beginning of the process. This takes place through the issue of prior information notices (PINs) through the EU tenders website, Sell2Wales and, in an attempt to engage directly with Welsh SMEs, *'Open for Business'* events. These exhibitions and networking events take place across Wales and provide an opportunity for prospective suppliers and purchasers to meet informally, and for NWSSP-PS to brief the market, respond to queries and to see what products are being produced locally. This information can then fed into the planning process for particular contracts. Early market engagement therefore identifies opportunities for supply chain collaboration in terms of doing things differently, but also informs decisions on whether to extend existing contracts.

Figure 31: The standard planning process stages and relevant considerations	
Stages	*Brief Description, Rationale and Instruments*
Establishing the Need	Sustainable Risk Assessment (SRA)
EU Threshold Applicable	Determines procedures and options (restricted, open)
Project Management Structure	Include all stakeholders; define communication
Current Arrangements	Define, understand and review current practice through engagement with stakeholders to inform the procurement strategy. Includes the scope, nature and purpose of the requirement; rationale for needs; proposed expenditure; relevant processes; suppliers; contract conditions; good and bad experiences.
Market Analysis	Current market analysis, key suppliers, capacity, forecasts, impact and influence procurement might have on the market, identify opportunities to stimulate the market through reviewing requirements and strategy.
Pre-procurement Research	SRA to assess key impacts and develop specification; market engagement to assess available options.
Specification	Critical statement of needs throughout contract period by all stakeholders and procurement professionals informed by SRA.
Preferred procurement strategy	Confirm requirements and process that will be applied to acquire the goods, to be consistent with relevant policies and plans. Produce a specification in collaboration with stakeholders. Produce risk assessment and identify who should manage risks. Learn from previous experience. Identify the preferred contract requirements. Ensure that the procurement allows SMEs to bid (also in SRA). Determine evaluation criteria in accordance with law. Compile action plan to include timescales, progress measurement methodology, skills and resource requirements. Refine the Business Case to reflect the procurement strategy.
Selection criteria	Determine PQQ (not applicable to open procedure).
Award criteria	The most economically advantageous tender (MEAT) to take into account quality, technical merit and running costs. Award criteria and relative weightings to be determined and form part of tender document.

Adapted from Value Wales Template available from
http://buy4wales.deployment.sequence.co.uk/PRP/prp/planning/index.html

Sourcing and contracting procedures across healthcare in Wales are becoming more standardised to drive efficiency, process standardisation further reinforced by the integration of all LHB procurement personnel into the NWSSP-PS. Standardisation and simplification has also enabled standard terms to be incorporated within contracts, which also ensures that legal requirements of fairness, transparency and competition are structurally embedded and that transaction costs are minimised.

Standard terms in NHS Wales contracts include:

- an obligation on the contractor to ensure value for money by identifying cost savings, providing annual compliance reports

- the contractual right to seek price adjustment within the contract period, where market evidence is available

- a requirement to use the standard electronic trading system

- anti-corruption clauses to prevent bribery and incentives to purchase

- an explicit requirement to comply with environmental law, regulations, voluntary agreements and codes of practice, in particular the Producer Responsibility Obligations (Packaging and Waste) Regulations 2007.

- compliance with the Equity Act (2010) notwithstanding the supplier may not be a public body, and Human Rights Act 1998 (NHS Wales 2012) to ensure equality and non-discrimination.

In addition to standardised contract terms, NWSSP-PS have adopted, as default, framework agreements in order to group together similar categories of provisions and the two stage restricted procedure and MEAT criteria to ensure qualitative considerations inform lowest price.

The existing framework contracts managed by NWSSP-PS are claimed to represent 60% of all NHS catering expenditure (NWSSP-PS1, 2012)[16] and so there is considerable scope to rationalise and extend the use of frameworks through integration and managing demand. The framework approach to contracting groups products within catalogues of similar goods, the purchasing function within the LHBs for the collaborative contracts being to match their requirements to the range of goods within that catalogue. Products available to catering staff are presently

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[16] £8.2m represents 41.6% of the £19.7m shown to be spent on food provisions stated in the EFPMS (NWSSP-FS, 2012)

controlled by managers within the LHBs, but will be increasingly simplified and standardised across Wales as the menu framework is adopted, potential also having been identified through the 'All Wales' catering model.

The default use of the restricted procedure for food is primarily linked to food safety, NWSSP-PS requiring full traceability for food products. This ensures that only those potential contractors who meet minimum quality standards for management and food safety are able to supply food to hospitals. Contractors are required to have STS safety accreditation, but those supplying raw meat (beef pork and lamb) are also required to provide documentary evidence of full traceability, to be made available to NWSSP-PS throughout the duration of the contract. Raw meat is also DNA tested in an audit programme that has been in place since 2006 (NWSSP-PS, 2013a). STS accreditation is available to all food suppliers to public bodies in Wales through a fixed price contract, negotiated by NWSSP-PS.

Adoption of MEAT, rather than lowest price, ensures that procedures cannot be challenged for the use of quality criteria in evaluation tenders, but it is critical that those quality criteria are determined during the planning stage using robust but reasonable, relevant and legally compliant criteria. The SRA (EA, 2007) provides the means by which such criteria are identified and is used in all of the collaborative food contracts and other contracts valued over £25,000. The use of external expert bodies, such as the Camden and Chorleywood Food Research Association and Hybu Cig Cymru, in designing and validating selection and evaluation criteria form an integral part of the planning process but also ensure that due accountability for subjective, political objectives is structurally embedded.

The SRA takes the user through a standard process by providing a series of generic prompts that invite the user to think beyond the immediate purchasing decision of what and how much to buy, to identify strengths, weaknesses, opportunities and threats (SWOT) for the entire contract period. It also leads the user to relate the purchasing decision to wider organisational objectives, policies and strategies, which both legitimise and ensure accountability for qualitative best value concerns, rather than cheapest price. Generic issues are identified in the SRA, such as raw materials, manufacturing, managing use and end of life/disposal, embracing environmental and socio-economic opportunities as well as impacts and using these in conjunction with the UK sustainable development framework indicators, enable the development of an action plan. The indicators themselves enable the purchaser to identify minimum requirements that are legally permissible.

Embedding a SWOT analysis into the process also prompts the purchaser to challenge existing practice and push existing boundaries, for instance through market engagement and supplier, or product, development. Thus at an operational level, the SRA extends purchasing considerations beyond organisational needs to embrace supply chain considerations.

In general terms NWSSP-PS have identified transport, packaging and waste as key impacts of their procurement activities, which are becoming embedded as standard terms within tenders. In addition, their CSR policy guides ethical procurement, although their work with food procurement is still framed in terms of environmental and economic sustainability. Items addressed as standard within the SRA for food tender documents include delivery, packaging and waste.

6.3.1.1   Deliveries

The impact of deliveries is considered a key sustainability concern, the structures and spatial distribution of the LHBs providing some contextual explanation. NWSSP-PS hold some non-perishable ambient goods in central stores, strategically purchased in favourable market conditions, which can be ordered direct by hospital sites and are delivered with other non-food products. Catering systems, and thereby delivery needs, vary by and within LHBs and whilst delivery locations and frequency can be reduced where there is centralised cook-freeze production, many goods, such as bread and milk, still need to be delivered direct, in practice to over 100 hospital kitchen locations. In an attempt to mitigate the CO_2 impact of deliveries, contractors are offered an opportunity to join the nationally chilled distribution contract, at a fixed 13% of unit price.

6.3.1.2   Packaging

NWSSP-PS has developed a supplier qualification questionnaire, in collaboration with Envirowise, which relates to packaging and is intended to encourage and inform the sustainable use of resources. Packaging considerations therefore form part of the standard tender process in respect of waste. Recycled packaging is the preferred option, but the overall aim is to minimise packaging and maximise the use of recyclable materials. It is also a contractual requirement that packaging be removed by, and at the cost of, the contractor.

6.3.1.3   Waste

There is a contractual requirement that waste must be disposed of in a manner that causes no harm to people or the environment. NWSSP-PS have also embedded

incorporate a contractual obligation for suppliers to collaborate with NWSSP-PS on waste reduction and with Fareshare and food banks in respect of surplus food products.

Although many of the elements of the planning protocol are able to be standardised, the quality criteria for specification and evaluation are contingent upon the particular product being purchased and its intended use. These quality criteria are determined by the main stakeholder group, the CAG, supported by industry experts. For a product where a standard specification might be appropriate, such as milk, butter, eggs, cheese and tinned products, a higher weighting is affixed to cost, whilst products where the taste, flavour, nutritional content and texture define difference an quality, such as ice cream and yoghurt, price would not necessarily be the deciding factor.

The critical review of current contracts is integral to the planning stage and it is unusual for award criteria weightings to be replicated from one contract to another. Figure 32 illustrates the changing criteria for the meat and yoghurt. Despite the emphasis on quality driving cost, both examples show an increase in the relative weighting of price over quality, although it is important to note that the site visit in the former meat contract is now a minimum requirement within the PQQ stage.

The estimated quantity of a particular product is a significant factor in ensuring that lowest cost is achieved for any particular specification. The framework contracts do not commit the purchaser, either to buying at all, or to purchasing any minimum quantity. A reasonable estimate of demand therefore enables certainty and planning from the supplier perspective which should result in the best price over the contract duration, but also security of supply. Criticised by some informants as anti-competitive structures, as consequence of which the prices in frameworks are not always perceived to be the cheapest that can be obtained at any one point in time, some informants were seemingly unaware that one of the objects of sustainability is to achieve fair outcomes. Notably such expressions were limited, and within facilities management, rather than actors with a direct input into meal production, procurement, or food service.

The obligation to demonstrate value for money is included as a standard contract term on framework contracts, which enables either party to renegotiate where market prices demonstrate prices have either increased or decreased during the contract period. Catering managers, as purchasers, are therefore empowered to negotiate, with support from NWSSP-PS as holders of market knowledge.

Figure 32 : Award Criteria NHS 'All Wales' Meat and Yoghurt Contracts Data source: http://ted.europa.eu						
Contract Title	Date	Award Criteria & Weighting %		Date	Award Criteria & Weighting %	
Meat, Raw Frozen & Chilled	08.09 AW3844	Price	40	10.12 AW403	Lowest Price	45
		Technical Specification	25		Fixed Price	5
		Site Visit	20		Technical	30
		Delivery	5		Delivery	10
		Tender Compliance	5		Minimum order value	5
		Environment	5		Environment	5
Yoghurt	3.09 AW3938	Nutrition	40	1.13 AW4009	Lowest Price	40
		Price	30		Fixed Price	10
		Colour	10		Flavour	12.5
		Flavour	10		Texture: Mouth Feel	12.5
		Texture	10		Lead time	10
					Customer Service	10
					Environment	5

The outcome of the planning stage of sourcing and contracting is the action plan, which is regularly reviewed as a means of managing the on-going procurement process. As NWSSP-PS are agents for the LHBs and Trusts, authority from those stakeholders is required before the tender stage, to ensure accountability. A Contract Briefing Paper is produced which provides information on the proposed process; the market for the products in question; outcomes of the SWOT analysis and how opportunities, such as SME engagement can and are being met; proposals for award criteria and how contracts and communication with the supplier are to be managed until conclusion of the contract period.

The project also has to be signed off within NWSSP-PS and the hosting body, Velindre NHS Trust, before the tendering process begins. The precise procedure is dependent upon contract value, but has, since the formation of NWSSP-PS, become a much more bureaucratic procedure, potentially involving executive and non-executive members of the host Trust Board, rather than just procurement managers within NWSSP-PS.

6.3.2 Stage 2: Tender and Bidding

NWSSP-PS use electronic means in the tendering process and opportunities are published through the Welsh Government's Supply2Wales website, in accordance with their commitment to the Open Doors Charter (WAG, 2008b). Whilst the use of

electronic tendering has been cited as a reason for lack of engagement by SMEs, NWSSP-PS work closely with the Supplier Development Service to help SMEs to develop skills in order to overcome this barrier. The long planning period leading up to publication of the tender is crucial to putting this into practice.

The first stage PQQ within the default restricted procedure enables NWSSP-PS to eliminate any suppliers who do not meet the minimum technical standards, such as those which do not meet food safety accreditation. For high risk products such as meat, there will also be a technical inspection of premises in accordance with STS procedures. Standard questions such as those relating to packaging and recycling policies and initiatives are routinely raised at this stage and contractors are required to confirm agreement to specified contract terms, delivery requirements and addresses, and that they can meet estimated quantitative requirements. Failure to adhere to all of the necessary PQQ conditions or to agree to the specified terms renders the offer void, and no quality or commercial evaluation will take place. Those successful at stage 1 will be asked to complete the commercial data sheet, which is a price matrix for the specification(s), and provide samples for evaluation in the contract award stage.

Due diligence regarding the financial status of the suppliers, by the use of credit reference agencies and company references, forms part of this stage of the process.

6.3.3 Stage 3: Contract Award

A structured, predetermined and transparent approach to evaluation is required to ensure decisions are made legally and equitably and to bring about value for money. The evaluation criteria are set during the planning process, and published with the tender documents.

For hospital food, the CAG are responsible for qualitative assessment and NWSSP-PS for process and pricing evaluation, supported by external assessors as appropriate. Interviews may be carried out with suppliers, but again, should be according to a pre-determined agenda to ensure equity, transparency and accountability. If interviews are to be undertaken, or further queries need to be raised, the same procedures have to apply to all parties.

Organoleptic and product quality evaluation for food is carried out by CAG catering and nutrition members and, depending upon the product, can involve up to 13 assessors and includes blind tasting methodologies for products where qualities

such as taste, smell and texture are critical. The technical evaluation criteria, such as price, packaging and customer service, are evaluated by NWSSP-PS, with consultation with the CAG on subjective matters such as responses to questions on packaging. Any minimum technical requirements will, however, have formed part of the tender documents and are therefore not negotiable at this stage.

The evaluation and award process is facilitated by NWSSP-PS to ensure that the procedures are fairly conducted, the correct methodology is adopted, and evaluation complies with the specification criteria. Quality assessment should not, for instance, be a comparative process, but one in which each product is scored directly against the specification criteria. A weighted criteria and quality/cost matrix is used to ensure best value though use of MEAT.

Following evaluation of the tenders submitted, a briefing is sent to stakeholder LHBs seeking their approval to proceed with the award notification, following which there is a statutory standstill period before contracts are completed. To ensure transparency and fairness, all bidders are notified of the intention to award and are provided with the details of the winning tender. A more in-depth debrief has to be offered to unsuccessful bidders, but is, in practice, viewed as beneficial to both buyers and sellers in terms of improving quality in future practice and supporting supplier development.

Following this standstill period the contract can be put in place and a statutory award notice is published in accordance with EU regulations. At this point the cycle moves into Stage 4, Contract Management, the specification for which is also included in the planning document and briefing paper.

6.3.4 Stage 4: Contract Management

Much of the added value in a contract is gained through post award management, which within the structural confines of sourcing and contracting, provides accountability within governance. The management process embraces far more than dealing with quality or performance issues, although a large part of the specified programme for contract management will be supplier meetings, reviews with stakeholders through the CAG and monitoring of purchases and delivery reports. Where key performance indicators are included in the contract, then this stage will enable management by reference to those indicators.

Developing relationships with suppliers is good practice and this phase offers an opportunity to improve on performance as well as reduce cost. Collaboration and

collective learning creates opportunities for innovation and informs future practice, but also builds trust - lack of trust from the supplier perspective having been identified as a barrier to participation by SMEs.

Contract cost management is, however, a primary concern within Stage 4. Although the frameworks are effectively a catalogue of standard goods available at uniform prices, there is a history of suppliers in practice charging differential prices to different hospitals and LHBs across Wales, as described by an informant in the following quotation.

> *"Are we buying the same product at different prices, and we know we are – so I'm buying a black forest gateaux - from 3663 or Brakes and I'm paying £5 and you're buying it from Brakes or 3663 and paying £4.50 – well we don't like that – we want to pay the same price, so that's one part of it, why have we got differential pricing in different parts of wales for the same thing? And again that's wider than food and it is absolutely typical because suppliers will get the biggest price they can for it."*

Within the pre 2012 structural arrangements such anomalies would be identified at the invoicing stage and sorted out retrospectively through the use of credit notes. The new electronic arrangements and integration within NWSSP-PS now enables such issues to be identified and dealt with promptly, as a consequence of which mutual benefits accrue in terms of reduced transaction costs, maintaining positive relationships and overall efficiency.

As the frameworks do not necessarily fix prices, suppliers and purchasers have contractual rights to amend prices in line with market movements. NWSSP-PS use commercial market price benchmarking, but also collaborate with other public sector purchasers, particularly the NHS in England, Scotland and Northern Ireland in order to compare and ensure cost efficiency. Food represents a particular commodity area where prices have been continually rising in recent years, and consequently opportunities to reduce prices within contracts are considered to be few. Nevertheless, benchmarking practices also enable market opportunities and trends to be identified, which feeds back into contract planning.

6.4   Learning to Do Things Differently: The 2012 Yoghurt Contract

The 'All Wales' contract for yoghurt was due to be put to tender in 2012, and in a departure from the routine standard practices previously adopted, NWSSP-PS have

been able to demonstrate compliance with SME sourcing policy, the emphasis on changing practice being within the planning stage of the procurement cycle. The project has been recognised as good practice, and was commended as an example of supplier engagement in the UK Government's Excellence in Public Procurement Awards in 2012.

6.4.1 Identifying barriers and opportunities

The barriers to putting policy into practice through procurement persistently refer to structural barriers, in particular the definition of whole life cost, EU legislation, and lack of alignment between legal and policy in frameworks. Procurement research with SMEs in Wales, however, identified specific barriers to SME involvement in public procurement contracts as:

- "*the complexity of the public sector procurement process;*
- *the difficulty experienced in completing PQQ documentation;*
- *a lack of transparency in the evaluation and feedback process;*
- *use of non-contract specific risk criteria which are sometimes unduly onerous compared to the value or risk posed by the contract;*
- *obtaining access to, and use of 'approved lists."* (Ringwald et al 2009, p.4)

The minimum pre-qualification requirement for STS food safety accreditation was also seen as excessive my Welsh food SMEs, and consequently a barrier to their participation.

The way in which NWSSP-PS and their stakeholder organisations have approached the yoghurt contract demonstrates a departure from the safety of tried and tested processes in order to develop their own service quality, relationships with suppliers, and demonstrate an ability to learn how to manage rather than avoid risk. The contextual choice of the yoghurt contract nevertheless reflects a relatively low risk product in terms of food safety, potentially limiting the ability to scale up for other products.

The yoghurt contract was one which was due to be renewed in April 2012. The previous framework agreement (EU 2010/S 100-150693), was awarded on 1 May 2010 to a large national food supplier, Brakes, as sole supplier of twenty product lines, although contract analysis revealed that only fourteen had been purchased during the contract period. Brakes had been one of 3 bidders who passed the first PQQ stage of the restricted procedure tender. The evaluation criteria were weighted

in favour of quality criteria, with 40% awarded for nutritional content, 30% for price, and 10% each for colour, flavour and texture. The contract was awarded for the "*Direct delivery of yoghurts and yoghurt drinks [Mullerlight, Muller Rice, Ubley, Elm Farm, Yeo Valley, Rowen Glen, Danone Activia, Actimil]*." (Source: contract ref: AW3938).

The opportunity to work with SMEs and to work differently in this sector came about through a SWOT analysis (Figure 33) and followed a collaborative capacity building project with Forum for the Future and their Best Food Forward (BFF) team. Lack of internal funding to innovate is a consistent problem within the NHS, and although NWSSP-PS have overcome this barrier for a number of projects through '*Invest to Save*' funding, in the case of yoghurt, it was the charitable organisation, the Waterloo Foundation, who provided funding to enable the project.

Figure 33: SWOT Analysis Yoghurt Contract (AW4009, 2012) Source NWSSP-PS

Strengths:

- "All Wales" nutritional framework provides nutritional specification
- Stable market
- Established SME base in Wales

Weaknesses:

- Low contract utilisation
- Increase in price of milk
- Minimum delivery quantities an issue for smaller sites
- Strong brand loyalty

Opportunities:

- Developing a closer working relationship with existing / new suppliers and SME's.
- Resolve current contract issues with minimum delivery quantities

Threats:

- Branded products widely available from a number of distributors, risk that HB may buy off contract
- High level of product variation in the market affecting contract utilisation

Source: Contract Ref: AW4009, 2012, Briefing Paper to LHBs

Through their work with the BFF Team, NWSSP-PS were able to identify synergies between their own work with hospital food and exemplar case studies from the private, third and alternative sectors. In doing so they were able to identify specific challenges for their own organisation, but were also able to use customer research to understand specific issues from the seller's perspective, in this case the need for a more personal or relational approach and the need to recognise the value of a more direct but potentially multiple supplier networked structure.

Analysis of their ideas and solutions, represented in Figure 34, provided both rationale and mechanisms to enable them to put theory into practice. The BFF project team provided them with support in communicating and implementing their work with the Welsh Dairy industry, characterised by a high representation of small producers, and thereby compatible with Welsh policy on using Welsh SMEs for food procurement.

6.4.2 Demonstrating Flexibility: Managing Risk for Policy Outcomes

Although the default tendering process within NWSSP-PS has always been the restricted procedure, by acknowledging the low food safety risk of yoghurt as well as an active Welsh SME market, they have been able to depart from the default two stage restricted procedure. By adopting a single stage open tender process suppliers are deemed to self-eliminate: if the supplier is aware that they do not meet the minimum contract requirements or cannot supply the required quantities or specifications, then they do not put in a bid, thereby reducing waste for both supplier and the contracting body.

A further adaptation to standard procedures, solely to accommodate SMEs, has been the relaxation of the pre-qualification requirement for STS food safety accreditation. The minimum requirement in this contract is that suppliers can have an alternative, recognised food safety accreditation, but must undertake to upgrade to the national STS minimum standard, should they be successful at tender. An 'All Wales' contract with STS is available for this, at a fixed price to suppliers.

Flexibility in bidding for lots was also seen as critical in enabling SMEs to participate because of the market structure and the spatial distribution of demand. The contract was therefore structured to enable bids to be made for baskets of products (patient and non-patient), scale, or by specific LHB. Whilst the risk to NWSSP-PS from this experimental approach was perceived to be in terms of more onerous contract management, this was expected to be balanced in practice by the more customer focused and responsive way in which SMEs conduct their business.

Figure 34:   Best Food Forward Project Summary

Key:
Insights into our challenge
What we did
What we will take forward

Pre-project
- Thought: Difficult to identify SMEs. Events are often not timed in sync with tendering. Lots of different interpretations of EU regulations.
- Need to engage SMEs. Must be within EU regulations

Scope
- Thought: It's too large to look at all food areas
- Focused idea to dairy. How might we work collaboratively with Welsh dairy companies to supply more sustainable products to the NHS?
- Focus attention to smaller areas

Inspire
- Thought: Suppliers want to work with the public sector. They want to ask questions. And they like face to face contact. They want to understand the procurement process.
- Identified key stakeholders using analogous experiences (including recruitment agency) and extreme users. Communicated to gain insights
- Use techniques to identify stakeholders in the future

Untangle
- Thought: Lots of suppliers would like to work together but they have no means to facilitate this. Lots of SMEs can't bid for large contracts.
- Teased out key themes and challenges
- Make people aware that they can talk to you. As far as time allows, get out and meet suppliers

Generate
- Thought: Networked value chain is more than we can do alone. It needs whole public sector involvement. Use existing portals and networks.
- Brainstorm ideas! Prototyped key ideas: personal procurement and the networked value chain
- Use brainstorming and involve people from other teams when generating ideas

Implement
- Pilot personal procurement on yoghurt contract
- Identify contracts to apply personal procurement to beyond the pilot

Communicate
- Thought: Need wider public sector engagement. Use existing resources and communications channels.
- Continuous communication with Value Wales food group and CAG
- Communicate opportunities for suppliers and NHS to collaborate. Further strengthen existing relationships

Source: http://www.forumforthefuture.org/sites/default/files/project/downloads/best-food-forward-summaries-nwssp.pdf   10

Accordingly, specific SME friendly but fair and transparent evaluation criteria have been included. In addition to the standard terms and conditions already outlined, prospective suppliers are required to provide access on demand for inspection purposes. Specified additives and genetically modified organisms are prohibited; food labelling is required in respect of specified and known allergens and nutritional data for each product must be supplied as part of the technical considerations.

'Sustainability' in the tender document refers entirely to waste, but also seeks collaboration between the supplier and food banks in respect of surplus to requirement products. As the yoghurt specification requires a 10 day shelf life, in practice this might occur, for instance, where branded yoghurt products are supplied in portions specific to the NHS, rather than those produced for retail or non-patient sale, and where actual demand does not meet expectations, resulting in overproduction. As a consequence, the risk is with the producer rather than the purchaser, potentially increased by the delivery requirement for a lead time from order to delivery of 1-3 days. There are, nevertheless, embedded delivery options that embrace principles of environmental sustainability, in particular the opportunity to join the collaborative chilled distribution contract with 3663 at the specified cost (13% of unit price), which would allow more frequent deliveries through an existing delivery network.

The existing contract was due to expire in 2012, and the tender notice, including nutritional specification, was published with the intention of the contract commencing 1 August 2012 (EU ref 114030-2012). Despite prior market engagement and supplier briefings, which suggested that there were products available as well as SME capacity, only one of the three bids[17] met the technical specification and none at all for one particular product. As a result of the failure to meet the technical qualifications, only one bid could be assessed against the qualitative and commercial criteria.

This lack of competition on price prompted NWSSP-PS to review the project to ensure value for money was being achieved. As they were aware of supplier interest at the proposed specification and no queries were raised by any of those companies who tendered, the decision was taken to re-consider the nutritional specification and to return to the market with a new tender. As a consequence the nutritional specification for patient yoghurts was amended, mainly to widen the

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[17] One of the three bids was an intermediary bid on behalf of three Welsh SME producers

acceptable range for the technical metric of calorific content, but only on some products.

The revised tender documents included a product specification with a total of nine patient products, including high energy, healthy and child specific options, and nine non-patient options, with more general requirements. Supporting documentation was provided to the tenderers so that for instance the required nutritional information and pricing were provided in the correct format. Estimated quantities and addresses of sites for delivery were also provided, with a requirement for deliveries to a potential 103 named sites. Market engagement and briefings were undertaken to ensure that the technical criteria were clear, and no queries were raised. All of the actual bidders attended the briefing.

The award criteria, which were not changed for the re-tender process, and the relative weighting to be used to determine the MEAT, are shown in Figure 35. The award criteria for non-patient yoghurts were heavily weighted on price, with 65% lowest price and 10% for the ability to fix the price. Technical criteria related to customer service (10%), lead times (10%) and environment (5%).

6.4.3 Tender Outcomes

The re-tender process produced four bids, two UK based wholesalers, a Welsh wholesaler bidding on behalf of three Welsh SMEs, and one Welsh SME. Despite the revised nutritional standards and supplier engagement, the majority of the bids failed the technical nutritional tests and therefore neither commercial nor qualitative criteria could be considered. The more stringent patient food criteria were met by one company, the Welsh SME, for eight out of the nine patient products, but only on some lines by the other bidders. The consortia bid failed to meet all but one of the patient yoghurt nutritional criteria.

The qualitative elements of the evaluation included sensory tests, undertaken by a food safety advisor, dietitian, procurement officer and catering manager, and assessment of the other evaluation criteria. All bidders, for instance, committed to reducing their impact and improving environmental performance, and a lead time of 1-3 days. The larger distribution companies had a higher minimum order requirement than the SME, which was able to guarantee fixed prices half of the contract period, double the time offered by the others.

The outcome of the evaluation was that the Welsh SME was the successful bidder for eight out of the nine patient and two of the nine non-patient product lines,

although the price differential was described by the project manager to be nominal, higher quality being the primary deciding factor. The two national distribution companies were awarded six and three lines respectively, and are to supply yoghurts made in the UK by SMEs as well as international brands.

Figure 35 : Award Criteria Patient Yoghurt Contract AW4009		
Source: Instructions to Tendered and Specification for the Direct Delivery of Yoghurt to the NHS in Wales AW4009 2012		
Commercial Criteria		
40%	Lowest price	Lowest price on a line by line basis. Offers scored on a relative scale to lowest price
10%	Fixed price	10% 12 months from contract date 5% 9 months 0% < 9 months or no fixed price
Technical Criteria		
12.5%	Flavour	Product representing flavour stated
		2.5% unsatisfactory
		7.5% satisfactory
		12.5% fully meets flavour described
12.5%	Texture and Mouth feel	Texture as described, e.g. drinking yoghurt
		2.5% unsatisfactory
		7.5% satisfactory
		12.5% fully meets product specified
5%	Environmental	Outline approach to commitment to waste reduction, especially packaging levels and commitment to improving performance. 5% awarded if agree to collaborate with NHSSSP to reduce packaging throughout contract
10%	Lead Time	10% for 1-3 days from order
		5% for 4-5 days from order
		0% for 6 or more days to order
10%	Customer Service	Support available to LHBs and Trusts, such as marketing and training materials, complaints handling procedure and availability of representatives. 10% awarded to bidders who outline both approach and services offered

6.4.4 Unintended Consequences

Although not one of the criteria for the evaluation, the SME which won the award has, in practice, demonstrated innovation and collaboration in the production and distribution of its yoghurt.

On the production side, the independent manufacturer produces yoghurt in collaboration with a North Wales dairy company, which coincidentally already supplies milk to the NHS. The partnership between those parties is based upon the yoghurt being produced in dairy owned premises with plant procured by the yoghurt maker. The dairy is also contracted by the yoghurt maker to deliver products to NHS sites in North Wales integrated with its own daily milk delivery service, a cheaper and more convenient solution than the national NHS contract with the 3663 distribution network. For South Wales deliveries, the yoghurt is to be delivered through the contractor with the South Wales milk contract. Transport efficiency and economies have therefore contributed to both environmental and economic sustainability.

The project design was intended to break down the contract framework to engage and accommodate SMEs and their particular characteristics in a more networked supply model, in order to demonstrate social sustainability as an outcome of an economic based objective. The outcome is very much in favour of one Welsh SME, itself demonstrating product and process innovation, and to that extent the project has met its core objectives in a more streamlined supply chain.

The stumbling block for wider participation in the contract award does appear to have been the technical specification for the nutritional quality of the product. In both tenders, the other three SMEs and the larger distributors failed to offer products that met the given minimum standards, and thereby excluded themselves from the qualitative and commercial evaluation. This occurred even though briefing meetings where those standards were explained were attended by those parties. The use of the open procedure to cut down on SME suppliers' abortive costs does not appear to have been effective, the consortia bid from the three Welsh SMEs failing to meet the technical requirements and thereby eliminating them from the competitive element of the selection procedure.

Despite having to review and re-tender to demonstrate fair competition in awarding the contract, the use of electronic tendering simplifies the process and minimises the costs thereof. Concerns about the cost effects in contract management of a broader network of multiple suppliers were also unfounded.

Although successful in meeting the project objectives, with additional but unintended sustainability gains, the positive outcomes in terms of cost savings, the primary aim of the NWSSP, are largely unquantifiable. By specifying in detail on quality however, the process has ensured that the lowest price has been obtained through competition. Ideally, there would have been four bids to compare in the commercial stage, but as there was a re-tender in this instance, and competition was between large and small contractors, there is greater certainty that the lowest price for the specification, and therefore best value, has been achieved.

In addition, the two national distribution companies are to supply non-patient yoghurts made in the UK by SMEs and an international brand, yoghurt production of the latter being just over the England/Wales border. Ironically this company is closer to South Wales than the successful SME, and claims to source its milk from within thirty miles of its dairy, where possible.

6.5   Sourcing and Contracting for Qualitative Outcomes

The structures within NHS Wales place strategic importance on integration and standardisation as the means of delivering an efficient service, and this is in evidence within the activities of NWSSP-PS. Although constitutionally separate from the LHBs and Trusts, NWSSP is structurally integrated into the constitutional structures of healthcare governance as a partnership with a stakeholder board to ensure clinical leadership. Despite distinct constitutional objectives that focus on cost savings, this structure enables NHS values and needs to inform processes within NWSSP, whilst stakeholder collaboration through the CAG for all sourcing and contracting integrates NWSSP-PS processes into the NCP and thereby healthcare governance.

The procurement route planner is a standardised process developed in collaboration between WG and NGOs which guides action and steers actors towards putting core sustainability principles into practice. Adoption ensures that critical considerations, such as the SRA, are embedded into structures, although there is still a need for leadership to ensure that it is used effectively. The standardised process also steers actors to legitimately manage, rather than avoid risk, and compliance, when linked to appropriate action, demonstrates accountability.

This case study of nutritional governance demonstrates how frameworks, as collective contracts, have much lower transaction costs for purchasing organisations than where products are either bought off contract or through multiple contracts,

discrepancies and differential charging by contractors commonly cited practices by practitioners in this research. Structural integration of procurement across Wales has removed the need to coordinate and collaborate in managing costs within the framework contracts, leading to consistent pricing and lowest cost for all purchasing bodies. Thus the frameworks, as structures, are not the problem in themselves, the primary barrier being the way in which the processes are carried out.

Structuring demand for goods as frameworks is, nevertheless, perceived by some actors as both SME unfriendly and anti-competitive, and therefore unable to meet sustainable development policy and regulatory objectives. The primary objectives of sustainable procurement are, however, underpinned by principles of fairness and transparency. As demonstrated in the case of the 2012 yoghurt contract, frameworks enable flexibility in both demand and supply. Goods can be specified on quality criteria and contracts broken down into lots to accommodate SME market structures. In the yoghurt case study, the market ultimately determined the structure of the framework contract, firstly because suppliers were apparently unable to meet the technical nutritional requirements, forcing reconsideration of the technical standards, secondly by the way in which the actual bids were structured, and thirdly by rejecting the NWSSP-PS supply chain proposal in favour of their own innovative approach to delivery.

Perceptions nevertheless remain that frameworks are not necessarily cheaper than buying direct from producers. Cost, as an outcome of procurement activity, is essentially market led, the pre-tender planning and marketing activities of NWSSP-PS critical in establishing market potential and stimulating interest. At the time of this research, quality considerations in the finished meal and nutritional standards provide the technical framework that determines the detail of purchasing needs, the 'All Wales' menu simplifying the range of goods to be included in tenders. The technical nutritional standards embedded in the menu may also offer some protection against a political cost cutting agenda by setting minimum acceptable standards, notwithstanding the potential effect on waste and overall costs, as outlined in Chapter 5.

Process thinking, as the way in which discrete processes are carried out, therefore helps to overcome the persistent policy challenge of a deterministic approach to whole life costs, and enables the policy imperative, most economically advantageous tender, to be reframed as effectiveness and efficiency, which in turn enables quality and safety outcomes to lead in determining cost, rather than the

absolute cheapest in terms of price. Thus lack of technical skills for whole life costing need not be a barrier to change.

Planning is, however, an essential stage of the sourcing and contracting process. Through collaboration with NGOs, LHB caterers and dietitians, appropriate qualitative considerations can be identified, market structures ascertained and contracts structured accordingly. The flexibility of the framework contracts enables the market to determine price, as a consequence of which the lowest cost is determined by qualitative standards.

This emphasis on qualitative concerns is, however, informed by previous experience and stakeholder involvement, as collective learning. As with the NCP, temporal sequencing is critical to sourcing and contracting, planning preceding action and accountability for outcomes.

The themes emerging from this Chapter concur with earlier chapters relating to the NCP and context. Governance in respect of the particular procurement process is contingent, leadership, learning and collaboration being essential and related conditions of change. Although structurally empowered through constitutional devolution of authority and responsibility for meeting the political agenda for cost savings, the longstanding embedded stakeholder structures of the CAGs within NWSSP-PS ensure qualitative stakeholder needs are the primary determinant of cost within the regulatory framework for procurement.

The increasing strategic importance of procurement within healthcare governance follows the trajectory demonstrated within Chapter 3 in relation to public services in Wales. The role of NWSSP-PS is, for instance, widening beyond sourcing and contracting to look more holistically at efficiency across the NHS, adopting a strategic approach to systemic waste reduction, through simplification and standardisation of processes to best practice models.

As with the context and content of strategic change, re-structuring from function to process across the traditional clinical-operational divide is a necessary pre-condition for successful change. Of particular note in the case of sourcing and contracting, the collaborative stakeholder structures were in place before the 2003 and 2009 reorganisation of healthcare. The integration of procurement into one body, despite previous evidence of good practice within NHS Wales, therefore reinforces the argument that structure matters, the capacity of agency to bring about bottom up change limited in scale. Nevertheless, structures alone do not ensure change is

brought about, evidence, in the case of NWSP-PS, being the acknowledgement that there is room for improvement in their own SPAF.

The case study of yoghurt supports the idea put forward in Chapter 5 that structural empowerment is merely a starting point for behaviour change. The need to justify action by adapting and adopting best practice, as in the joint development of the BFF project, suggests that there are also psychological conditions which precede behaviour change.

PART 4
UNDERSTANDING AND EXPLAINING CHANGE

GOVERNANCE

CONCLUSIONS

CHAPTER 7
A Case of Governance

7.1 Introduction

Critical realist research follows the logic of '*what is this?*' in order to be able to answer the question '*what is this a case of?*' to explain change. The former question has been answered in Chapters 5 and 6, which describes sustainable public procurement, the latter being the focus of this Chapter, governance. Within NHS Wales, this is defined as *"A system of accountability to citizens, service users, stakeholders and the wider community, within which healthcare organisations work, take decisions and lead their people to achieve their objectives"* (NHS Wales, 2012c). Governance is therefore the primary mechanism that explains strategic change in the context of this research.

Pettigrew's theoretical framework (1987, 1997) suggests that explanation can be found within the complexity of non-linear processes, which he describes as the embeddedness of nested structures, as well as within the historical context and the connections between action and the desired outcome(s). The preceding Chapters each relate to the description of these nested governance structures, material from which is used in this Chapter to build up an argument to support the thesis that sustainable public procurement is a process of governance.

The temporal dimension, as a core underlying principle of Pettigrew's theory of emergence (ibid) is also evident as a series of necessary pre-conditions for action. The constitutional structures of healthcare governance, for instance, provide for planning and therefore continuity, whilst governance processes promote flexibility, enable responsiveness and are necessary for continuous, adaptive and incremental change, as well as accountability. Thus constitution precedes and enables process and therefore action, the outcomes of which can then form the antecedent structures for future action.

Following the format of the constitutional and processual frameworks for governance in Chapter 1, this Chapter explores emerging mechanisms and their contribution towards explanation. Thus discussion of the political and ethical frameworks reveal that devolution, integration, differentiation, standardisation and simplification have been critical factors in bringing about change, and that the principle of equity, for social justice and sustainable development, operationalized as dignity and respect, guide behaviour.

Within the processes of governance, needs assessment, for the qualitative outcome of effectiveness, is part of a planning process that also considers quantitative need, for efficiency. The accountability framework relates to action, as well as outcomes of best value for both clinical effectiveness and operational efficiency, and equity for social justice and sustainable development. Needs and outcomes are therefore structurally linked by a process of planning and accountability, guided by a set of related values that link sustainable development to action. The mutually dependent conditions of the process of governance emerging from the data are shown to be leadership, learning and collaboration.

Although not necessarily apparent within each of the preceding chapters, the holistic view demonstrates planning in the form of the constitutional framework. The Chapter therefore concludes by suggesting that governance is not just a matter of needs assessment, action, outcomes and accountability, but that a planning stage is essential, comes before action, which necessarily precedes accountability.

7.2   A Political Framework of Healthcare Governance

The literature review, summarised as heuristics in Chapter 1, stresses the political layers inherent as hierarchical determinants of whether individuals or organisations engage with sustainability in public procurement practice. Although often framed in terms of the legal constraints which originate from the EU, the existence of good practice examples suggests that as a fixed, and, within the EU universal influence, concentrating solely on the legal framework is unlikely to broaden our understanding of the barriers practitioners face in practice.

Nevertheless, EU policy, guidance and direction have shaped the economic and social environments of member states, differentiated by their political direction and the way in which public services are delivered. The UK is an example, with primary legislative and taxation rights, control over certain policy areas and the setting of global budgets for devolved nations retained in London. Responsibility for service delivery through budget allocations, policy and strategy and the structures of public services is devolved by the UK government. Differences between England and the devolved nations are particularly apparent in the case of healthcare systems, represented by the formal institutions of the NHS with attendant structures controlled and guided by the respective governments and their political and moral values. Successive political coalitions in Wales, however, suggest that collaboration may be necessary for long term change, by providing continuity, enabling a process

of change built upon mutual learning and challenging the short termism inherent in UK political cycles.

Funded publicly and ultimately by UK taxation, the delivery of healthcare services in Wales is an intrinsically economic operation, with hospital based care and treatment mostly provided by public, rather than private sector providers. WG sets the political and moral agenda as well as exerts control over resources for specific goods and services.

The ultimate political control mechanism available to WG is legislation, although the need to legislate perhaps represents a failure of the persuasive role of the state. The EU commitment to market structures and competition, alongside difficulties in defining standards and metrics for compliance with abstract concepts, are real constraints to using legislation as a mechanism of control where outcomes rather than compliance, is the goal. The consequential limitations of the civil courts, and the need to identify an aggrieved party, limit the effectiveness of legislation beyond financial penalties. An alternative approach is apparent within Welsh healthcare structures, sustainable development and best value being constitutional requirements of subordinate bodies.

Nevertheless, the continuing political reluctance to apply sanctions, either through conditional funding or by refusing to meet budget overspends, suggests that the balance of power still lies with those subordinate organisations. Whilst this may be attributed to weak leadership from government, the alternative view is that sanctions that directly affect the delivery of welfare services are politically and socially unacceptable. The supply and demand relationship within the UK publicly funded healthcare system inevitably means that financial sanctions will affect the quality, safety or extent of the provision of healthcare. Regulation through audit and inspection are, as Martin (2010) suggests, the most effective way of improving performance, intensifying regulatory controls increasing the risks associated with routine compliance and perverse incentives. Regulation in the form of legislation can therefore be a barrier to achieving genuine long term, or cultural change.

Legislation apart, WG sets out the vision and priorities for the people of Wales. The historical context has demonstrated how sustainable development in Wales has evolved from a constitutional aspiration, through a period when it was seen as a separate but cross-cutting policy theme, to one where it is structurally embedded within an integrated policy framework, if not apparent in practice. More detailed cross-cutting strategies such as the public health and food strategies (WAG, 2009d;

WG, 2012g) provide specific directional guidance, but in terms of the evolution and development of public health as a core theme within healthcare governance, the post 2009 structural links between government and healthcare reinforce the earlier intentions of 'Better Wales' (WAG, 2001).

Adopting a broad conception of public health as a core political theme also provides the guiding principle for the development of healthcare governance. Healthcare in Wales is undergoing a transition from a focus on health inequalities as collective outcomes, to one with a greater concern for individual qualitative outcomes in line with the revised Bevan Principles (BC, 2011). By acknowledging that the determinants of public health are related to social as well as economic and environmental conditions, public health is inextricably linked to the Welsh conception of sustainable development, as a social rather than just an economic or environmental policy concern. Evidence of the increased political importance of healthcare as a positive element of social policy is further provided by the constitutional integration of health and social care within government. The DHSSC holds responsibility for health, but is integrated with the NHS and professions through shared key roles of the Director General, CMO and CNO, the CMO also leading on public health.

As well as setting a moral agenda by promoting equity and public health, government also sets controls the allocation of financial resources, thereby constraining the NHS in its operational capacity. Conflicting political requirements, for instance to attain financial economies, appear to be at odds with rising demand for health services, expanding technical possibilities within medicine and the need for continuous qualitative improvements for patients. The longstanding challenge for the NHS in Wales has therefore been to improve quality and safety, deemed to reflect better patient outcomes for patients, and effectiveness and efficiency in healthcare governance, within constrained budgets. Allocation of resources within LHBs is largely at the discretion of individual Boards and consequently is open to political behaviour, but tradition persists and allocations are according to function within a departmental structure (MacArthur et al, 2012).

The planning and delivery of healthcare services is also devolved to LHBs and Trusts, the overarching concern for equity and public health determining a need to accommodate difference within the healthcare system. Nevertheless, the respective roles and responsibilities of devolved organisations, key senior actors and primary aims are set within the respective constitutions, alongside commitments to sustainable development and best value. Thus there is a high degree of

constitutional standardisation and clear hierarchical lines of responsibility within the constitutional structure of healthcare governance.

In addition to integration through shared roles within WG, there is evidence of organisational integration across the current NHS configuration, notably in terms of advisory capacity and support for service delivery. At the highest level, the Bevan Commission, seven statutory and five non-statutory committees advise WG, whilst the activities of the LHBs are supported by statutory joint committees for specialised (WHSSC) and shared services (NWSSP). The three NHS Trusts provide 'All Wales' specialist healthcare services, one of which is NHS Wales Public Health Trust, and LHBs also have a constitutional requirement for a Director of Public Health on their respective Boards, thereby integrating the role of public health within healthcare governance structures. Support for workforce and operational development has also been provided within the NHS, the NLIAH providing training and advice on leadership, innovation and learning.

The core aim of NWSSP, within which procurement expertise is located, is to bring about cost savings for their stakeholders. The partnership structure, despite the constitutional imperative to save money rather than just achieve efficiencies, is integrated into the overall values framework of the NHS through its stakeholder board. The structure therefore ties the partnership to LHB and Trust stakeholders, who set the overarching aims and values, enabling qualitative concerns to be legitimately embedded in purchasing practice as effectiveness criteria. Such constitutional ties do not, however, exist with supply chain stakeholders, policy providing political guidance on prioritising Welsh SME suppliers.

Key informants within the NWSSP nevertheless expressed opinions of frustration with the stakeholder led structure and felt that the partnership arrangement actually diminishes opportunities for saving money compared to an independent body:

> *"By keeping us within the NHS, you actually can't create your own culture because you are part of these larger organisations with a much larger cultures dominated…. quite rightly by clinical issues and care - shared services isn't - yes we have a connection with the NHS and I think it helps enormously understanding the NHS to be able to operate within it, but that doesn't mean that you should adopt their cultural practices in terms of managing a business".*

LHBs also retain spending powers up to £1m, have control over resources and the ultimate power to decide what and whether to buy, although in practice senior

management use product editing to restrict the options available for their own staff to purchase. Nevertheless, tensions were apparent between caterers and procurement professionals.

> *"If we take yoghurts, WHS want the cheapest, catering managers want quality. There's a lot of waste if we don't use branded products, so we tend to use Muller, but have them packaged in smaller tubs. There's no point in having stuff that patients either don't recognise or won't eat as it then becomes waste."* (Caterer)

The 2012 yoghurt contract, awarded to a local rather than international brand, is therefore a test of whether existing routines and perceptions from LHB purchasing practices are being overcome.

The failure to integrate the NHS estate into the facilities division is also considered to be a missed opportunity to generate savings, as each organisation retains its own non-strategic estates and maintenance departments, food service and catering models, relying solely on social processes of co-operation and collaboration rather than any structural imperative.

In contrast, the structural integration of all NHS procurement into the NWSSP-PS demonstrates the strategic importance of procurement. The move towards advising Finance Directors directly on cost savings programmes, not just on contracting and supply chain matters, is clear evidence of procurement becoming embedded within NHS governance. The role of NWSSP-FS, however, remains that of advisors and administrators, the latter in respect of the EFPMS and PEARS. This suggests relatively poor strategic importance is attached to facilities management, and thereby catering, compared to procurement.

By integrating service provision and mandating common structures for LHBs and Trusts, WG has therefore attempted to provide stability and continuity to underpin the need to innovate in order to achieve its goal of a world class, patient centred health service. In doing so, however, it has also attempted to eliminate the opportunity for competition and ensure equity in terms of the distribution of health services. The high degree of constitutional integration with government could also be argued as a strategy to protect public ownership of the NHS, any future move towards market based healthcare provision requiring explicit political action and major structural reform. Whilst public ownership does not prevent non-public provision of healthcare, it provides structural and political support for keeping healthcare, as an economic activity, within the Welsh economy. Notwithstanding this

apparent anti-competitive strategy, creating a level playing field also enables comparison and benchmarking for performance management and therefore supports NHS as well as the respective LHB and Trusts' governance.

The integration of healthcare organisations in 2009 also appeared to be an overt political act and was contrary to the recommendations of Sir Derek Wanless (WAG, 2003a). He recommended that care provision be restructured around care pathways within the existing constitutional framework, rather than risk conflict and resistance to yet another structural change. His recommendation was for a public health transition, where individuals would assume responsibility for their own health and care would be more prevention rather than treatment based. Efficiency savings, and therefore better value for money, were anticipated solely as a result of fewer in-patient stays. Nevertheless, subsequent experience of the cost of the highly localised and spatially fragmented 2003 configuration appears to have been the primary motivation for the 2009 re-organisation suggesting that, despite its apparent political motive, the purpose was economic.

The 2009 structural Integration also enabled a shift in power from secondary care to community based care and public health, thereby enabling a social re-orientation towards wellbeing and alignment with the WG conception of sustainable development. Nevertheless, responses to the public consultation, although revealing a lack of fundamental objection to the proposals to integrate, expressed concerns about the loss of local voice and lack of unified culture in larger organisations, as well pointing out that despite the primary aim of reducing the reliance on hospital based care, power remained with the former Trusts, and thereby hospital care. As well as general consensus for radical change, the previous voluntary mergers between some Trusts demonstrate a willingness to collaborate as a way of improving efficiency and service quality, albeit on a limited scale.

The new deterministic, if more networked constitutional structure for healthcare governance has contributed to the efficiency agenda through a combination of simplification and standardisation that has reduced bureaucracy as well as transactional costs. It has also provided clear lines of accountability by setting standardised terms of reference, role descriptions and minimum requirements for accountability structures within devolved organisations. This seemingly rigid formal organisational configuration is nevertheless only part of a political framework that supports action structured around processes.

The future challenge is, however, more acute, as the emphasis remains on improved outcomes, but within a diminishing budget. As MacArthur et al (2012) suggest, economies, as outcomes of better public purchasing activities, are unlikely to meet the overwhelming challenge to reduce the overall costs of running the NHS. As the overall constitutional structure of healthcare governance has reached an optimal degree of integration, the pressure has shifted from efficiency to economy, and responsibility for making those cost savings effectively devolved to LHBs and Trusts. As a consequence the challenge is to change the way in which services are delivered, governance providing the structure to do so.

7.3   An Ethical Framework of Healthcare Governance

The overall aim of the NHS is to achieve equitable outcomes from healthcare delivery. The principle of equity is, however, framed in practice through the espoused values of dignity and respect, intended to achieve quality and safety through individual caring practices and actions that demonstrate attentiveness, responsiveness and respect. In essence these are embedded principles that steer the course of healthcare governance away from a broad consequentialist and utilitarian approach towards a more general deontological approach that can accommodate differentiated outcomes.

Values of dignity and respect guide policy and strategy within the NHS operational framework and underpin the healthcare standards, the aims of the OPC and form the focus of the work of the CHC. The concepts of dignity and respect are interrelated, and underpinned the CoE resolution on food in hospitals (CoE, 2003) as well as the FOC (WAG, 2003). The principles also form the Healthcare Standard 10 (WG, 2012d), although are also arguably the operational equivalent of the principles within overarching Standard 2, Equality, Diversity and Human Rights (WG, 2012e). The essence of the principles is that action is directed towards recognising and accommodating individual and cultural differences in the practice of care.

Dignity and respect are nevertheless values, rather than virtues, providing guidance on how to behave towards others rather than personal attributes such as compassion. Behaving with dignity and respecting others, in developing policies and in providing care in practice does not necessarily require the simultaneous reciprocal relationship suggested in the feminist ethic of care, but is arguably a necessary pre-condition for such a relationship. The use of dignity and respect as a guide for behaviour links the activities of caring with the individual, but also as part

of communities of care, as particular vulnerable groups have particular needs that cannot solely be met through individual caring activities.

Putting care into practice through the behaviours of attentiveness, responsiveness and respect, as suggested by an ethic of care, was in evidence in many interview narratives. The attentiveness and responsiveness of the food technologist in the example given in Chapter 5 is undoubtedly an act of individual caring as a relational but contingent concept. The technologist could, for instance, have produced the meal and left it for the patient to eat it on his own. The carer was nevertheless wholly dependent upon others' innovation to be able to offer the particular menu and food. The production of special menus for patients with swallowing difficulties demonstrates an institutional approach to both dignity and respect as the meal service confers dignity through respect for difference and equity in meeting differentiated individual needs.

In political terms these instances might be attributed to devolution. Ogbonna and Harris (2002) suggest, however, that collectively sharing the content of culture, assumptions values and artefacts, can exist in distinct social units at any particular point of time. The argument following from this is that care can inform group culture. In practice, differences in care quality and outcomes are reported to exist at ward level and are attributed to ward leadership, but the existence of those differences does not prevent care from being part of a conception of culture, even if the continuing variances in practice and publicised reports of poor practice indicate that there is no institutional culture of care.

The political emphasis on public health in Wales places the institutional focus on wellbeing as an outcome of care, differentiated according to individual medical and cultural needs as well as personal preference. Institutional care, as proposed by Engster (2007) therefore becomes an enabling process rather than an individual act of caring. As Engster (ibid) effectively argues, this conception of care is an abstraction from virtues to values, the ethical dimension put into cultural practice through alignment of core values within multiple processes which links the individual, communities of health and the organisation. Thus embeddedness, as Engster's view of economy in society, provides a link with a realist conception of governance as embedded structures and social processes. Values can also, following this argument, be linked to Schein's (2010) conception of culture, not just as a symbolic statement of governing aims, but manifested in practices through actual, if differentiated, behaviour.

Equity, as public health and the principal aim of the NHS in its service delivery, relates to both needs and outcomes in a process of governance. By promoting the principles of dignity and respect as interrelated but also relational concepts, individual and collective dignity is enabled by respectful behaviour and dignity and respect become embedded in equity and thereby justice and sustainable development. At the individual level the three conditions of the feminist ethic of care, attentiveness, respect and responsiveness enable caring practices to be delivered. These practices can, however, take place irrespective of virtues, most frequently conflated with values in media portrayals of lack of care as the virtue of compassion.

7.4   Governance in Action: Nutritional Care

The actual delivery of healthcare is an aggregation of operational practices brought into being through social interaction with the aim that outcomes are delivered at the individual level to achieve wellbeing and equity, a consequence of which are wider public health and sustainable development outcomes. Such activities take place within the political framework of control and accountability, but it is the action of agency on those constitutional structures that enables governance as action. Rather than co-ordination being a necessary condition of new governance, as Kooiman (2003) suggests, collaboration, in the context of this study, provides both the social glue for continuity as well as the principle enabler of change through leadership, innovation, and learning. Collaboration, it is argued, therefore provides evidence of relational embeddedness in governance.

The symbolic significance of the concept of care within Welsh healthcare governance is apparent within the notion of care pathways, which have been promoted since Devolution as an innovative way of improving both care and individual patient outcomes as well as achieving greater efficiencies. Led by clinical concerns and the need for equity, the pathways approach challenges the existing fragmented nature of healthcare provision that is ultimately attached to episodes of ill-health, individual illnesses and departmental budgets, rather than holistically centred on the patient. Although, in theory, the process approach could have applied across the more fragmented organisational structure that was in place before 2009, the integration of primary and secondary care has removed some of the inter-organisational barriers that existed in providing continuity of care, and therefore provides evidence of government providing supporting structures to enable change to be put into practice.

Evidence of high level political support for process structures is further demonstrated by the 1000 Lives Plus programme and the NCP, each considered to be innovations in care practice. Such support also demonstrates a political commitment to challenge existing behaviours as well as genuine devolution of authority to bring about change.

Although reliant upon collaboration and multi-disciplinary working, the development of process structures is also dependent upon leadership, from practitioners as well as from Boards. Board leadership is practiced by devolving authority and responsibility for immediate care to practitioners, but is also about enabling actors to challenge existing practices, innovate and to learn. Where innovations are developed, the role of the Board can be to mandate, or alternatively to encourage more widespread change. When linked to outcomes, strong Board leadership is demonstrated by LHB X in their organisation wide adoption of a new catering and food service model. Conversely, LHB Z could be argued shows weak leadership in the way that it has failed to develop a best practice model, particularly where the opportunity of new hospital premises presented an opportunity to do so.

Although empowering ward sisters and charge nurses, as devolution of authority to lead and responsibility for patients' care, is a national priority, the nursing profession as a whole has demonstrated leadership in the development of the NCP, and the associated accountability frameworks. The development of the NCP built from others' experiences in the development of care pathways in general, as well as experiences from the FOC, thereby necessitating collaboration with clinical, dietetic and catering professionals. Notably absent from the working group for the NCP, were finance and procurement personnel, although the group included civil servants as representatives from WG, and advisers from NWSSP-FS. NWSSP-PS were, however, within working groups for the other development strands of the FOC. This lack of financial expertise could, however, be considered as positive rather than problematic, as it demonstrates just how quality has been prioritised over cost considerations, although from a structural perspective it could also be attributed to conflicts between professional cultures, an overt political act of exclusion, or a legacy of departmental fragmentation.

The NCP nevertheless demonstrates political and cultural commitment to nutrition as part of care by the nursing profession. The prioritisation of nutrition as part of the nursing dashboard and the development of an agreed metric to link needs and outcomes of quality and safety to action enables performance management for accountability and thereby embeds nutrition in governance. For 'nutritional care' to

be embedded in governance, however, theory suggests that the values associated with caring practice, dignity and respect, need to guide action. Nevertheless, the development of the NCP demonstrates how process structures can accommodate change through learning as a social process, as a consequence of which structures can be adapted without radical reform.

A combination of devolution of authority and resources and collaboration enabled actors within LHB X to develop a more holistic best practice catering and food service model, based upon process rather than function. The intention was to improve the patient mealtime experience, and therefore the effectiveness of the service for patients as well as efficiency outcomes for the LHB, but actual outcomes included much higher staff satisfaction, although some initial resistance was experienced from some nursing staff. Coaching, in the form of awareness training, mentoring by peers and re-framing the meal service as nutritional care, are described as having been effective in dispelling such concerns and putting the changes into practice.

Whilst the NCP is a process structure that affects each hospital patient, the majority of care processes are more specific, but patients' individual needs are met by aggregating bundles appropriate to their needs. Programmes such as the ERAS successfully demonstrate innovation, clinical effectiveness, improved patient experience and economic efficiency, success attributed to multi-disciplinary working between clinical, therapies, managerial *and* finance groups (ERAS, 2012a). Whilst ERAS follows the 'bundle' approach, the core principles have been adapted, refined and put into practice across other areas of elective surgery, demonstrating learning and structural adaptation. The sharing of lived experiences of a particular pathways approach has demonstrated how functional as well as cultural boundaries can be overcome through a focus on the patient, quality of care and a drive to improve efficiency through effectiveness. The outcome of the NCP for the LHB is patient and staff satisfaction, as well as economic efficiency, demonstrated not in terms of cost savings, but in a higher number of procedures and shorter patient stays.

The success of the methodology used to develop process structures for care is apparent in the speed and scale of its development, but also through the institutional commitment to the 'plan-do-study-act' cycle, that enables and encourages innovation. The critical elements of the methodology are, however, leadership and collaboration. 'Starting small' also draws from frontline practitioners' experiences to identify problems and design possible solutions, the milkshake round offering an example of a very simple, small but potentially more widely applicable

initiative. The aim of the methodology is to find the particular process model that identifies and reduces harm and waste and can be managed by establishing variations in practice from clearly defined best practice models. Setting the best practice standards within a quality framework therefore needs to involve all stakeholders, including patients. Resultant innovations need to be shown to be effective and efficient before they are put into practice; effectiveness and efficiency being the primary drivers for wider adoption, actors retaining discretion within the scope of their devolved authority.

The principles of how devolution, collaboration, leadership and learning operate in practice are demonstrated by reference to LHB Z. The reorganisation of food service on one ward in LHB Z was instigated by the ward sister and nursing assistant, but was put into practice by the entire ward team, adapting the previous food service model for the benefit of patients' experience. Staff were not only unanimous in their views of better outcomes in terms of the palatability of the food, but also in terms of the improved ward environment. The more streamlined food service, along with protected mealtimes, released an estimated 20 minutes for staff to assist patients directly, or deliver care. As good practice, the details are shared across the LHB, but adoption is not mandated by the Board, ward sisters retaining the authority to decide whether to bring about changes. Lack of staff was cited as a reason why other wards had not adopted the practice, but as one of the wards who had subsequently adopted it was the admissions ward, with a much more unpredictable daily schedule, such a resource based reasoning appears to be weak, suggesting that behaviour and cognitive issues are contributory or explanatory features of change implementation. Whilst innovation requires leadership, implementation across the LHB therefore requires political and cultural commitment as well as high level leadership.

Leadership is therefore concerned with challenging existing practices. Weak leadership from the Board was demonstrated in LHB Z, which uses a range of catering technologies according to locality, rather than a CPU for meal production. Rather than challenge existing practice to see if things could be done more effectively and efficiently, new hospitals were designed to continue with existing technologies and routines. Catering and facilities staff were consulted, but expressly overruled during the kitchen design in one new hospital, on the grounds of the economic cost of delaying completion, the outcome being an inadequately functioning kitchen and catering equipment, both of which have had to be remedied

at significant cost. The smaller of the two new hospitals within the LHB also has the larger and more effective central kitchen facilities.

The commitment of the Board in LHB X is, in contrast, apparent in the way it has enabled, supported and learned from ward level leadership and collaboration in designing and implementing a new food service model. The direction for a single, standardised catering and food service model across the LHB was led by principles of effectiveness over economy and patient and staff outcomes rather than cost. Weak leadership within governance might therefore be associated with lack of collaboration and a failure to learn.

The essence of the methodology associated with developing process structures is to empower practitioners to challenge existing practices as a way of adding value to the service, with effectiveness driving process efficiency, principles which are equally apparent in the specific example of the yoghurt procurement process described in Chapter 6. The challenge is, however, to broaden their adoption in practice, evidence from the former Catering and Nutritional Framework (WAG, 2002a), the EFPMS and the Sustainable Development Toolkit (WHC, 2007) suggesting that mandating adoption is an ineffective way of ensuring behaviour change, there being no effective means of enforcement.

Coaching and raising awareness are the primary means of disseminating good practice and thereby facilitating learning. Comprehensive internet based materials are available for the 1000 Lives Plus programme, including video interviews with practitioners and evidence of successful initiatives. Good practice examples specifically in relation to the NCP have also been shared in seminars and on the internet, facilitated by the WAO. Specific interactive training resources are also available on the intranet, with all ward staff required to undertake specific training on nutritional screening and care through this medium. Despite assurances, given by the CEO of the NHS to the PAC that training was received by ward staff, the recent RCN policy briefing raises questions about whether, in an environment which emphasises the need to cut costs, frontline staff are actually empowered to use such resources (RCN, 2012). Interviews with key nursing staff in LHBs also suggested that lack of time and the need for computers to be used for clinical matters, meant that other means were being devised in order to deliver the training. Nevertheless, dissemination of peer related experiences, by practitioners, is considered the most effective way of coaching and bringing about change in practice. Coaching, rather than training, provides for an interactive mode of learning and therefore provides an opportunity for reasoning, the outcome of which is an

understanding why change is needed as well as knowledge of what experienced outcomes can be expected from action.

Although MacArthur et al (2012) stress that quality needs to lead economy, and concur that process structures are the most appropriate to deliver best value, they argue that there is still a need to integrate financial accounting practices into the clinical pathways to provide a business case for quality, evidence of economic savings being the most likely driver of wider adoption across LHBs. They suggest that despite the prevalence of process methodologies in clinical governance, NHS Wales' budgets remain fragmented according to departments and functions, which they, rightly or wrongly, attribute to a lack of financial capacity.

7.5 Outcomes

The theoretical framework for governance processes, to align with Pettigrew's principles, separates outcomes from accountability, which also enables differentiation in needs and outcomes to accord with principles of equity. Healthcare provision in Wales, despite being publicly funded, remains an economic activity and as such, needs primarily to demonstrate best value. Best value is nevertheless related to outcomes of quality and patient safety, principles which guide nutritional care as well as the sourcing and contracting of hospital food provisions. Procurement outcomes, in the case of consumable provisions extend beyond healthcare governance structures, and are therefore guided by WG policies, rather than constitutionally embedded within governance. In Wales, policies prioritise the need for social outcomes, which it has been argued includes sustainable development, to support the local economy and the environment. The strategic role of procurement is therefore to align national policy and strategy to action through sourcing and contracting activities. The policy principles of sustainable development and best value are also structurally embedded in healthcare governance, providing the highest form of legitimisation for quality and effectiveness leading cost in both governance and procurement activities.

7.5.1 Achieving Best Value

Despite the political and economic drivers of the organisational reconfiguration, the new integrated structures are essentially a simplification of the pre-2009 arrangements which embody standardised roles and set minimum standards for accountability. Standardised core values supported by a common set of healthcare standards lead subordinate organisations' activities towards common objectives of

quality and safety. Thus there is a high degree of constitutional and process standardisation in healthcare governance in Wales. The rationale for such standardisation is that it reduces inefficiencies, and where underpinned by best practice standards, reduces the risk of harm, improves individual outcomes and therefore ensures a more effective, better quality, service.

Zokaei et al (2010) however suggest that standardisation needs to be balanced with simplification and devolution to bring about effective innovation through social interaction, collaboration and iterative learning, necessary pre-conditions to overcome social and cultural differences and bring about change.

The NCP provides an example of a simplified and standardised process now in place within hospitals, which has come about through devolution and collaboration. It has, for instance, standard documentation, simplified to correspond to, and be integrated with, the familiar medical charts, mitigating the impact of the need for additional recording and perception of increased workload. Despite political and professional support, compliance, as observed in the HIW reports (HIW, 2012a), remains variable, a practical example of weak leadership as well as a deficiency of accountability processes within LHB governance.

The nutritional standards (WAG, 2011), informed by NHS Scotland, have been simplified for Welsh use by dietitians, and is in the process of being integrated into the 'All Wales' menu framework. The recipes within the framework are being adjusted to meet the nutritional requirements, with 67 of the 393 items meeting the standards by January 2013 (NWSSP-PS, 2013). Widely viewed as one of the more significant drivers of the recent changes in the quality of hospital food, at least for those not already using nutritionally assessed recipes, the standards also arguably provide a safety net to protect quality from the more recent cost cutting imperative.

Despite being developed in collaboration between NHS organisations and WG, the technical nature of the guidelines does not relieve existing tensions between portion size, patient appetite, actual intake, and waste. Menu items are nutritionally analysed for a full portion size, and even if a patient has a poor appetite and requests a small meal, a full portion needs to be produced by the kitchen staff to meet the nutritional requirements. Adequate nutritional intake for the most vulnerable is also likely to rely upon between meals snacks. The opportunity to reduce food waste, and thereby cost, is consequently constrained.

Notwithstanding the existing pressure to reduce waste and to contain costs, the emphasis from key actors within WG and across the NHS is emphatically on

nutritional quality as a driver of a holistically improved nutritional care. The cost pressures imposed by the nutritional guidelines by the need to provide between meal snacks has yet to be quantified or experienced, but the menu framework should bring about greater certainty and the possibility of reducing costs within the tendering process. Speaking about the cost of snacks, a catering manager remarked:

> *"On top of that I have to give them the snack. A cheese platter with biscuits and a glass of milk – I've got to cater for that as well – where's the budget coming from? You've got 6 patients in a bay, if one gets a snack and another fancies one, then we've got to give them one."*

Where catering budgets are set according to gross catering costs, however, further economies can only be achieved by cutting staff time, and thereby the quality of patient experience. The adoption of an agreed standardised meal production and food service model, including specification of roles and responsibilities, provides an opportunity to shield the entire NCP from the pressure to cut costs.

The technical nature of the nutritional standards, whilst supporting the effectiveness agenda, does not necessarily support the food lobby in their drive for more fresh and local produce. There is, for instance, perceived to be no scientific difference in nutritional content between fresh, frozen and pre-prepared food provisions. Unprocessed, tinned and frozen products also offer consistency, measurable amounts of salt and sugars, the perception of higher food safety, widespread availability and are more suited to framework contracts. As a catering manager and former private sector chef pointed out during an interview, frozen food is now the accepted industry standard in most high street restaurant chains and should not be looked upon as an inferior product.

> *"I can tell you and I have been in the business for …. years, not necessarily in the NHS, I've been in catering … years and it is very difficult to get a quality plate of food in front of the patient conventionally. This system is the best system, and I never thought I would say that about frozen food, this system is the best system for feeding patients. There is nothing better."*

The industry perspective is, however, driven by the profit motive as a consequence of which minimum standards are set at the level that customers find acceptable, rather than what is necessarily the highest quality. This is arguably mirrored in catering practice with healthcare, with lowest cost a substitute for highest profit.

The recent food scare relating to horsemeat in food supply chains suggests, on the face of it, that food safety is less of a concern to the private sector, or indeed consumers. Apart from fresh beef, pork and lamb, which are routinely tested for safety and DNA, NWSSP-PS rely upon supplier trust for proof of provenance, supported by documentary evidence only where problems occur, and industry certification and inspection for safety.

The use of technical standards is not necessarily compatible with alternative societal interests such as promoting locally produced or the highest quality food. At 1% of LHB expenditure (NWSSP-FS, 2012) the cost of improving the quality of the ingredients for hospital meals is insignificant to NHS expenditure as a whole, but without an unequivocal economic argument linking food quality directly to improved patient outcomes and thereby effectiveness, the principle of increasing expenditure on better quality provisions is highly unlikely to be accepted by Boards.

The development of a standard catering model was driven by concerns for added value through efficiencies rather than the cheapest option, and came about through collaboration across the LHBs, albeit within the confines of facilities management. The cook-freeze regional model was considered by the Catering Group as the overall best value option, taking into account the excess capacity within the existing LHB's CPU. In contrast to the LHB's own competitive strategy behind the expansion of their facility, the catering group recommended a structure based upon partnership rather than simply buying the meals from the NHS owned producer, thereby circumventing EU procurement rules, but also ensuring that economic activity in providing meals remains within the NHS and Wales. This recommended collaborative model, to be based in the existing production facility in South Wales, nevertheless removes further opportunities to use fresh produce, as it has not been designed with anything other than frozen or pre-prepared ingredients in mind.

Unlike the exemplar CPU in Cornwall, now part of the North Cornwall NHS Trust, there is no kitchen space for the preparation of, for instance, fresh vegetables. One informant who had visited Cornwall also expressed concern about the amount of waste generated from raw food preparation, especially when using mechanical means, although no corresponding concern was expressed for the intrinsic material or embodied waste in pre-prepared or frozen produce. Even where meals are produced conventionally within individual hospital kitchens in LHBs, the lack of physical kitchen, fridge and storage space mitigates against the widespread use of fresh or unprepared produce. Catering, procurement managers and policymakers have, however, expressed an interest in developing further the work that one

catering manager has started with the Soil Association and the Food for Life Catering Mark (NWSSP-PS, 2012). Embedding food into nutritional care across Wales has arguably provided a new focus for actors and provided an opportunity to simplify and standardise menus based upon technical considerations, but with quality driving change as effectiveness, following from which efficiencies and new opportunities emerge.

Simplification and standardisation can also empower actors to question existing practices. Within NWSSP-PS standard templates guide each food procurement contract. Rather than merely ensure compliance, the SRA provides a simplified framework that ensures integrity of process. It seeks, for instance, to ensure that due process is carried out in accordance with the regulatory framework, but also that opportunities are identified and acted upon according to the specific nature of the products being purchased. Standardisation and simplification at a more strategic level can therefore be balanced by integration and differentiation of groups of products at a practical level in framework contracts, to enable efficiencies and minimise costs. Pre-contract planning is, however, essential for achieving desired outcomes, the needs of governance processes placing suppliers, as well as patients, as stakeholders within governance. The standard use of qualitative frameworks, in time, becomes second nature and thereby part of organisational culture, as the taken for granted way that things are done.

The simplification and standardisation suggested as necessary is apparent in structures and processes, but the effectiveness in practice remains underpinned by the principles of equity which require integration to be balanced by differentiation. Simplification and standardisation alone do not bring about changes in behaviour, but in practice can reduce bureaucracy, thereby removing barriers to innovation, leadership and learning, but *without* the integration of values and qualitative considerations into processes, economy is, as the trend appears to be, likely to overcome effectiveness, leading to value but not necessarily best value.

7.5.2 Patient Experience of Nutritional Care

Accountability ultimately relates to outcomes and in respect of nutritional care, these are patient experience and equity, delivered through the NCP and supported by the provision of food and fluids.

The measurement and monitoring of patient experience uses well established methods and standardised questions for patient surveys, the results of which show consistently good levels of satisfaction with the food and meal-service. This is

corroborated by the WAO survey of patients who had been discharged from hospital and were not, therefore, under any perceived pressure to provide positive responses. Internal audits are also strengthened by triangulating results with data from other sources. When volunteers have been used to gather patient views, however, surveys have revealed slightly lower levels of satisfaction.

Informants in this research nevertheless expressed a commitment to continuous improvement and management of quality rather than mere acceptance of the qualitative audit data, and the primary reason for adoption of the standard food service and catering model in LHB X was stated to be improved patient satisfaction and the consequential psychological benefits to catering and nursing staff in terms of job satisfaction, illustrated by the following comment from a catering manager:.

> *"…girls who have come from a big industrial kitchen where they have been stood by the side of a large flight dishwasher machine feeding in dirty crockery and cutlery and things – now our job is a lot more meaningful to them, and part of a team, certainly part of a team and very much part of the patient recovery process. That was the whole idea behind it and it is working a charm, because I used to get lots of letters from patients thanking me for the stay, thanking me for the food, and I don't get any letters any more - they all go to the girls, which is great"*

The nature of the NCP is so fundamental to the objective of care, that the overall cost effectiveness is not being questioned by actors. Although this may be attributable to lack of financial management capacity (MacArthur et al, 2012), this has not prevented the development of the pathway and associated performance management tools. This does, however, displace pressure for cost efficiency onto catering and contracting operations to ensure that economic efficiencies are being obtained.

7.5.3 Supply Chain

> *"I think you have everything that is good and wrong in catering at the moment. I think there is great scope for improvement in the way we purchase local products and working with growers to make the best of what's available – reducing food miles. I don't think that's anyone's priority and never has been and I don't think it will be for a while – there are other things they want to get right first. …….. it will become the norm. But I think it's the 'All Wales' approach that really kicks people up the backside." (Caterer)*

Despite some evidence, within the design and delivery of in-house healthcare, of economy in society rather than in markets, the actual outcomes of governance activities in procurement remain at the mercy of commodity markets. Procurement, as the purchasing of goods and services outside of the public sector links state actors with markets. With services, appropriate structures can be legitimately used to retain strong constitutional ties with service providers, but those structures are unavailable for the purchase of consumables, such as food. Although the structures of commodity markets can be accommodated in procurement through creativity and collaboration in planning, market effects on product availability and prices can mitigate against the use of locally produced food.

The response from NWSSP has been political. Where local food is available, contracts have been planned and designed to accommodate particular market structures. For produce for which there is no local market, then local wholesalers have been successful in winning tenders, although there can be unintended consequences that ultimately mean that the full economic benefit of sourcing locally cannot be retained within the Welsh economy. WG policy for food is to re-localise food supply chains (WAG, 2009b), but with local food production largely confined to meat and dairy products, the scope to purchase food produced in Wales is constrained. A catering manager interviewed as part of this study tried, for instance, to provide a special St David's Day menu for patients but was unable to do so as she was unable to source particular vegetables produced in Wales.

The influence of external markets on lamb prices in particular, is a constraint on the inclusion of Welsh lamb on hospital menus, although informants in this study felt they could have bought Welsh lamb more cheaply locally than on the national framework contracts, a point demonstrated during the recent BBC programme "Operation Hospital Food" (BBC, 2013 26.2.13). The price of lamb is, however, such that it does not, irrespective of origin, feature regularly on a nutritionally compliant Welsh 'Public Plate' in the NHS, despite the presence of lamb recipes on the menu and procurement frameworks. With no nutritional benefit over the alternative, cheaper Welsh beef, the local economic argument is that the beef industry is equally entitled to be supported by the Welsh public sector. Security and consistency of supply is essential to the efficiency and quality of meals produced in, for instance, the NHS, which promotes the use of frozen and tinned produce.

The Welsh Government, rather than individual organisations, is considered by actors to be the appropriate body to be developing larger scale new market opportunities, yet there is no current work in progress in VW in respect of food,

despite the level of demand from public sector purchasers. One informant offered the opinion, in respect of VW, that *"one aspect of it which they have left off food is some elements of fresh food, because they believe that it's in the too difficult to do box"*.

The procurement of yoghurt demonstrates how NWSSP-PS have identified and taken the opportunity to innovate by challenging previous practice. Anticipating the need for a more fragmented supply network, the planning and design stage was carefully managed to align with the expected market structures. In the end it was the technical standards that effectively excluded three SMEs, although the winning tender, also a SME, was able to meet the standards. That particular SME is also working closely with a LHB and the CAG in further product development.

SMEs, despite being local producers or wholesalers, are themselves vulnerable to global market structures. Welsh Country Foods, which is the wholesale supplier of the NHS Wales meat contract in North Wales, employed 310 local people until April 2013, when its parent company, the European Vion group, closed the abattoir and lamb processing division (Vion, 2013). This was attributed, by the company, to the loss of a major contract with supermarket ASDA, who negotiated a new supply contract with an alternative producer in South Wales. Economic losses, as a direct result of the closure, are to the local community and the Welsh economy. 64,000 Welsh lambs are reported to have been purchased annually by the company, direct from Welsh farmers, providing the Welsh Meat Promotion body, Hybu Cig Cymru, with an estimated at £0.5m annual income from slaughter levies. Lack of local alternative slaughter facilities could see the point of slaughter levy move to England, and will inevitably result in increased food miles and risks to animal welfare as locally reared animals will have to travel further and possibly to England, for slaughter (FW, 2013).

Similar contradictions are apparent from the yoghurt procurement process. One of the suppliers of non-patient yoghurt is an international brand, uses milk from Wales and is located on the English side of the Welsh border. The ownership structure will inevitably result in a leakage of profits outside of the UK, but local employment, including in Wales, is supported by its supply chain.

However local sourcing policies are embedded in structures for consumables, purchasers cannot ultimately protect against markets and any consequential leakage from the local or regional economy. Ultimately this is not, as often claimed, a constraint of EU law, as the principles of fairness and transparency are implicit in

governance structures and activities founded upon principles of equity, fairness and democracy. Changing practice is therefore about how processes are carried out.

7.6 Ensuring Accountability through Governance

Despite the inference in the structures of the NHS in Wales that the main concerns within governance stem from devolution and collaboration, there needs to be a robust system of accountability to ensure that governance actually meets needs, delivers the required outcomes and resources are used effectively and efficiently.

Accountability in the NHS in Wales comprises a framework of standardised processes of self-regulation, external accountability to government and citizens through audit, inspection and public reporting. The drive for continuous improvement has, however, steered practice from a narrow managerial perspective towards governance in an altogether more democratic process where there are multiple modes and loci for leadership, innovation is welcomed and learning is accepted as best practice.

A transition towards process structures and the need to demonstrate continuous improvement have, in practice, been steering mechanisms towards performance management as part of the accountability framework. The move from operational to quality and then excellence as drivers within the delivery frameworks is symbolic of transitional change, but also of adaptation and learning. Leadership is provided from WG, but the detail of accountability mechanisms and metrics are defined through collaboration, with responsibility for measuring and monitoring performance and taking corrective action devolved to LHBs and Trusts, and ultimately to ward level and the respective professions. Clear direction and structural responsibility is therefore essential, but not necessarily the only concern. Registered nurses have operational and professional responsibility for nutritional care and catering managers for the quality of the meals they produce. Procurement personnel are ultimately responsible for ensuring correct and legal processes are used in setting up and awarding contracts, with dietitians and catering managers taking responsibility for quality within contract specifications, guided by procurement on cost and purchasing outcomes. Thus nutritional care becomes a collective responsibility, provided that the culture supports collaboration rather than competition and blame.

The NHS operational frameworks are intended to provide guidance for action by setting out expectations for service delivery as a process within governance. Ensuring that the technical and process standards underpinning accountability are

devised through collaboration with practitioners is an essential part of a largely devolved regulatory regime, the theory being that such measures instil confidence and are more likely to be adopted and used. The Welsh Government Standards Board (WGSB) provides independent validation of appropriate metrics and was used for the nursing dashboard, although notably not the revised EFPMS data definitions. Although informants involved in its development were critical of the time WGSB took to ratify the dashboard metrics, they were supportive that they ensured that the standards were relevant, achievable and appropriate.

The service frameworks themselves have been simplified and standardised to reflect core principles and thereby accommodate complexity, but are not necessarily or simply a matter of devolving budgets and responsibility supported by guidance. Standards are key components of the regulatory frameworks as a consequence of which they are part of the constitutional structure of healthcare governance. Unlike the rigid constitutional healthcare governance structures, however, the operational frameworks allow flexibility and thereby equity, which also requires accountability to *multiple* stakeholders within and outside of the respective organisations.

Accountability in practice is for the quality of the care of individuals, their families and communities as well as to government. Government has ultimate responsibility to citizens, for the way in which it chooses to deliver and support healthcare as well as how it allocates financial resources between the various activities in governing. These accountability principles apply equally to all stakeholders. The transition to public health is beginning to place more responsibility on patients and their families, especially for their own nutritional care, indirectly by providing quality bedside menus, public displays of the food and fluid chart guides for health promotion, or more directly through involvement in recording patient's own food and fluid intake, in hospital and in the community. This emphasis on accountability as self-help, or co-production, was viewed by Wanless (2003a) as essential to overcoming the dependency culture of Welsh citizens and the transition to a public health system based on prevention. Thus accountability in governance is relational with an element of mutual or institutional interdependency as envisaged by Engster (2007).

7.6.1 Public Accountability through Audit

The formal structures supporting accountability are those of audit, primarily internal as part of self-governance, with independent scrutiny as the main central and public control mechanism. The role and scope of internal audit within LHB governance is effectively mandated by government through standard SOs, SFIs, model terms of

reference and healthcare standards. In practice, these standards are developed in collaboration through multi-disciplinary groups, and are supplemented by metrics and management tools developed by the respective professions, as experts in their field. Formal mandated audits are supplemented by in-house food quality audits, devised within the respective LHBs. LHB Z, for instance, ensures that one third of its wards are inspected for food quality and patient experience over the course of a year, the inspection team involving a member of the CHC, with other staff encouraged to participate to provide alternative perspectives. Board members also take part in informal walk-round inspections.

Accountability is also demonstrated through the professional route by a clear line of accountability for the quality of care within the nursing profession, nurse directors holding responsibility to their Board and to the CNO. Public accountability, in accordance with the need for transparency, is put into practice through publication, the results of FOC audits, annual reports and the intended annual governance statement providing examples (WAG, 2011; WG, 2012g).

Powers of unannounced inspections, as a more robust form of external scrutiny, lie with the CHCs and HIW. The CHC inspection methodology has also been amended to conform with recommendations by the OPC, who has made a significant contribution to the accountability framework through their focus on dignity in care of older people. The role of audit by these bodies is to ensure patient safety and experience objectives are being met, the WAO audit role being more aligned with a broader governance perspective that includes financial accountability. HIW have also undertaken a pilot governance review of Cwm Taf LHB (HIW, 2012). LHB and Trust responses to audit take the form of action plans, internal governance processes providing the only means of ensuring timely and appropriate action is taken.

The application and greater efficacy of the external audit framework is apparent in the case of the NCP. Although already within their programme for thematic inspections, the WAO delayed their Hospital Nutrition and Catering audits to allow the pathway to be put into practice. The aim was to carry out audit inspection, interviews and examine documents, but in a departure from previous practice to gather a wider range of comments from the public through an on-line questionnaire, with participation widely promoted by societal groups with an interest in patient care. The focus of the audit was the whole nutritional pathway, including procurement, catering management, and food service and sought to see whether the nursing elements of the pathway were being embedded in practice, the quality of the food

was adequate and there was appropriate accountability for catering expenditure. Little comment was made specifically of the procurement role or supply chain outcomes, other than stressing the need to promote Welsh local sourcing policy. Although there was a detailed and comprehensive audit methodology, the guiding standard agreed between the team was based on the qualitative, but inherently subjective, principle of "*would my mother approve*" (key informant). The planned and agreed inspection programme was subject to last minute changes to the ward schedule, which gave the effect of the inspections being unannounced. Some continuity was provided as the team included at least one member who had been on the inspection team in 2001 (AC, 2001; ACW, 2002).

By the time the 'All Wales' report was published (WAO, 2011a) LHBs were actively working with the WAO together in meeting the recommendations. Specific guidance was produced by the WAO in the form of leaflets for both patients and Board members (WAO, 2011b, 2011c) and key accountability recommendations related to compliance with nutritional assessment recording, a continuing problem highlighted in the later reports by HIW (HIW 2012a), as well as the financial accountability for non-patient food subsidies and waste. To assist the LHBs, the WAO held a shared practice seminar which enabled practitioners to share their experiences through case studies, some of which remain on the web based Good Practice Exchange facility hosted by the WAO. The seminar had 60 attendees from across Wales. 26 case studies were made available through the web portal, with examples of innovation as well as good management practice. Many of the examples shared followed the 1000 Lives Plus methodology, and originated at ward level or were directed at specific patient groups.

Although external inspection and audit reports are routinely published, the publication of individual LHB audit reports by the WAO demonstrates a move towards greater transparency. Rather than remain hidden within the LHBs own, albeit publicly available, internal systems, the action plans for the HIW dignity and essential care inspections are, with one exception, available on-line alongside the respective HIW reports. Publication of internal audit data, such as the FOC, is also a relatively recent initiative (WG, 2012).

The external audit regime itself is promoted by government as an example of collaboration that promotes efficiency by reducing duplication. Although the audit processes consider quantitative and qualitative data, the methods employed rely heavily upon periodic sampling methodologies, and in the case of the Hospital Nutrition and Catering audit by WAO, financial data provided by LHBs for the

EFPMS. A further weakness inherent in the external audit accountability framework is that the various reports provide only a snapshot view rather than a basis for managing healthcare processes and functions effectively or efficiently. As such they are primarily a checking mechanism, rather than a substitute for performance management, but perhaps more significantly in terms of patient outcomes, focus on effectiveness and efficiency, rather than necessarily lowest cost.

Nevertheless, the timing and co-ordination of the various audits that include elements of nutritional care has served to reinforce the need for effective accountability by continuous improvement. The relative strength of the WAO is that their recommendations actually hold the NHS and WG to account in the NAW, but the continuous improvement and development of governance within LHBs remains devolved to those organisations.

The weakness of a regulatory framework based on standards and audits is that they tend to promote incremental change within organisations, although any more rigid central regulatory control could quite easily constrain innovation. Conversely incremental changes can endure, and the triangulation of inspections and reports within the collaborative audit regime provides an environment that can monitor improvements.

Audit and annual reporting are also intrinsically historic, which allows for reflection but is nevertheless detached from any notion of demonstrating that organisations are continuously challenging their existing practices. As a consequence, the regulatory framework is heavily dependent upon the respective bodies' own integrity in governance. The use of public reporting places information in the public sphere and enables comparison between organisations, but remains a weak driver of change. Self-accountability ultimately lacks sanctions and carries the risk of being self-promoting rather than critical about existing practice.

7.6.2 Demonstrating Continuous Improvement by Performance Management

The political emphasis on continuous improvement is concerned with challenging the way things are done as a more fundamental approach to bringing about effectiveness and efficiency. Performance is expected to be managed by benchmarking and is promoted as the means of identifying variance from best practice, thereby eliminating waste on unnecessary or duplicated actions, and causing harm in healthcare processes. Where best practice is clearly defined and an appropriate metric agreed, those metrics can form the basis for benchmarking,

but to ensure actual, if incremental, progress, the metric has to be relevant and linked to action. Thus change co-exists with continuity, in healthcare clinical leadership innovating for fundamental change and management measuring and monitoring progress.

The major innovation within healthcare governance in Wales has undoubtedly been the drive towards process rather than more traditional task or transactional based governance structures. In order to ensure progress, however, performance needs to be continuously measured, monitored and variance used to identify weaknesses and appropriate action taken *in a timely manner.* In practice, however, accountability remains broadly based on the functional paradigm. Although the external nutritional audits (WAO, 2010a) were framed by the NCP, existing accountability structures remain fractured between nursing, catering, facilities and procurement, there being no connection between FOC, EFPMS and procurement performance. Although this perspective recognises processes as discrete, objective entities, it lacks the process thinking that Senge (2006) and Seddon (2008) link with the concept of the learning organisation, or indeed a process of organisational learning.

The fragmented nature of accountability, even where continuous improvement methodologies are employed, is also apparent within the NWSSP, where external accreditation standards are used to demonstrate compliance with industry standards and continuous organisational improvement processes. As can be seen by the differences in external accreditations between the divisions of the NWSSP, such schemes rarely cover all of the activities of an organisation.

The original sustainable development toolkit (WHC 2007.034) was mandated as a managerial aid to enable continuous improvement across healthcare, but there is no evidence that it was used in practice. The toolkit effectively abdicated the responsibility for sustainability in procurement to NWSSP-PS, who use the SPAF to measure their own sustainable procurement performance. The managerial perspective embedded in these tools breaks an organisation's activities into tasks, measures compliance with standard procedures, or seeks opinions of customer satisfaction. As such they actively seek to provide a view of continuity and incremental linear progression within the organisation, but also provide the structural basis for political behaviour in prioritising which area to target for change. Inevitably those that are more difficult, or not likely to have any significant impact on organisational performance, will be relegated to the 'unfeasible' category enshrined in HM Treasury's Green Book (HMIT, 2007) following the private sector practice revealed in the study by Rimmington et al(2006).

The EFPMS was an early performance management initiative, developed following the 2002 Nutrition and Catering Framework. The 2011 WAO audit highlighted, however, that it was not actually used by LHBs and questioned whether it was fit for purpose, implying that the metrics were inappropriate, irrelevant or even that the EFPMS itself was out of date. The subsequent, perhaps rushed, response to the WAO report and impending PAC was to revise the metrics used rather than ask any challenging questions about the purpose or relevance of the system itself. Rather than address the appropriateness of the metrics, the review became an exercise in manipulating existing data, rendering the system ineffective for cost management purposes. The revised metrics do however enable benchmarking. Cost data is now more transparent, as the agreed metrics are published on a hospital by hospital basis rather than as aggregate figures.

The revised data definitions demonstrate compliance with the PAC recommendations but do not represent any fundamental review of the system. The revisions to the cost of meal production, for instance, removed any regeneration or ward based staff costs, the area where there are differences in practice at hospital level, and where nursing, catering, and hospitality staff are employed to differing degrees. In addition, the requirement to account for non-patient catering subsidies has resulted in many LHBs apportioning the patient costs from the global catering and provisions costs, those apportioned figures being neither consistent within the LHBs, nor with the figures actually measured in other LHBs. As a consequence the comparative element is not that of actual cost. The data available for comparison, where apportioned from the whole rather than measured, is therefore open to manipulation depending upon the preferred outcome, which at the present time is the reduction in the cost of over-catered waste.

The rationale for the requirement for financial accountability for the cost of avoidable food waste is financial rather than environmental. The measurement of served but uneaten food waste, whether by means of observation of the plated left-overs or by consideration of the food and fluid chart data, is however considered unethical, due to the many personal and medical related reasons why patients do not to eat the meals they have ordered or are given. Merging the nursing and catering data could however provide a measure of the effectiveness, if not cost management, of the integrated nutritional pathway as a basis for performance management.

The apparent inability to properly manage catering costs was highlighted by the WAO (WAO, 2011), and is aptly demonstrated by conflicting figures from NWSSP-FS, NWSSP-PS and responses to official information requests. Although NWSSP-

PS were able to provide figures to WG for expenditure on the 'All Wales' central contracts, the large gap when compared to expenditure stated in the EFPMS suggests that there is a need for greater accountability, notwithstanding some of the gap can be attributed to NHS Supply Chain collaborative contracts. Despite being praised for the catering management system in LHB Z, they were, for this study, unable to *readily* identify how much they had spent on each of the 'All Wales' contracts over a financial year. A similar response was received to a request for data from procurement personnel within LHB X. Neither financial accountability, nor performance are linked holistically to any need to measure how hospital food procurement is actually contributing to other WG policy areas, such as local purchasing.

The move to an integrated standardised, nutritionally assessed menu framework and to a single best practice catering model should provide an opportunity to remove the potential for difference in terms of the cost of providing and serving patient meals, leaving the differences that can be effectively managed by LHBs as compliance with nutritional assessment and action taken, volume, or cost of waste and percentage of local purchasing, in a more valid process based performance management system. As MacArthur et al (2012) point out, financial management within NHS Wales has retained its functional perspective, which they attribute to tradition, rather than culture, and the fact that financial managers allocate budgets on a project, departmental or task basis. Lack of financial capacity is proposed as the reason why, despite consensus that the pathways approach is more effective and more efficient, costs are rarely measured in this way.

7.7 Demonstrating Sustainable Development and Best Value through Governance

The emerging mechanisms, as part of an explanation of change, have been brought together for critical discussion in this Chapter. Governance is proposed as the primary mechanism of change at a strategic level, as a process whereby the action of agency on structures over time shapes change. This is apparent as the multiple embedded processes of sourcing and contracting, the governance of nutritional care in hospitals, healthcare governance and the governance of public services in Wales, where planning and accountability are guided by a common set of related values that have steered change towards a focus on care.

Thus the dynamic nature of processual governance encourages and accommodates change, the cumulative effect of which is of considerably greater importance than

individual actions. Hospital food, for instance, has become part of nutritional care, and food, as nutrition, is becoming embedded in other, discrete, healthcare processes. These processes are individually and collectively conditional upon a more enduring constitutional framework which sets the rules of the game: the political expectations and regulatory and ethical frameworks for action.

Radical constitutional changes in recent years have been planned and implemented by WG, as a constitutional stakeholder in NHS Wales, but after consultation with other stakeholders, in practice perhaps representing a relatively weak form of collaboration with experts and citizens. Nevertheless, within those constitutional structures, practitioners have been leading change in the planning and development of healthcare delivery, enabled by the devolution of resources and authority, but put into practice through leadership, collaboration and learning.

The ethical framework demonstrates a value set that operationalizes the primary ethical requirement for equity, and thereby social justice and sustainable development. Although there is no evidence of a culture of care as part of a moral economy, there is evidence of service provision being structured around care as an institutional process, rather than treatment as function, thereby enabling the re-framing of patient meals as nutrition and embedding of nutrition in care.

Accountability structures have also shifted from an alignment with function, firstly towards process in the case of the WAO and values and process in respect of HIW, OPC and CHCs. This re-orientation to process has shifted the model of accountability towards performance management as a continuous process of improvement. Transparency in reporting is considered to be the most appropriate means of demonstrating sustained improvement based upon governance outcomes of best value, where qualitative outcomes of effectiveness lead economic efficiency as a reduction in waste. Although the reliance remains primarily with self-assessment, this is supported by a regime of external inspections, based upon dignity and respect, and clear constitutional responsibility for equity, sustainable development and best value.

The constituent parts of the constitutional governance framework identified from the literature are apparent in the governance of healthcare in Wales, the governance of nutritional care in hospitals and in the procurement of food. As a result of the research, however, the heuristic for governance processes can be refined to include planning, a stage in process informed by multiple stakeholder needs which

precedes action and thereby embedding continuity as well as action, in micro-processes of governance (Figure 36).

Figure 36: A Refined Theoretical Framework: Governance of Nutritional Care (Source: Author)

At present, governance is driven by qualitative clinical concerns for quality and safety, as the effectiveness of healthcare processes. Concerns for the future are, however, not only to expand the adoption of best practice models, for both effectiveness and efficiency, but to mitigate the effects of economic pressures on nutritional care. Although this research suggests that there remains scope to achieve and demonstrate greater efficiency by reducing systemic and physical waste, some of which can be brought about through standardisation and adoption of best practice in catering, greater integration of the currently separate accountability frameworks could produce valuable data to support or question present practice. This lack of capacity to learn is arguably linked to leadership, but highlights the simultaneous need for collaboration as a necessary condition of change.

Strategic change, in this context, has been brought about through governance, by restructuring from function to process and aligning values with needs and outcomes, in a continuous process of planning and accountability.

CHAPTER 8
Conclusions

8.1 Introduction

The critical realist perspective is the key determinant of the methods adopted for the entirety of this study, which as Yeung (1997) and Reed (2009) argue represents both philosophy and method, although such comments are arguably only applicable to a retroductive approach based upon morphogenesis and therefore the dualism of structure and agency. As a deeply analytical approach, retroduction enables structures and agency to be separated, events placed in context and time, and the relative power between structures and agency at any one moment can be uncovered as part of the explanation.

Without the deeper analytical approach of retroduction, the enabling powers of particular structures and the emergence of process as an alternative structure to hierarchy, network and market, are likely to have been lost within the discourse. The critical nature of the methodology also enables the key research findings to be related to policy and practice through the logic of enquiry that links sustainable public procurement, as an ill-defined construct, to a process of governance, represented by a cycle of needs assessment, planning and accountability for both action and outcomes.

This study has primarily demonstrated that the interactions between structures, as separate but real objects of analysis, as well as the actions of agency on those structures collectively explain change. The importance of structures is that they drive and legitimise action, thereby enabling innovation, but also attach accountability to roles, rather than corporate entities. In addition, the relativist approach to the research has advantages over both positivism and constructivism in that it enables theoretical propositions to be tested at an individual, organisational and institutional scale without being constrained by the boundaries of phenomenology and a one-dimensional ontology.

This Chapter is structured around the research questions, the' what why and how' of change, followed by consideration of the future challenges to hospital based nutritional governance within a publicly funded healthcare system.

Restructuring organisational functions to organisational processes, in this case from food as a hospital meal service to food as nutrition embedded in care, is shown to

be necessary in order to bring about change. A more laissez-faire approach that relies solely upon agency to bring about enduring change perhaps lacks the legitimacy that structures provide, suggesting that at an individual, as well as institutional level, structural empowerment is a necessary pre-condition of change.

Although there has been political concern for the cost of the NHS since its conception, the drivers of change in practice have been quality, safety, availability and cost. The dualism of best value and sustainable development is, however, evidence of the political and economic tensions that prevail and influence governance processes. The pressure remains, for instance, on caterers to constrain or reduce costs, without detriment to the quality of nutritional care and patient experience. Such tensions are also apparent within the constitutional structures, the quality of care driving clinical governance, and cost reduction the operational support provided by NWSSP. To date, however, the structures have supported the qualitative agenda, most recently apparent in the integration of the nutritional standards in the development of the 'All Wales' Menu Framework.

The differences highlighted in the evidence presented in this thesis suggest that although governance is the mechanism for strategic change at an institutional scale, explanation also lies within behaviour at an individual level. Differences have, for instance, been shown to exist between wards in the same hospital, the level to which authority, responsibility and resources are devolved. Consideration of these individual factors is therefore a significant part of any explanation of change, and is considered in 8.4, drawing from Engster's (2005, 2007) relativist, or processual approach to political and moral theory and care.

Future concerns echo the past as the tensions between effectiveness and cost efficiency, the balance perhaps shifting towards the latter, reducing budgets challenging the ability of the healthcare system to meet demand. Nevertheless it is proposed that by embedding principles within governance as structure and action, adverse changes are perhaps easier to resist, and non-participation more difficult to avoid.

The Chapter concludes by considering the contribution of the research, to academic debates, policy development and practice, and provides reflections on the research and its limitations, suggesting some future research avenues that have emerged from this study.

8.2 What changes have been made in the governance of hospital based nutritional care?

The transition within hospital food provisioning in healthcare governance in Wales has been from that of a meals service, to one of nutritional care. Although the cultural transition that would be demonstrated by caring, as taken for granted behaviour, has not yet been achieved, the governance structures and service delivery frameworks have been put in place to steer future governance in that direction.

The planned restructuring of the constitutional structures of healthcare has simplified and standardised healthcare bodies as well as individual and collective roles and responsibilities, which has, in turn, enabled, if not yet put into practice, continuous performance monitoring and therefore timely and appropriate management interventions. The political focus on equity, the patient and wellbeing, links needs and outcomes. This has been enabled by restructuring healthcare delivery from a fragmented functional structure to one of integrated process that structurally links multiple activities. Thus values and individual needs are being integrated into operational frameworks, but critically in terms of this study, have enabled hospital food to be integrated into nutritional care. Food, as nutrition, is becoming structurally embedded in governance through a number of care-related processes.

Quality and Safety in patient outcomes, and effectiveness and efficiency in organisational outcomes, are the drivers of change. The activities of NWSSP-PS are guided by their stakeholders' values and aims, historically through the CAG, but now structurally through the more recent stakeholder Board. Although part of a separate organisation, procurement activities are linked by the structural process of the NCP. Where best practice is in operation, nursing and catering activities within hospitals are integrated as a strategic demand process where needs of stakeholders and the need to buy are addressed in the planning for procurement of food provisions. The food procurement process, as sourcing and contracting, is, however, constrained by the fact that food provisions are consumables, and as such market exposure and therefore market structures for particular products are a significant constraint on purchasing activities being able to achieve desired supply chain outcomes. As a strategic process within healthcare governance and part of an embedded structural process, ensuring best value follows the dominant logic of effectiveness resulting in efficiency and legitimises the adoption of the same value set in procurement practice.

8.3 Why have those changes been made?

Evidence of the need for change is both contextual and historic. Concerns about patient centred services are espoused by all UK healthcare bodies, along with the need to constrain costs. Within Wales, however, there is also a constitutional commitment to sustainable development, with a more recent trend towards defining sustainable development as a social, rather than economic or environmental policy concern. Nevertheless, there has been a clear trend in government directives from the need for cost containment to one of cost saving, the simplified constitutional structures of the NHS in Wales radically reducing bureaucracy and associated costs, rather than solely for political gain. The separate structuring of support services, such as procurement, has reinforced the strategic role of procurement above and beyond sourcing and contracting, although within the NCP there is scope for further strategic activity in terms of performance management and efficiency cost savings.

The politics of the constitutional re-structuring are arguably that of keeping NHS Wales in public ownership, the highly integrated, standardised structures within governance a stark contrast to the disparate healthcare organisation in England. The rejection of competition, in favour of reinforcing the existing collaborative relationships within NHS Wales is primary evidence of such behaviour, although there are arguments that benchmarking performance is essentially a competitive strategy that can set informal 'average' targets, rather than motivate continuous improvement. This political imperative for public ownership is not, however, synonymous with direct public provision, discrete healthcare processes, or functions such as meal production, easily identifiable units for contracting to commercial concerns. Strategic planning for procurement, in particular central policies and the choice of structures, are critical to prioritising quality over cost within EU regulation and therefore maximising social policy and local economic objectives.

The changes that have been made within healthcare governance are, it is argued, primarily economic and political, with an increasing emphasis on the economic as a driver of future practice. This places particular pressure on catering and procurement to demonstrate cost savings, lack of capacity for process accounting hampering financial accountability in clinical pathways, although within the domain of nutritional care the nutritional standards are a qualitative driver of economic savings through simplification and standardisation. These principles are expected to apply despite the relatively modest cost of catering operations.

8.4   How have those changes been brought about?

This study has demonstrated empirically the strengths and weaknesses of healthcare governance in Wales. The power of the constitutional structures of governance is in directing and supporting change, but is also dependent upon the embeddedness of constitutional processes within the constitutional structures of governance. The efficacy of governance in an institutional context, as with healthcare, is therefore reliant upon needs, actions and outcomes based upon an interrelated set of values. There is however, a separate role for planning, as an interim stage preceding action, and a mechanism for providing stability and continuity within governance.

The evidence of efficacy is demonstrated through accountability structures. In the context of this research, strategy is aligned with equity in order to meet individual needs and achieve public health outcomes, actions are based upon principles of dignity and respect, with material outcomes for patients of quality and safety, and for governance, including embedded processes such as procurement, effectiveness and efficiency.

The changes within healthcare structures and the transition from hospital meal service to nutritional care have been brought about by the multiple actions and interactions of agency on the multiple structures of healthcare delivery, underpinned by shared values, but critically a culture of collaboration, rather than a culture of care. This structural role of nutrition is also apparent in the context of the study, healthcare governance from its emerging role within other care processes.

Changes have been radical in terms of the structuring nutritional care around care processes rather than a meals service, with associated process thinking demonstrated in some, but not all, catering and food service operations, and in sourcing and contracting processes. Incremental change, as in adapting processes for service delivery to improve effectiveness and efficiency is also apparent.

Structural enablers of change within the governance of nutritional care have been devolution of authority, balanced by clear responsibility and lines of accountability; integration, also balanced by differentiation to achieve equitable outcomes and standardisation, qualified by simplification for efficiency. Social enablers of change have been leadership, in conjunction with collaboration and learning, an outcome of which can be innovation.

These key variables in governance provide only a partial explanation of change, as all are insufficient, in isolation, to enable positive change. Devolution of

responsibility for instance, needs to be accompanied by resources and powers, and does not necessarily attach any form of accountability. Actions resulting from devolution have also been shown to be conditional upon collaboration. Integration, although achieving simplification, must be balanced by differentiation to ensure equitable outcomes, and is put into practice through multiple frameworks, for service delivery, the menu framework and the procurement frameworks. Likewise, effective outcomes from social processes have been shown to require leadership, collaboration and learning. Examples where any one of these is missing provide evidence that the adoption of best practice is either sporadic or only partial.

Evidence also suggests that the locus of difference is at ward level, where nurses have constitutional and process responsibility in governance for patient nutrition. Empowerment of nurses was a political aim of 'Free to Lead Free to Care' (WAG, 2008; 2008a). The multiple loci of leadership and innovation uncovered by this research support this argument, as many of the changes that have emerged are as a result of individuals and groups being empowered to bring about change. Conversely, lack of empowerment at ward level has been highlighted in external audit (WAO, 2010a; 2011a).

The political framing of empowerment in this context is, however, one of structural empowerment, as in devolution. Pre-conditions for structural empowerment being put into action suggest that devolution needs to be of authority, responsibility and resources. The evidence from this study suggests however, rather than resources of staff or money, time is the principal resource need for qualitative outcomes. This goes some way to explaining why there remain differences in practice, but also suggests that although empowerment is a necessary condition of change, there are potentially other, cognitive factors that enable or constrain changes in practice.

Cognitive resources relate to perceptions and can derive from meaningfulness, competence, self-determination and impact (Lee and Koh, 2001 p.686). According to these authors, there is consensus across differing branches of psychology that competence relates to self-belief, in terms of perceived capability to perform with skill, but they also argue that the psychological concept of empowerment is relative, rather than absolute, and as such is both structural and relational. Preuss and Walker, from the supply chain management perspective, highlight the importance of structures, but also conclude that education and communication are key enablers of change (2011). Although they do not associate this directly with empowerment, they observe instead that change is a matter of adaptation, thereby linking their conclusions to process and governance.

This research suggests, however, that confidence, either 'self' in one's own ability, or that there will be an appropriate leadership and learning response to action, are significant cognitive factors that drive individual and collective action. This is aptly demonstrated by the efficacy of the nursing forums, which enable senior nurses to mentor inexperienced ward sisters and charge nurses on matters such as how to assert authority to enforce protected mealtimes.

This discussion therefore suggests that structural empowerment precedes cognitive engagement, followed by action, but that a more integrative concept than empowerment, such as that of capabilities, explains how change is brought about from an institutional perspective.

Engster presents a case for a political theory of justice founded upon the concept of capabilities (2004; 2005; 2007), which was argued in Chapter 1 as a moral foundation for sustainable development, based upon a political and ethical concern for care as an economic activity. He refers specifically to Sen's (1993) conception of capabilities as the interplay between opportunities and internal capacities creating the ability to choose and freedom to achieve. The concept of capabilities therefore links structural empowerment, as devolution, with the cognitive dimension, as internal capacity, with the specific behavioural dimension of caring as an economic activity. Although Engster's political theory of justice relies more on Martha Nussbaum's writing and natural law theory, the differences between the two are considered by Alexander (2008) to be a matter of abstraction, Nussbaum being more helpful in developing a substantive political theory (2000). Nevertheless, Sen's own writing on justice (2009) is also concerned with process rather than structure, justice being a relative concept which is aligned with the principles of equity, thereby differentiating individual and collective capabilities over time, rather than necessarily being a matter of individual concern, or indeed being fixed in time.

This process view of capabilities suggests that lack of structural empowerment, as a pre-condition for cognitive empowerment, denies the freedom to choose, and therefore realise those capabilities. Action, in a processual dimension, further suggests that needs and outcomes can be continually re-determined according to principles of justice, as equity. Ultimately, however, the concept of individual and collective capabilities is reliant upon the realisation of choice.

Resolving issues related to lack of capabilities requires structural and social responses. Responsibilities and values can be clearly defined and mandated by embedding principles in constitutional structures, although effectiveness can only

come about where general principles are operationalized. Action can be assured in structures through performance management. Ensuring action, as desired behaviour, can be brought about through reasoning, as part of coaching, in order to enable understanding. Although Mannion et al (2005) suggest inculcating values is an appropriate strategy for developing culture change, such actions are more aligned with teaching, and perhaps coercion or mandate, which has been shown to be ineffective in bringing about behavioural change.

In more general terms, the changes that have, and continue to be, brought about in the governance of nutritional care in hospitals in Wales, have done so as a consequence of governance. Healthcare governance in Wales is a complex system of constitutional structures, within which the NCP is an example of one objective process, and nutrition is embedded in care through clinical governance. Action in governance is, however, brought about through the interaction of multiple actors with those structures, which in turn are adapted in order to accommodate emerging needs and desired outcomes, but within a planned and relatively stable constitutional framework.

8.5   What are the Governance Challenges of Implementing 'Sustainability' in the context of this study?

Although appearing to be political responses contained within Wales, many of the structural changes that have historically been brought about in NHS Wales have been responses to external economic conditions, although as many of those originate from the settlement from the UK government, the political argument remains strong. The changes brought about in 2003 and 2009 were a response to the need to contain costs, and a robust constitutional framework was put in place to support healthcare delivery and to keep NHS Wales in public ownership.

Increasing financial pressures, as a result of falling revenue and increased demand, have been accompanied by an apparent failure to meet the required savings through efficiency alone, and consequently the economic and political pressures have turned towards cost reduction. Lack of financial capability in accounting for healthcare processes, or whole life costing, offers a partial explanation, but the historic realisation of budget shortfalls being met by WG, suggest that there is a cultural expectation that will be particularly hard to overcome. As a result of the constitutional structures, the onus for cost cutting has effectively been abdicated to LHBs.

The specific challenge for governance is to protect quality, particularly within nutritional care, from the cost cutting agenda, which concerns patient care as well as food provisions. The nutritional standards and menu framework contribute to this, although there is a real risk that the need to provide snacks in addition to meals will increase total costs, unless, and in the unlikely event, that efficiency savings are made in the short term, and can be demonstrated through accountability mechanisms.

Although this research suggests that there are further efficiencies that can be realised within the NCP, by standardising catering and foodservice across the NHS, there will also be capital costs to those LHBs that do not already adopt regeneration technology. Rationalising the framework contracts is a further efficiency which is currently underway.

The primary aim of nutritional care is to ensure patients get the right food, at the right time to ensure that their clinical and cultural nutritional needs are met. Good practice is inconsistent, and this research suggests that this lack of capability needs to be addressed. As over 60% of catering costs are staff related (NWSSP-FS, 2012), which increases when nursing, regeneration and procurement staff time is included, the rational, or simplistic, response is to look for savings in staff costs. There is increasing evidence that nursing staff are now being deprived of the time to undertake training (RCN, 2012) and so there needs to be a political commitment to enabling best practice. The RCN advocate a requirement for practice based professional development as part of the regulatory framework, but this research suggests that it needs to be within the constitutional framework to have any effect. In essence, capability deficits cannot be addressed without a political commitment from WG, NHS Wales and the respective Boards; without leadership, collaboration *and* learning.

Evidence suggests that legislation and direction are ineffective means of ensuring change is put into practice. Embedding principles and particular models of tried and tested best practice within the structural framework of healthcare organisations and adopting process structures for governance are, it is suggested by this research, more effective in driving and supporting change.

8.6 Contribution of the Research

This research makes a number of contributions to academic debates, has the potential to impact both policy development as well as practice.

The adoption of a processual perspective, as the double movement of objective and abstract process has filled a number of gaps in academic knowledge relating to sustainable public procurement, the 'Public Plate' and more generally on sustainability governance. It has also contributed to a relatively small body of literature relating to process within the discipline of organisation studies.

In addition, the study makes a more direct theoretical link between moral philosophy, political theory and sustainable development. Although scholars have made the links between food systems, public procurement and moral economy through the 'Public Plate' those links have relied heavily upon an individual relational ethic of care. The translation to political theory within this body of literature has been based upon feminist theory, in particular Tronto's assertion that an ethic of care, as a substantive concern, ought to be imported into the political order through practical debate about the status of care in society, rather than any metaethical discussion about the principles of care and justice (1993).

Engster challenges the objective and material foundations of Tronto's conception of care by suggesting that caring activities are not necessarily a product of an individual relationship, but a process of caring that '*makes the development and basic well being of another its direct end'* (2005, p.51). The idea that sustainable development is differentiated from environmental sustainability, or environmental justice, by its anthropocentric emphasis on social justice perpetuates the notion of differentiation between competing priorities relying on the triple bottom line to re-integrate the three pillars of sustainable development. Engster argues for consideration of these issues from a relativist or processual perspective, and therefore concurs with Sen's '*Idea of Justice'* (2010). This releases an ethic of care from the constraints of individuality within feminist theory, enabling an institutional perspective that has far greater potential as a more general moral and political theory.

Through the processual idea of structural embeddedness, an ethic of care becomes an individual, institutional and political concern, linked to action at an individual level in dyadic caring practices, and the state as the ultimate protector of basic needs, not just in relation to human subjects. Engster's theory therefore climbs the theoretical hierarchy so that social, environmental and generational justice are embedded within a more general political theory of justice which is not only concerned with outcomes, but the way in which processes are carried out, in terms of care as attentiveness, responsiveness and respect. This theoretical link between process thinking and the concepts of capabilities, care, justice and sustainable development

were material to the eventual consideration of capabilities as a process of reasoning and understanding at an individual level.

The third contribution to theoretical debates is in relation to Pettigrew's theory of emergent change (1987,1997), discussion of which, in conjunction with discussion on the range of possible perspectives within critical realism, have been set out within this thesis. This study presents a strong argument in favour of the principles of morphogenesis; that structure and agency need to be treated as an analytical dualism in order to unravel the intricacies of real interactions over time as part of the process of explaining change. It is argued that the level of abstraction inherent in structuration theory fails to account for the significance of time, power and alternative or multiple interactions between agency and structures at particular moments or across periods of time. The emphasis on concerns with discursive practises inherent in structuration theory perhaps over-socialise change, which, given the public sector context of this research and the known perceptions of barriers from the literature would have been a weakness in the research design. The sequencing of the interactions between agency and different structures, as analytically separate entities, has been critical in providing a reasoned account of change and discovery of the mechanisms appropriate to an explanation of strategic change in this study.

The literature on sustainable public procurement is also shown to be constrained by its underlying functional managerial perspective. Whilst the critical realist ontology seeks to relate '*what this is*' to '*what this is case of',* and as a consequence produces '*how to*' knowledge, this study also demonstrates empirically the link between middle range theory, for instance sustainable public procurement, to the higher order theory of sustainable development. The sustainable public procurement literature has evolved from a private, rather than public sector perspective, the assumptions perhaps being that internal efficiency is taken for granted in the private sector, markets in general being the mechanisms that eliminate those members who are seen to be inefficient.

Studying process, in this case as an analytical abstraction of change, demonstrates that the processual approach to single case studies is replicable and generalizable, through the concept of structural embeddedness. As such, the governance frameworks developed in this thesis provide a framework for the study of sustainability governance, in alternative contexts, or when aligned with other outcomes, alternative contexts.

The in-depth focus on Wales, as a region with devolved powers and resources, situates the study within the emerging debates about regional resilience, the contextual emphasis being on sustaining the publicly owned and funded healthcare system, thereby keeping economic activity within Wales, perhaps as economy in society, as well as supporting the Welsh economy through local purchasing, as economy in markets. It also provides empirical evidence of innovation within healthcare systems.

The policy and practice implications of this research are essentially structural. Restructuring from function to process has been shown to be critical in bringing about change. The constitutional structuring of sustainable development and best value links responsibility and accountability to Boards and particular roles, overcoming the potential problem of identifying who is responsible in statutory regulation. The use of frameworks as a secondary, but necessary structural form enables creativity and innovation and encourages bottom up adaptations based upon experience and professionalism. Thus structural forms need to be complex, but not necessarily over-bureaucratic, in order to embody stability as well as enable adaptation. Governance for sustainability has, however, to be based upon a related set of values that can operationalize abstract concepts.

Demonstrating how sustainable public procurement is related to governance is therefore a major contribution to both policy and practice.

8.7 Future Research Avenues

This research has developed and refined a conceptual map for governance in the context of public service delivery and sustainable development. As such it provides a framework for similar research into alternative contexts, either as single case studies, or on a comparative basis, which would enable the theory to be tested for its own end, rather than as a stepping stone to causal explanation.

It also provides the rationale for in-depth study of the concepts which have been shown to be mechanisms of change in practice, such as leadership, learning and collaboration.

Specific and potentially significant gaps have been highlighted during the course of this study, namely the need to develop rigorous models for whole life, or process, costing of processes within the organisation, although research into whole life costing for the supply chain has already been found to be unfeasible (Defra, 2010). Despite the fact that the progress that has been made in restructuring nutritional

governance has done so without that capability, future concerns for reducing costs within a demand led healthcare system place a greater emphasis on economy.

The analytical separation of structure and agency has revealed the significance of both in bringing about change. It has also highlighted the constraining nature of technical standards, in this case for nutritional care. The standards, based upon calorific values, determine the volume of food that needs to be produced, irrespective of individual requirements, and contributes towards food and potentially nutritional waste. A study based upon the hospital meal itself, how the qualities of the ingredients relate to the volume of food produced and the resultant waste, would provide a critical contribution to existing knowledge. There is, therefore, the potential to study waste in a more holistic way, with the potential to perhaps challenge the scientific basis that underpins the accepted technical nutritional standards.

8.8   Limitations of and Reflections on this Study

There are inherent limitations in any studies with a longitudinal dimension, particularly those where contemporary change forms the substance of the study. Artificial limits need to be imposed by the researcher, dependent upon the reason for undertaking the research. Nevertheless, such limits do not need to be arbitrary, and by using a variety of data collection methods data collection and analysis can provide a robust foundation for subsequent reasoning. The quality of the contemporary data enables greater explanation than solely using historical recollections and published material.

The yoghurt contract was intended to be studied as it progressed in real time and as such the study was unable to benefit from data from the contract management stage of the cycle. The benefits of contemporary rather than historic study were, however, felt to have outweighed the need for the study contract management period, the richness of the data felt to be of more value than recollections of past events. It is also arguable that any lessons learned from experience would not be readily apparent until the planning stage of the succeeding contract and there is no guarantee that what might well be considered to be commercially sensitive information would be available to the researcher.

The entire research project has been based upon the retroductive methodology, which provides a robust but nevertheless challenging framework. As a highly analytical process, it does, however, overcome the limitations of weak constructivist approaches to studying organisational change in the particularly complex context of governance. The underlying logic of enquiry for critical realist studies – the transition

264

from '*what is this?*' as an objective entity, to '*what is this a case of?*' in an abstract form*,* means that it is not always possible to define the limits of the study. In this case, without expanding the context to include Welsh public services, the necessary conditions of change, vertical *and* horizontal collaboration, would not, in the researcher's view, have been reasonably proven. The volume of potential data was therefore continually expanding as the project progressed. Although seemingly open ended, the interview strategy to focus on roles, responsibilities and change, maintained a form of construct validity as it attached the scope of the interviews to the previously defined framework. Rather than being purely inductive, therefore, theory constrained the data to that which was relevant.

The use of an alternate templates strategy incorporating different analysis strategies also helped in the project management. The different strategies, in some cases, produced the same potential mechanisms, but the outcomes of the different approaches were ultimately tested by the search for rival explanations. Whilst there is always the argument that researchers tend to adopt perspectives aligned to their own way of thinking, retroduction is perhaps best suited to those researchers who prefer visual, or non-verbal reasoning, rather than solely discursive and descriptive approaches to analysis. Nevertheless, it was very easy to become lost in the data and to lose sight of the primary aim of explaining strategic change in the search for causal mechanisms. Using a narrative strategy in constructing the written thesis as themes emerged, was, however a significant tool in refining subsequent theoretical frameworks, and ultimately in reaching conclusions.

The adoption of a narrative approach to explanation, however, renders the written thesis a summary of the research findings, the messiness of the analytical and thought processes hidden behind and within the finished text. Although essential within the retroduction methodology, the neatness of the relationship between initial theory and conclusions in the written thesis perhaps invites scepticism as to just how critical the approach is. The deeply analytical nature of the retroductive method is, however, inherently critical in the range of data collected and the processes of data analysis adopted. The need to continually use inductive and deductive techniques, moving from the empirical to the abstract as the research proceeds is also representative of a continuous process of reflection.

There is, nevertheless, a huge sense of satisfaction in bringing the evidence together, even if articulating the complexity of methods and results in the written work is challenged by the need to demonstrate transparency for rigour within a word

limit. The methodology does, however, enable the answers to difficult, complex and practice based problems to be addressed in a robust, critical and reflexive way.

APPENDIX 1
LIST OF ABBREVIATIONS

ASPB	Assembly Sponsored Public Bodies
BETS	Department of Business Enterprise, Technology and Science
CAG	Foodstuffs Commodities Advisory Group
CEO	Chief Executive Officer
CHC	Community Health Council
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
COE	Council of Europe
CPU	Central Production Unit
DEFRA	Department Environment Food and Rural Affairs
DHS	Department of Health and Social Care
DHSSC	Department of Health Social Services and Children
EIB	Efficiency and Innovation Board
EFPMS	Estates and Facilities Performance Management System
EU	European Union
FOC	Fundamentals of Care
GOWA	Government of Wales Act
GPA	Government Procurement Agreement
HACCP	Hazard Analysis Critical Control Point
HIW	Healthcare Inspectorate Wales
LHB	Local Health Board
LIFT	Local Improvement Finance Trust
MEAT	Most Economically Advantageous Tender
NAO	National Audit Office
NAW	National Assembly Wales

NCP	Nutritional Care Pathway
NGO	Non-Governmental Organisation
NHS	National Health Service
NLIAH	National Leadership and Innovation Agency in Healthcare
NWSSP	NHS Wales Shared Services Partnership
NWSSP-FS	Facilities Services
NWSSP-PS	Procurement Services
OGC	Office of Government Commerce
OPC	Older Peoples Commissioner
PAC	Public Accounts Committee
PDO	Protected Designation of Origin
PEARS	Patient Environment Assessment Reporting System
PGI	Protected Geographical Indication
PQQ	Pre-Qualification Questionnaire
PSFPI	Public Sector Food Procurement Initiative
PSLG	Public Sector Leadership Group
SDS	Sustainable Development Scheme
SFI	Standing Financial Instructions
SME	Small and Medium-sized Enterprise
SO	Standing Orders
SPAF	Sustainable Procurement Assessment Framework
SPP	Welsh Procurement Initiative Sustainable Procurement Programme
SPTF	Sustainable Procurement Task Force
SQuID	Supplier Qualification Information Database
SRA	Sustainability Risk Assessment
SWOT	Strengths, Weaknesses, Opportunities, Threats
UK	United Kingdom
VW	Value Wales

WAG	Welsh Assembly Government
WAO	Wales Audit office
WG	Welsh Government
WHO	World Health Organisation
WHS	Welsh Health Supplies
WO	Welsh Office
WPI	Welsh Procurement Initiative

APPENDIX 2
Interview Schedule and Informant Information

Informal Scoping Interviews	
Welsh Government NWSSP (FS and PS) LHB Nutrition and Dietetics Manager NHS Sustainable Development Unit LHB Hotel Services Manger	1 each
Formal In-depth Interviews by Strategic Role (number of interviews in brackets)	
Welsh Government	Heads of Department (3) Deputy Heads of Department (1)
NWSSP	Divisional Directors (2) Head of Department (1) Facilities Manager (2) Sourcing and Contracting (2)
LHBs (2)	Non-Executive Board Member (1) Deputy Director (2) Departmental Director (1) Head of Department (Dietetics and Catering) (3) Operational Catering Managers (3) Dietitian (1)
WAO	Project Auditor (1)
Informal interviews (email) and discussions during site visits	
LHBs	Ward Sister; Ward Caterers; Ward Hostess; Facilities Managers; Head of Hotel Services; Head Chefs.
WG	Policy Manager

Information provided to Informants prior to interview:

INFORMATION SHEET FOR RESEARCH PARTICIPANTS

The following is information for participants to this study. This is intended to anticipate some of the queries which research participants might have. I shall be happy to deal with any other queries personally, either by email (BloomfieldC@cardiff.ac.uk), or by telephone (07801893096).

I would like to emphasise that this study is <u>not</u> an evaluation of performance of the organisation, individuals or groups, nor the procurement, catering or food service in the organisation. The identity of the hospital case studies and the research participants will remain anonymous in the written thesis and any published material or presentations arising from the study.

Reason for Study

My particular interest in hospital food stems from an accidental co-incidence of studying hospital food as part of a local regeneration project for my MSc and my personal experience of patient and visitor food in different hospitals, as a parent of a young adult, over a period of some weeks. That experience was of varying quality and variety of the food, perhaps linked to different production and service systems, but also observation of the variety of needs and preferences that have to be met as well as how often meals were left unfinished. Whilst there has been a lot of interest and many studies relating to the procurement of school food and sustainability in procurement, my observations suggested that the organisational context of public food procurement was particularly relevant and more particularly that the school meals model was not something that would necessarily transfer seamlessly to hospitals.

My PhD is an investigation into the process of procurement and how hospital food and sustainable development are linked in that process. The focus of my study is on experiences of change from the perspective of those actively involved in that process. The research will be undertaken in case study hospitals in Wales.

The National Health Service Research Ethics Service has deemed the study to be an evaluation and therefore NREC is not required. Ethical approval has been obtained from Cardiff University, School of City and Regional Planning.

My PhD Supervisor is Professor Kevin Morgan, who can be contacted at: School of City and Regional Planning, Cardiff University, Glamorgan Building, King Edward VII Avenue, Cardiff, Wales, CF10 3WA; email MorganKJ@cardiff.ac.uk; telephone +44 (0)29 208 76090.

Participation

Your participation in this work is highly appreciated but is, at all stages, entirely voluntary. Written copies of transcripts of interviews with you will be made available upon request. For the purposes of validation of the research, copies of extracts of the written thesis relating to interviews will be provided for prior to submission for examination. Withdrawal of permission to use material can therefore be requested at any time prior to submission.

APPENDIX 3

The Nutritional Care Pathway

The formal procedures for the Nutritional Care Pathway are applicable across NHS Wales. Copies of the official documentation for the assessment framework, food map, fluid and food intake resources are reproduced in this Appendix.

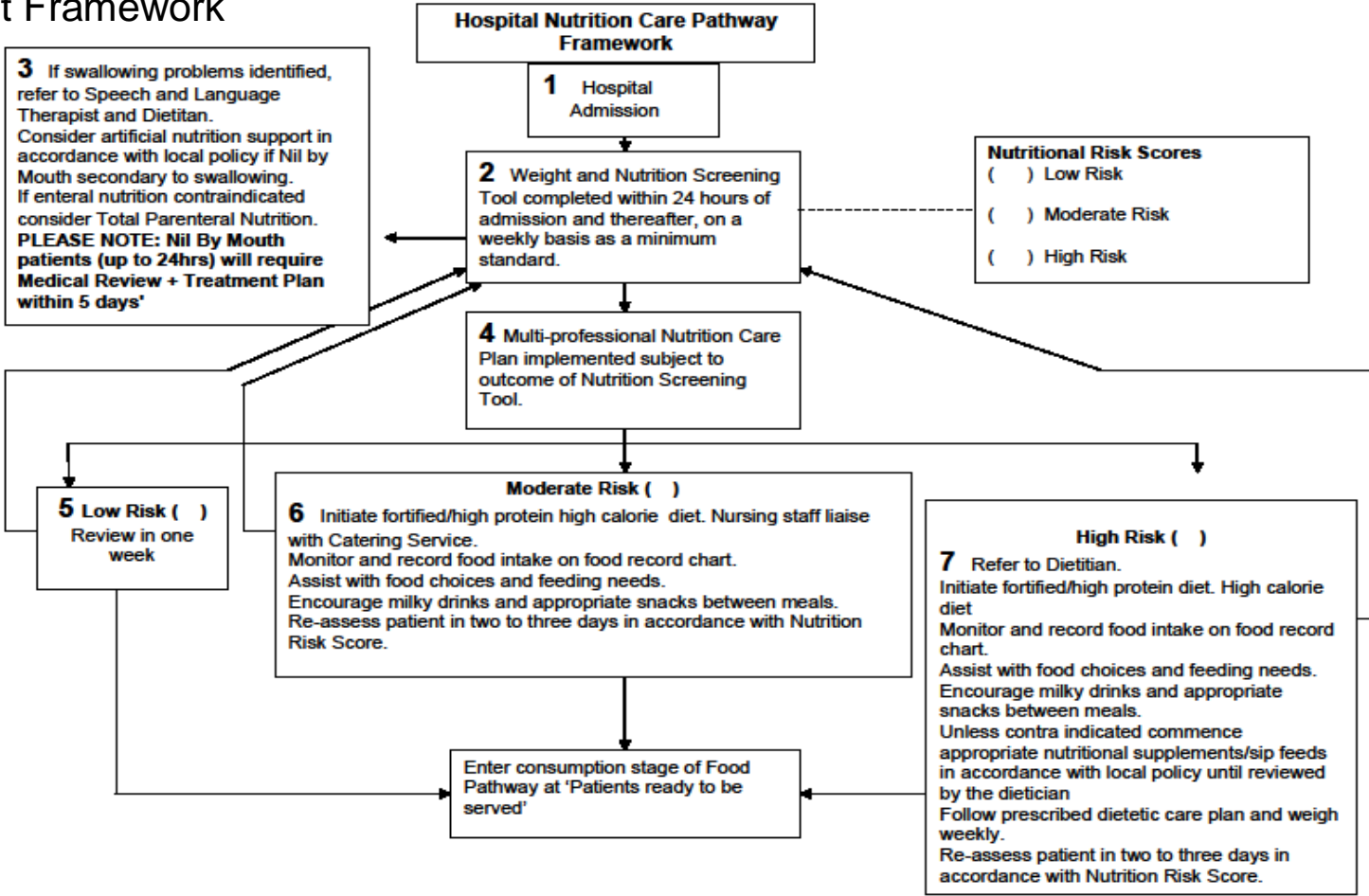The Food and Fluid Charts are on Display on the Wards.

Assessment Framework

Hospital Nutrition Care Pathway Framework

1 Hospital Admission

2 Weight and Nutrition Screening Tool completed within 24 hours of admission and thereafter, on a weekly basis as a minimum standard.

3 If swallowing problems identified, refer to Speech and Language Therapist and Dietitan.
Consider artificial nutrition support in accordance with local policy if Nil by Mouth secondary to swallowing.
If enteral nutrition contraindicated consider Total Parenteral Nutrition.
PLEASE NOTE: Nil By Mouth patients (up to 24hrs) will require Medical Review + Treatment Plan within 5 days'

Nutritional Risk Scores
( ) Low Risk
( ) Moderate Risk
( ) High Risk

4 Multi-professional Nutrition Care Plan implemented subject to outcome of Nutrition Screening Tool.

5 Low Risk ( )
Review in one week

Moderate Risk ( )
6 Initiate fortified/high protein high calorie diet. Nursing staff liaise with Catering Service.
Monitor and record food intake on food record chart.
Assist with food choices and feeding needs.
Encourage milky drinks and appropriate snacks between meals.
Re-assess patient in two to three days in accordance with Nutrition Risk Score.

High Risk ( )
7 Refer to Dietitian.
Initiate fortified/high protein diet. High calorie diet
Monitor and record food intake on food record chart.
Assist with food choices and feeding needs.
Encourage milky drinks and appropriate snacks between meals.
Unless contra indicated commence appropriate nutritional supplements/sip feeds in accordance with local policy until reviewed by the dietician
Follow prescribed dietetic care plan and weigh weekly.
Re-assess patient in two to three days in accordance with Nutrition Risk Score.

Enter consumption stage of Food Pathway at 'Patients ready to be served'

Food Map

Procurement Stage of the Food Process

- Per capita funding allowance x bed number
- Catering Budget Holder
- Product range "National"
- Rurality / Ethnicity of local area
- Patient Feedback
- Product range "Local"
- Range and Quantity of food on site
- Range of Suppliers
- Advisory Process
- Food Safety Legislation
- Market forces
- Professional Knowledge
- Public / Media Perception
- Health Promotion messages

- Dietetic Advice
- Case mix
- Menu range
- National nutritional standards

Production and Distribution stage of the Food Process

- Menu cycle design
- Aggregated patient choice per meal
- Nutritional analysis of recipies
- Production
- Audit / Inspection / regulation
- Staffing
- Skills
- Shifts
- Environment of catering areas (including Plant and equipment)
- Outputs
- Waste / overproduction
- Plated food / Bulk food
- Storage heated / chilled
- Sub Storage E.g. Satellite Hospitals
- Delivery via trolley/van
- Arrival of Food / Fluids in Clinical Area

Patient Experience Process

- Arrival of Food / Fluids in Clinical Area
- Preparing ward environment for meal time
- Initial nutritional screening on admission
- Patients ready to be served with meal of choice
- Development of nutritional care plan
- Registered Nursing
- HCSW
- Serving
- Catering Staff
- Therapeutic Diets
- On going monitoring of fluid and food intake
- Registered Nursing
- HCSW
- Assistance to eat
- Relatives
- Volunteers
- Further nutritional assessment as required
- Patient Experience & Patient Views Sought

Hospital Nutritional Care Pathway Framework

Fluid Record Chart

Fluid Volume Guide

This information is designed to help you with accurate documentation of oral intake on the Fluid Record Chart.
Please refer to the photographs below when completing the Fluid Record Chart.
All fluid intake must be recorded accurately.

Full Cup = 150ml

Full Plastic Cup = 150ml

Full Beaker = 200ml

Full Beaker = 200ml

Full Beaker = 200ml

Full Mug = 200ml

Full Glass = 200ml

Full Jug = 1000ml

Daily Fluid Intake/Output Chart

Weekly Intake/Output Chart

Daily and Weekly All Wales Fluid Intake and Output Chart Guidelines for Completion

Other Sources of Fluid

Ice cream

Jelly

Soup

Food Record Chart

Food Record Chart Guide

This information sheet is designed to help with accurate documentation of the portion sizes on the Food Record Chart.
Please refer to the photographs below when filling in the Food Record Chart.
All food intake must be recorded accurately.

MEAL SIZES

Small   Medium   Large

MAIN MEAL - amount eaten

None   ¼   ½   ¾

DESSERT - amount eaten

None   ¼   ½   ¾

Other Sources of Food

Nutritional supplements   Puréed meal

APPENDIX 4

All Wales Nutrition and Catering Standards for Food and Fluid for Hospital Inpatients

available from

http://wales.gov.uk/topics/health/publications/health/guidance/nutrition/?lang=en

All Wales Nutrition and Catering Standards for Food and Fluid for Hospital Inpatients
Concise Guide and Implementation Plan

This is a concise guide to the standards laid out in the All Wales Catering and Nutrition Standards for Food and Fluid for Hospital Inpatients. That document should be referred to, in full, for implementation and for detailed information on each of the standards.

This guide should be used as an audit tool following implementation of the standards. (Note – The figures given in brackets refer to the chapters where the standards can be found in the main document.)

THE FOLLOWING STANDARDS MUST BE IMPLEMENTED BY 31ST JANUARY 2012

Recognising the nutritional needs of the hospital patient
- There must be local assessment of the dietary needs of each hospital population. (2.1)
- The All Wales Nutrition Care Pathway should be followed. (2.4)
- An assessment of each patient's dietary needs should form part of the nutritional care plan. (2.4)

Menu Planning (2.5)
- A multidisciplinary group must take responsibility for menu planning.
- Menu planning should be undertaken using recognised menu planning principles.

Snacks
- Snacks that are included within the standard menu should provide a minimum of 100kcal and 1.5 g protein. The exception will be those patients who would benefit from a healthy option such as fruit.
- A bedtime snack must be offered to all patients (minimum 100kcal, 1.5 g protein).

Milk
- An on ward milk allowance of 500mls should be allocated for each patient, for breakfast cereals and beverages. This is in addition to milk used in the kitchen. Milk can be full fat or semi skimmed depending on local need.

Fluids (Table 3 and section 4.3)
- There should be 7-8 beverage periods throughout the day, offering both hot and cold drinks.
- Beverages at the mid day and evening meals should be served after the meal.
- There must be provision to ensure patients are able to access a minimum of 1.5 litres of fluid per day.
- Water must be available at all times throughout the 24 hours, preferably chilled mains water.
- Water jugs should be changed 3 times a day.

Codes (Table 3 and section 6.3)
- Dietary codes should be kept to a minimum on the menu.

Food Service (3.5)
• The eating environment should be prepared in order for patients to enjoy their food in a dignified manner.
• Patients should be given the opportunity to choose their own food from a varied menu.
• A choice of portion sizes should be offered.
• Service should be flexible to allow patients to meet their energy and protein requirements.
• A missed meal service should be provided for patients who did not have the opportunity to have a meal at the normal time. A meal must provide a minimum of 300kcal and 18g protein per main course.
• Main meals should be available every 4 to 6 hours.
• The maximum period between the last main meal at night and the following breakfast should not exceed 14hours.
• Assistance to eat must be given to all patients who require it.
Ward Provisions (3.6)
• A range of items should be held at ward level in order for patients to be offered snacks and beverages when the hospital kitchen is closed. A list of minimum provisions is given in section 3.6.
Nutrient and Food Standards for Children (5)
Menu Planning
• Menu planning groups should consider producing a specially designed menu for children.
• The guidance on number of meal and dessert choices that should be provided at each meal service should be followed as laid out in the Better Hospital Food guidelines (2003).
• Child friendly, familiar dishes should be included.
• Food choice should be allowed as close to time of service as possible.
• There should be access to the main hospital menu to accommodate older children.
• The menu should achieve a combination and balance from the 5 food groups.
Fluids (5.4)
• A minimum of 7-8 beverages must be offered through the day.
• Appropriate drinking cups must be available for each stage of development.
• A choice of warm and cold drinks should be offered at each meal and snack, including low sugar varieties.
• Water must be available at all times throughout the 24 hours, preferably chilled mains water.
• Water jugs should be changed 3 times a day.
Snacks
• A range of suitable snacks, including high calorie snacks and drinks should be provided between meals. (5.5)
Milk
• 500ml whole milk or equivalent should be provided daily for each child.
Ward Provisions
• A range of items should be held in the ward kitchen to provide popular foods outside of normal mealtime service.
Therapeutic Diets for Adults and Children. (6)
• Where relevant catering service contracts must be sufficiently detailed to cover provision of therapeutic and special diets.
• Therapeutic diets must be considered in the menu planning process.

Menu Planning (2.5)
- Standard recipes must be used.
- Patient groups should be consulted before new menus are introduced.

Menu Framework (Table 3)
- The mid-day and evening meals must allow the choice of 3 courses to comprise:
  2 first course items;
  3 main course items, of which at least 2 should be hot;
  3 dessert courses, of which at least one should be hot.
- Fruit juice should be offered as a first course item on 2 occasions to meet the minimum Vitamin C specification of 40mgs.
- There must be a vegetarian option at each meal.
- There must be a combination and balance of foods from the 5 food groups.
- There must be meal choices that meet healthy eating principles.

Breakfast
- Breakfast must provide a minimum of 380 kcal and 8g protein, with an additional fortified / high protein, high calorie option for the nutritionally at risk.

Snacks
- Snacks of higher energy and protein density, for those patients identified at moderate or high risk should provide a minimum of 200kcal & 2.5 g protein.

Soup
- Where soup is served it should provide a minimum of 150kcal and 4g protein in a 175ml serving and be served with bread and spread.
- If soup is served as a hot main course then accompaniments must be served with it to give a total of 300 – 500kcal and 18g protein.

Therapeutic Diets for Adults and Children. (6)
- There must be a hospital protocol for the provision of all therapeutic diets, to include contingency for provision of diets that are required irregularly.

Special and Personal Diets (7)
- Special and personal diets should be considered at the planning stage.
- There must be policies and procedures in place to ensure minority groups can be provided with appropriate and familiar foods to meet their nutritional needs.

279

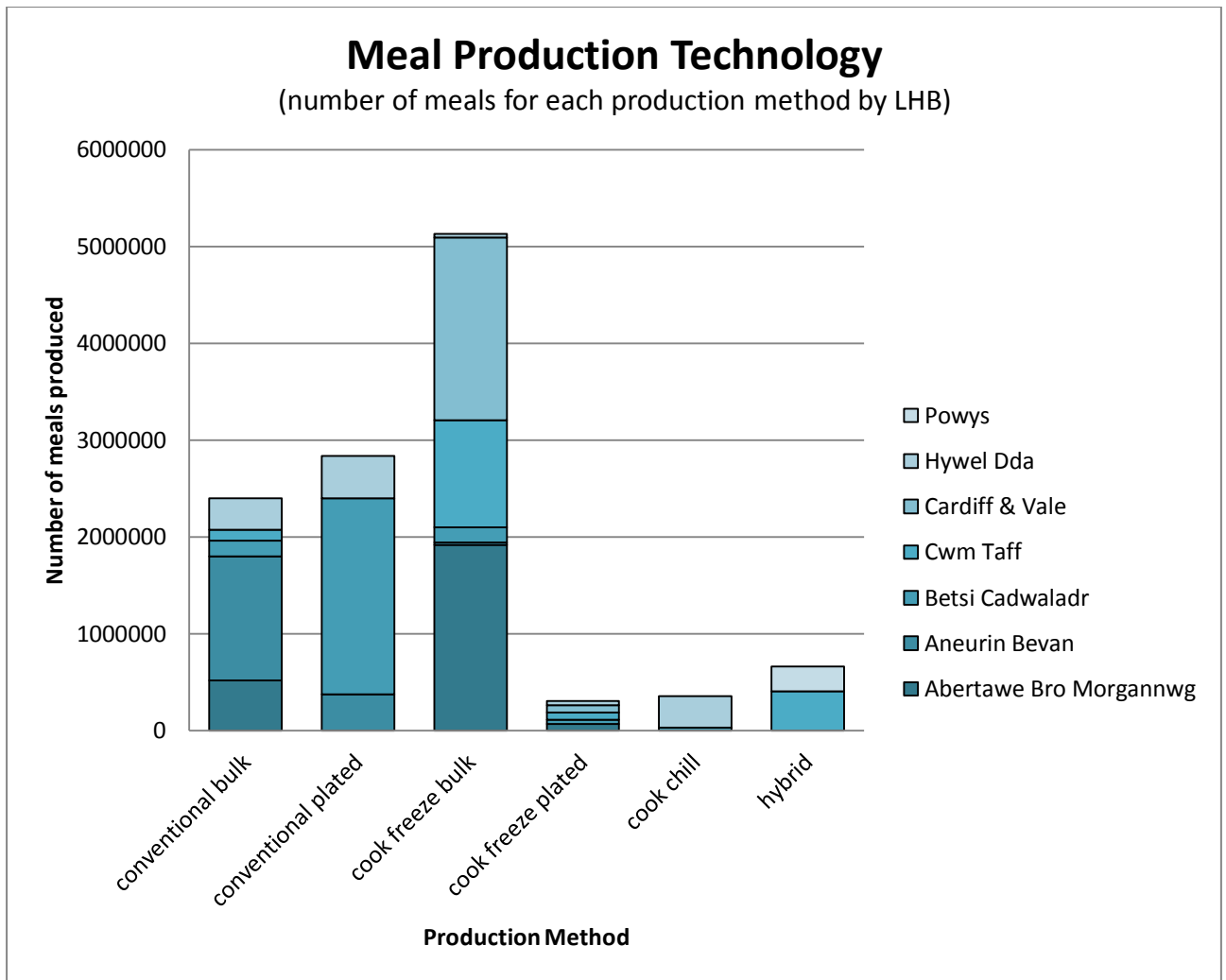| |
|---|
| **Menu Framework** (Table 3)
Mid day and evening meal
• Both the mid day and evening meal menus must include the following:
    A main course providing a minimum of 300kcal, 18g protein (12g for vegetarian option);
    A fortified or high protein high calorie option to provide minimum of 500kcal and 18g protein;
    At least one fortified or high protein high calorie dessert to provide a minimum of 300kcal, 5g protein. |
| **Food Service** (3.5)
• All staff involved in serving food to patients should be trained in how to do so properly and also in food hygiene. |
| **Therapeutic Diets for Adults and Children.** (6)
• Patients must be given a choice for all food and fluid provided for therapeutic and texture modified diets. |

THE FOLLOWING STANDARDS MUST BE IMPLEMENTED BY 30TH APRIL 2013

Menu Planning (2.5) • There must be a current nutritional analysis of all menus, undertaken by a Registered Dietitian. Minimum nutrients for menu analysis are laid out in Table 1.
Nutrient and Food Based Standards for Adults (3) **Nutrient Specification** • The hospital menu must be capable of meeting the nutrient specification as laid out in Table 2 (3.3) and provide food with concentrated energy and nutrients in small servings.
Nutrient and Food Standards for Children (5) **Menu Planning** • Nutritional analysis should be incorporated into the menu planning process.
Nutrient Specification • The hospital menu must be capable of meeting the nutrient specification as laid out in Table 13 (5.2) for macronutrients and as given in Appendices 3 to7 for micronutrients.
Therapeutic Diets for Adults and Children. (6) • Therapeutic diets must meet the requirements of clinical treatment and appropriate nutritional standards.

APPENDIX 5

Catering and Food Service Data: All Wales 2011-12

LHB	Gross Cost Patient Catering £	Provisions Costs (Patient and non-patient)	Number Patient Meals	Cost / Patient Meal £			Waste %	Waste £
				Average	High	Low		
Abertawe Bro Morganwg	6,598,031	4,284,707	2,501,937	2.64	5.60	1.38	5.15	160,537
Aneurin Bevan	5,432,280	3,381,442	1,683,063	3.23	7.0	2.59	8.7	200,258
Betsi Cadwaladr	8,491,855	3,243,973	2,417,097	3.51	19.53	1.28	4.39	108,770
Cardiff and Vale	7,857,477	3,145,335	1,965,761	4.0	5.38	1.53	9.45	217,745
Cwm Taff	4,930,175	2,811,672	1,624,535	3.03	3.71	1.74	3.78	70,959
Hywel DDa	4,204,594	1,970,172	1,166,597	3.6	8.16	1.92	7.61	112,394
Powys	1,335,899	514,246	257,381	5.19	7.81	1.78	12.88	59,054
Velindre NHS Trust	96,493	172,953	44,165	2.18	2.18	2.18	9.7	44,165
ALL WALES	**38,946,804**	**19,524,500**	**11,660,536**	**3.04**	**19.53**	**1.38**		**973,882**

Table produced by author from data source: NWSSP-FS, 2012

Meal Production Technology

(number of meals for each production method by LHB)

Produced by author from published data (NWSSP-FS, 2012)

Data reflects catering technologies in use in 2010-11, prior to the standardisation to cook freeze bulk by LHB X.

Excludes Velindre NHS Trust who do not produce their own meals

APPENDIX 6

Ethical Approval: Cardiff University and NRES Confirmation that full REC approval not required

CARDIFF SCHOOL OF CITY AND REGIONAL PLANNING

Ethical Approval Form

Staff and MPhil/PhD Projects

The completed form must be submitted at least TWO WEEKS before a SREC meeting to: Ruth Leo, Research Administrator / email: LeoR@cardiff.ac.uk / Tel Ext: 74462 / Room 2.95 Glamorgan Building)

Title of Project: Food in Hospitals: the Barriers and Opportunities for Public Procurement to contribute to Sustainable Development Objectives

Name of researcher(s): Claire Bloomfield

Date: 24.3.11
researcher:

Signature of lead

↑

~~**Staff project** *(delete as appropriate)*~~ **Student project** *(delete as appropriate)*

Anticipated Start Date of Fieldwork: Summer 2011

Recruitment Procedures:

Cardiff University's Child Protection Procedures:

	Recruitment Procedures:	Yes	No	N/A
1	Does your project include children under 16 years of age?		X	

2	Have you read the above Child Protection Procedures?	X		
3	Does your project include people with learning or communication difficulties?		X	
4	Does your project include people in custody?		X	
5	Is your project likely to include people involved in illegal activities?		X	
6	Does your project involve people belonging to a vulnerable group, other than those listed above?		X	
7	Does your project include people who are, or are likely to become your clients or clients of the department in which you work?		X	
8	Does your project include people for whom English / Welsh is not their first language?		X	

http://www.cardiff.ac.uk/sohcs/resources/Child%20Protection%20Proc edures%20-%20Interim%20Gdnce%20-%20SEOs%2003120.pdf.

If you have answered 'yes' to any of the above questions please outline (in an attached ethics statement) how you intend to deal with the ethical issues involved

Consent Procedures:		Yes	No	N/A
9	Will you tell participants that their participation is voluntary?	X		
10	Will you obtain written consent for participation? If "No" please explain how you will be getting informed consent.	X		
11	If the research is observational, will you ask participants for their consent to being observed?		X	
12	Will you tell participants that they may withdraw from the research at any time and for any reasons?	X		
13	Will you give potential participants a significant period of time to consider participation?	X		

If you have answered 'no' to any of these questions please explain (in your ethics statement) the reasons for your decision and how you intend to deal with any ethical decisions involved

Possible Harm to Participants:	Yes	No	N/A
14 Is there any realistic risk of any participants experiencing either physical or psychological distress or discomfort?		X	
15 Is there any realistic risk of any participants experiencing a detriment to their interests as a result of participation?		X	

If there are any risks to the participants you must explain in your ethics statement how you intend to minimise these risks

Data Protection:	Yes	No	N/A
16 Will any non-anonymised and/or personalised data be generated and/or stored?		X	
17 Will you have access to documents containing sensitive[18] data about living individuals?		X	
If "Yes" will you gain the consent of the individuals concerned?			

If there are any other potential ethical issues that you think the Committee should consider please explain them in an <u>ethics statement</u>. It is your obligation to bring to the attention of the Committee any ethical issues not covered on this form.

Health and Safety	Yes
18 Does the research meet the requirements of the University's Health & Safety policies? http://www.cardiff.ac.uk/osheu/complete_risk_assessment	X

---

[18] Sensitive data are *inter alia* data that relates to racial or ethnic origin, political opinions, religious beliefs, trade union membership, physical or mental health, sexual life, actual and alleged offences.

Please attach:

- Full project proposal

- Participant information form and Consent form (if available)

- Details concerning external funding (if applicable)

- An ethics statement (if needed based on your answers to the questions on the form – please enter onto the following blank page).

Finally please note also that the Ethics Committee must be notified immediately by the researcher/supervisor when the nature of the project proposed changes significantly from that originally approved by the committee

Ethics Statement:

Informed consent will be obtained from the organisation (Health Board/Hospital Trust) and participants to be interviewed both as individuals, and separately as part of the steering group/committee. Should interviewees not wish to participate in the group form, then no observation of that group will take place in that organisation, in order to protect that individual's identity and wishes, and the researcher will rely upon whatever documents are publicly available. This will protect the identity of those individuals who might feel uncomfortable or at risk by being observed as part of a group containing representatives of differing levels of seniority and influence within the organisation. By seeking direct individual consent to both individual and group participation only the researcher would be aware of who has not consented.

All participants will be able to withdraw from the research at any time up until the submission of the thesis for examination, or submission for publication of any material related to their participation in the research. The selection of the committee/steering group provides a clear boundary to the extent of the interviews, and would not involve patients, other than patient representatives who might be present on the steering group and those who might be present in public areas. There is no intention that the latter would be interviewed, and consent from the participating Health Board/Hospital Trust would be obtained before undertaking observation in those areas due to the potential presence of patients.

Both the participating organization and the individuals will be anonymised in order to protect identification and maintain confidentiality. Where possible, references to specific roles will be avoided in order to protect the identity of individuals and organisations.

Transcripts of interviews will be made available to participants and extracts of those parts of the finished thesis which make reference to their involvement, or include quotes from them, will be provided for validation and permission.

Although this study involves NHS employees and on NHS premises, the project has been considered by the NREC and they have determined that it does not require NHS research Ethics Committee Approval.

Response from NHS National Research Ethics Service Query Line

From: NRES Queries Line [mailto:queries@nres.npsa.nhs.uk]
Sent: 11 March 2011 17:12
To: 'Claire Bloomfield'
Subject: RE: Enquiry from NRES website: is my project research?

Thank you for your enquiry.

Your query was reviewed by our Queries Line Advisers.

Our leaflet "Defining Research", which explains how we differentiate research from other activities, is published at:

http://www.nres.npsa.nhs.uk/rec-community/guidance/#researchoraudit

Based on the information you provided, our advice is that the project is not considered to be research according to this guidance. Therefore it does not require ethical review by a NHS Research Ethics Committee.

I deem this to be service evaluation and hence would not require REC review.

If you are undertaking the project within the NHS, you should check with the relevant NHS care organisation(s) what other review arrangements or sources of advice apply to projects of this type. Guidance may be available from the clinical governance office.

Although ethical review by a NHS REC is not necessary in this case, all types of study involving human participants should be conducted in accordance with basic ethical principles such as informed consent and respect for the confidentiality of participants. When processing identifiable data there are also legal requirements under the Data Protection Act 2000. When undertaking an audit or service/therapy evaluation, the investigator and his/her team are responsible for considering the ethics of their project with advice from within their organisation. University projects may require approval by the university ethics committee.

This response should not be interpreted as giving a form of ethical approval or any endorsement of the project, but it may be provided to a journal or other body as evidence that ethical approval is not required under NHS research governance arrangements.

However, if you, your sponsor/funder or any NHS organisation feel that the project should be managed as research and/or that ethical review by a NHS REC is essential, please write setting out your reasons and we will be pleased to consider further.

Where NHS organisations have clarified that a project is not to be managed as research, the Research Governance Framework states that it should not be presented as research within the NHS.

If you have received advice on the same or a similar matter from a different source (for example directly from a Research Ethics Committee (REC) or from an NHS R&D department), it would be helpful if you could share the initial query and response received if then seeking additional advice through the NRES Queries service.

However, if you have been asked to follow a particular course of action by a REC as part of a provisional or conditional opinion, then the REC requirements are mandatory to the opinion, unless specifically revised by that REC. Should you wish to query the REC requirements, this should either be through contacting the REC direct or, alternatively, the relevant local operational manager.

Regards

Queries Line
National Research Ethics Service
National Patient Safety Agency
4-8 Maple Street
London
W1T 5HD

The NRES Queries Line is an email based service that provides advice from NRES senior management including operations managers based in our regional offices throughout England. Providing your query in an email helps us to quickly direct your enquiry to the most appropriate member of our team who can provide you with accurate written response. It also enables us to monitor the quality and timeliness of the advice given by NRES to ensure we can give you the best service possible, as well as use queries to continue to improve and to develop our processes.

Website: www.nres.npsa.nhs.uk
Email: queries@nres.npsa.nhs.uk

Ref: 04/31

Streamline your research application process with IRAS (Integrated Research Application System). To view IRAS and for further information visit: www.myresearchproject.org.uk

BIBLIOGRAPHY

AC. 2001. *Acute Hospital Portfolio: Catering, Review of National Findings*, London Audit Commission

Accounting for Sustainability Group. 2005. *Realising Aspirations – Or, using Value for Money to Make the Public Sector More Sustainable*, available from http://www.accountingforsustainability.org/wp-content/uploads/2011/12/Realising-Aspirations-Report-May-2005.pdf [last accessed 22.2.13]

Ackroyd, S. 2009. Research Designs for Realist Research in: Buchanan DA, Bryman A. 2009. eds. *The Sage Handbook of Organizational Research Methods*, London, Sage

Ackroyd, S. Kirkpatrick, I. Walker, R.M. 2007. Public Management Reform in the UK and its Consequences for Professional Organization: a Comparative Analysis, *Public Administration,* 85(1) pp. 9–26

ACW. 2002. *Acute Hospital Portfolio – A review of national findings on catering*, Audit Commission in Wales

Addicott, R. Ferlie, E . 2007. Understanding power relationships in healthcare networks, *Journal of Health Organization and Management*, 21 . 4/5. PP.393-405

Ahgren, B. 2010. Competition and integration in Swedish health care, *Health Policy,* 96 pp. 91-97

Alexander, JM. Capabilities and Social Justice: the Political Philosophy of Amartya Sen and Martha Nussbaum, Aldershot, Ashgate

Allison, S.P. 1999. *Hospital food as treatment. A Report for the working party of the British Association of Enteral and Parenteral Nutrition*, Maidenhead

Archer, M S. 2010. Morphogenesis versus structuration: on combining structure and action, *British Journal of Sociology*, 66 pp. 225-252

Argyris, C. and Schön, D. 1978. *Organizational learning: A theory of action perspective,* Reading: Addison Wesley.

Bachrach, P. and Baratz, M.S. 1962. Two faces of power, *American Political Science Review*, 56(4) pp. 947-952

Baker, S. 2007. *Sustainable Development,* London, Routledge

Baker, S. and Eckerberg, K. 2008. (Eds) *In pursuit of sustainable development: new governance practices at the sub-national level in Europe*, London, Routledge

BAPEN (undated) *The cost of disease-related malnutrition in the UK and economic considerations for the use of oral nutritional supplements (ONS) in adults*, British Association of Parenteral and Enteral Nutrition, available from, http://www.bapen.org.uk/professionals/publications-and-resources/bapen-reports/the-cost-of-disease-related-malnutrition-in-the-uk last accessed 18.2.13

Barnett, P., Tenbenselc, T. Cumming, J. Clayden, C. Ashton, T. Pledger, M. Burnett, M. 2009. Implementing new modes of governance in the New Zealand health system: An empirical study, *Health Policy*, 93 pp. 118–127

Baum, T. 2006. Operational performance of health care food service systems, *International Journal of Contemporary Hospitality Management* 20(2) pp. 215-227

Baum, T. 2007. Skills, training and development within an insular labour market: The changing role of catering managers in the healthcare environment, *Journal of Management Development*, 26(2) pp.132 – 14.

Baumgartner, R.G. 2011. Critical perspectives of sustainable development research and practice, *Journal of Cleaner Production*, 19 pp. 783-786

BBC. 2011. *Operation Hospital Food*, shown BBC1 Wales, 5-9 September 2011

BBC. 2013. *Operation Hospital Food*, shown BBC1 Wales, 25 February – 1 March

Beauchamp, T.L. Childress, J.F. 2009. *Principles of Biomedical Ethics,* 6th edn. Oxford, Oxford University Press

Beck, A.M., Balknas, U.N. Furst, P. 2001. Food and Nutritional care in Hospitals: How to prevent undernutrition, *Clinical Nutrition* 20(5) pp. 455-460

Berger, G., Steurer, R. 2008.   National Sustainable Development Strategies in EU member states, The Regional Dimension, in Baker, S. Eckerberg, K . 2008. (Eds). *In pursuit of sustainable development: new governance practices at the sub-national level in Europe*, London, Routledge

BC. 2011. *2008-2011 Forging a Better Future*, Bevan Commission

Bistrian, B.R. Blackburn, G,L. Vitale, J. Cochran, . Naylor,J . 1976. Prevalence of malnutrition in general medical patients, *Journal of the American Medical Association* 235(15) pp. 1567-1570

Boaz, A., & Ashby, D. (2003). *Fit for purpose? Assessing research quality for evidence based policy and practice.* London: ESRC UK Centre for Evidence Based Policy and Practice.

Bond, S. 1998. Eating matters – improving dietary care in hospitals, *Nursing Standard* 12(17) pp. 41-42

Brammer, S. Walker, H. 2011. Sustainable procurement in the public sector: an international comparative study, *International Journal of Operations and Production Management* 31(4) pp. 452-476

Bubeck, D. 1995. *Care, Gender, and Justice*. Oxford: Oxford University Press.

Bull, G. Nilsson, S. Williams, J. Rametsteiner, E. Hammett, T. Mabee, W. 2001. Wood procurement policy: An analysis of critical issues and stakeholders. *The Forestry Chronicle*, *77*:2, pp. 325-340.

Burnes, B . 2009. *Managing Change* (5th edn.), Harlow, Pearson Education

C&V, 2011, *Improving nutritional intake on a focused rehabilitation and medical evaluation ward . FRaME.: The Milkshake Round*, from Food For Thought, Wales Audit Office, from http://www.wao.gov.uk/assets/englishdocuments/FRaME_Milkshake_Round_CS_eng.pdf [last accessed 14.1.13]

CQC, 2011, *Dignity and Nutrition Inspection Programme, National Overview, London*, Care Quality Commission

Carnall, C.A. 2007. *Managing Change in Organizations (*5th edn.) Harlow, Pearson Education

Carter, C. Rogers, D.S. 2008. A framework of sustainable supp.ly chain management:
moving toward new theory, *International Journal of Physical Distribution & Logistics Management*, 38(5) pp. 360-387

Carter, N. 2007. *The Politics of the Environment: ideas, activism, policy (*2nd edn.) Cambridge, Cambridge University Press

Cassell C. 2009. Interviews in Organizational Research, in: Buchanan DA and Bryman A . 2009. (Eds) *The Sage Handbook of Organizational Research Methods*, London, Sage Publications

Christoff, P. 1996. Ecological Modernisation, Ecological Modernities, *Environmental Politics* 5(3) pp. 476-500

CMO. 2012.7 Communication to LHBs and NHS Trusts from Chief Medical Officer and Chief Nursing Officer dated 14 March 2012

Cochrane Collaboration . 2008. http://www.cochrane.org [last accessed 10.10.11]

CoE. 2003. *Resolution ResAP. 2003.3 on food and nutritional care in hospitals*, Council of Europe available from https://wcd.coe.int/ViewDoc.jsp?id=85747 [last accessed 23.7.12]

Coote, A . 2002 *Claiming the Health Dividend*, London, Kings Fund

Cousins, P. Lamming, R. Lawson, B. Squire, B. 2008. *Strategic Supply Management, Principles, Theories and Practice*, Harlow, Prentice Hall

Cribb, A . 2005. *Health and the good society : setting healthcare ethics in social context*, Oxford, Oxford University Press

Cross, . MacDonald . (2009) *Nutrition in Institutions*, Chichester, Wiley-Blackwell

Crouch, C. 2011., *The Strange Non-Death of Neoliberalism,* Cambridge, Polity

CTLHB. 2011. *Puree reformed meal service at Cwm Taf Health Board*, from Food For Thought, Wales Audit Office, available from http://www.wao.gov.uk/assets/englishdocuments/puree_meal_service_CS_eng.pdf [last accessed 14.1.13]

Dahl, R.A . 1957. The Concept of Power, *Behavioural Science*, 2 pp. 201-215

Danermark, B. Ekstrom,M, Jakobsen, L. Karlsson, J . 2002. *Explaining Society: An Introduction to Critical Realism in the Social Sciences, Abingdon*, Routledge

Defra. 2002. *The Strategy for Sustainable Farming and Food: Facing the Future*, London, Defra

Defra. 2003. Public Sector Food Procurement Initiative

Defra. 2005. Securing the Future – UK Government Sustainable Development Strategy

Defra. 2005a. *One Future Different Paths*, *The UK's Shared Framework for Sustainable Development,* London Defra

Defra. 2006. *Procuring the Future,* London, Defra

Defra. 2007. *The Public Sector Food Procurement Initiative,* London, Defra

Defra. 2010. *PAS2050 Informing Low Carbon, Procurement: Pilot Study – Food*, London, Department of Environment, Food and Rural Affairs, Department of Health

Denyer, D. Tranfield, D . 2009. Producing a Systematic Review in: Buchanan DA and Bryman A . 2009. (Eds) *The Sage Handbook of Organizational Research Methods*, London, Sage Publications

Deloitte. 2009. *Public Sector Food Procurement Initiative: Evaluation Report*, available from http://archive.defra.gov.uk/foodfarm/policy/publicsectorfood/index.htm [last accessed 21.2.13]

Dickinson, H. and Ham, C. 2008. *The Governance of Health Services in Small Countries: what are the lessons for Wales*? Health Services Management Centre, University of Birmingham,

Dickinson, A. Welch, C. Ager, L . 2008., No longer hungry in hospital: improving the hospital mealtime experience for older people through action research, *Journal of Clinical Nursing* 17 pp. 1492-1502

Dispatches. 2011. *The Truth about Hospital Food,* Channel Four, available from http://www.channel4.com/programmes/dispatches/episode-guide/series-81/episode-1 [last accessed 18.2.13]

Donelan, A . 2000. Dieticians and Caterers: An uncertain but critical relationship, *Nutrition and Food Science* 3 pp.123-127

Dryzek, J .S. 2002. *Deliberative Democracy and Beyond - Liberals, Critics, Contestations.* Oxford: Oxford University Press Oxford Scholarship Online. Oxford University Press. 26 June 2011 <http://dx.doi.org/10.1093/019925043X.001.0001>

EA. 2007. *Sustainability Risk Assessment*, Environment Agency

Eckersley, R . 1992. Environmentalism and Political Theory: Toward an Ecocentric Approach. Albany, NY: State University of New York Press.

Eckersley, R . 2004. *The Green State, Rethinking Democracy and Sovereignty*, MIT Press, Cambridge MA

Edwards, J. 2003. Is there such a thing as 'reasonable' or acceptable levels of food wastage in hospital food service? Letter to the Editor. *Food Service Technology*, 3:1, pp. 23-27.

Edwards SA, Edwards A, Salmon J . 2000. Food service management in hospitals, *International Journal of Contemporary Hospitality Management*, 12(4) pp. 262-266

Edwards, J. and Hartwell, H. 2004. A comparison of energy intake between eating positions in a NHS hospital - a pilot study. *Appetite*, 43(3) pp. 323-325

Edwards, J. and Hartwell, H. 2006. Hospital food service: a comparative analysis of systems and introducing the 'Steamplicity' concept. *Journal of Human Nutrition and Dietetics*, 19(6) pp. 421-430

Edwards, JSA. and Nash, AHM. 1999 The nutritional implications of food wastage in hospital food service management, *Nutrition & Food Science*, 99 (2) pp.89 - 98

EFPMS. 2012. *Estates and Facilities Performance Data*, Cardiff, NHSWSSP-FS

EIB. 2011. *Buying Smarter in Tougher Times, Cardiff,* Efficiency and Innovation Board, Welsh Assembly Government

Eisenhart, K.M. Graebner, M.E. 2007. Theory Building from Cases: Opportunities and Challenges, *Academy of Management Journal*, 50(1) pp. 25-32

Engster, D . 2004., Care Ethics and Natural Law Theory: Toward an Institutional Political Theory of Caring, *The Journal of Politics*, 66(1) pp. 113–135

Engster, D . 2005. Rethinking Care Theory: The Practice of Caring and the Obligation to Care, *Hypatia* 20(3) pp. 50-74

Engster, D . 2007. *The Heart of Justice: Care Ethics and Political Theory*, Oxford, Oxford University Press

Erridge, A. Greer, J. 2002. Partnerships and Public Procurement: Building Social Capital through Supply Relations, *Public Administration* 80(3) pp. 503-522

Erridge, A. Herrigan, S . 2012. Sustainable procurement in health and social care in Northern Ireland, *Public Money & Management,* 32(5) pp. 363-370.

EU 2004/18/EC *Directive 2004/18/EC of the European Parliament and of the Council*
of 31 March 2004 on the co-ordination of procedures for the award of public works contracts, public supp.ly contracts and public service contracts available from: http://eur-lex.europa.eu

EU . 2006. *Renewed EU Sustainable Development Strategy.* available from http://register.consilium.europa.eu/pdf/en/06/st10/st10117.en06.pdf [last accessed 25.7.12]

EU 2007/66/EC Directive 2007/66/EC of the European Parliament and of the Council
of 11 December 2007 amending Council Directives 89/665/EEC and 92/13/EEC with regard to improving the effectiveness of review procedures concerning the award of public contracts, available from http://eur-lex.europa.eu

Ferlie, E. Fitzgerald, L. Wood, M. Hawkins, C. 2005. The Nonspread of Innovations: the mediating role of professionals, *Academy of Management Journal* 40(1) pp.117-134

Foster, C. Kirwan, J. Slee, R. W. 2005. *The Cornwall Food Programme: Sustainable Food Procurement in the NHS.* Final version: SUS-CHAIN project case study of the European Commission funded project SUS-CHAIN . QLRT-2001-01349. Marketing sustainable agriculture: an analysis of the potential role of new food supp.ly chains in sustainable rural development.

FSA/WAG. 2003. *Food and Wellbeing: A National Strategy for Wales,* Cardiff, Food Standards Agency/Welsh Assembly Government

FW. 2013. Welsh red meat body warns of £500,000 levy loss, Farmers Weekly, 12 April 2013

Garrow . 1994. Starvation in Hospitals, BMJ 308(9) p.34

Giddens, A. 1979 *Central Problems in Social Theory: Action, Structure and Contradiction in Social Analysis*, London: Macmillan

Gilligan, C. 1982. *In a different voice : psychological theory and women's development*, Cambridge, Harvard University Press

Gordon, E. 2006. The Political context of evidence-based medicine: policymaking for daily haemodialysis, *Social Science & Medicine* 62 pp. 2707-19

Green, P. 2010. Efficiency Review: Key Findings and Recommendations, London, Cabinet Office available from http://download.cabinetoffice.gov.uk/efficiency/sirphilipgreenreview.pdf [accessed 17.6.11]

Griffiths, D. 1998. *50 Years of the National Health Service Estate in Wales*, Cardiff, Welsh Health Estates

Hall, M. and Purchase, D. 2006. Building or bodging? Attitudes to sustainability in UK public sector housing construction development. *Sustainable Development,* 14(3) pp. 205-218.

Hammersley, M. 2001. On "Systematic reviews of research literature: a "narrative" response to Evans and Benefield *British Educational Research Journal* 27(5), pp.543-554

Hart, E . 2010. Written Statement by Edwina Hart, Minister for Health and Social Services, 6 October 2010, available from http://wales.gov.uk/about/cabinet/cabinetstatements/2010/101006share/?lang=en [last accessed 12.11.12].

Hartwell, H. and Edwards, J. 2009. Descriptive Menus and Branding in Hospital Foodservice: A Pilot Study. *International Journal of Contemporary Hospitality Management*, 21(7) pp. 906-916.

Hartwell, H. and Edwards, J. 2003. A comparative analysis of 'plated' and 'bulk trolley' hospital food service systems. *Food Service Technology*, 3(3/4) pp. 133-142.

Hartwell, H. and Edwards, J. 2001. A preliminary assessment of two hospital food service systems using parameters of food safety and consumer opinion. *Journal of the Royal Society for the Promotion of Health*, 121(4) pp. 236-242.

Hartwell, H. Edwards, J. Beavis, J. 2007. Plate versus bulk trolley food service in a hospital: comparison of patients' satisfaction. *Nutrition*, 23 . 3., pp. 211-218.

Hartwell, H. Edwards, J. Symonds, C. 2006. Foodservice in hospital: development of a theoretical model for patient experience and satisfaction using one hospital in

the UK National Health Service as a case study. *Journal of Foodservice*, 17 . 5-6., pp. 226-238.

Held, V. 2005. *Ethics of Care, Personal, Political and Global*, Oxford, Oxford University Press

Hill, G.L. Blackett, R.L. Pickford, I. 1977. Malnutrition in Surgical patients. An unrecognised problem, *Lancet* 261. 8013.: pp. 689-692

HIW . 2012. A Review of Governance Arrangements at Cwm Taf Health Board, Caerphilly, Healthcare Inspectorate Wales

HIW. 2012a. Unannounced Dignity and Essential Care Reports, available from http://www.hiw.org.uk/page.cfm?orgid=477&pid=57445

HMT. 2003. *The Green Book*, H M Treasury, available from http://www.hm-treasury.gov.uk/d/green_book_complete.pdf [last accessed 22.2.13]

HMT . 2007. *Transforming Government Procurement*, Norwich , HMSO

HMT . 2009. *HM Treasury/Office of National Statistics Public Expenditure Statistical Analyses* . PESA.

Horan, D. and Coad, J. 2000. *Can nurses improve patient feeding?* Nursing Times; 96(50) pp. 33-4.

House of Commons Environmental Audit Committee, 2005, Greening Government: the 2004 Sustainable Development in Government Report, available from http://www.publications.parliament.uk/pa/cm200506/cmselect/cmenvaud/698/698.pdf [last accessed 22.2.13]

Hutt, J. 2012. Oral Statement to National Assembly, 19 June 2012 downloaded from http://www.assemblywales.org/bus-home/bus-chamber-fourth-assembly-rop.htm?act=dis&id=235388&ds=6%2F2012#04 25.7.12

Jones, C . 2011. Written Statement by the Welsh Assembly Government on One Wales Delivery Plan 31 March 2011, downloaded from http://wales.gov.uk/about/cabinet/cabinetstatements/2011/110331one/?lang=en 25.7.12

Hwang, J.L. Desombre, T. Eves, A. Kipps, M. 1999. An analysis of catering options within NHS acute hospitals. *International journal of health care quality assurance,* 12:(7) pp. 293-308.

Jochelson, K. 2005. *Sustainable Food and the NHS*: Executive Summary, London, Kings Fund

Jochelson, K. Norwood, S. Hussain, S. Heer, B. 2005. *Sustainable Food and the NHS: A report for the Better Hospital Food Programme*, London, Kings Fund (unpublished)

Jones, A . 2012., Speech at annual Hybu Cig Cymru Conference, 8 November 2012 available from http://hccmpw.org.uk/news_and_events/news/story/conference_2012_alun_davies

Johns, N. Hartwell, H. Morgan, M . 2010. Improving the provision of meals in hospital. The patients' viewpoint, *Appetite* 54 pp. 181-185

Johnson, P. Beuhring, A. Cassell, C. Symon, G. 2006. Evaluating qualitative management research: towards a contingent criteriology. *International Journal of Management Reviews*, 8, pp.131–156.

Kates, R. Parris, R.W. Leiserowitz, A.A . 2005. What is Sustainable Development? *Environment: Science and Policy for Sustainable Development*, 47(3) pp. 8–21.

Kelly, L.E. Tessier, S. Cahill, A. 2000. Still Hungry in Hospital: Identifying malnutrition in acute hospital admissions, *Quarterly Journal of Medicine*, 93(2) pp. 93-98

Kersley, H. 2011 *The Benefits of Procuring School Meals through the Food for Life Partnership: An economic analysis for FFLP*, London, New Economics Foundation

Kirkby. J. O'Keefe, P. Timberlake, L. 1995. *The Earthscan Reader in Sustainable Development*, London, Earthscan

Kirwan, J. and Foster, C. 2006. *Public sector food procurement through partnerships: the Cornwall Food Programme*. pp. 155-164. In D. Roep and H. Wiskerke . eds., Nourishing Networks: Fourteen Lessons About Creating Sustainable Food Supp.ly Chains. Rural Sociology Group, Wageningen University; and Reed Business Information, Agriboek, PO Box 4, 7000 BA Doetinchem, The Netherlands

Kirwan, J. and Foster, C. 2007. *Public sector food procurement in the UK: examining the creation of an alternative system.* pp. 185-201. In D. Maye, L. Holloway and M. Kneafsey . eds., Alternative Food Geographies: Representation and Practice. Elsevier: Oxford.

Kitchen, L. Marsden, T. 2011. Constructing sustainable communities: a theoretical exploration of the bioeconomy and eco-economy paradigms, *Local Environment* 16(8) pp. 753–769.

Klein, R. 2010. *The New Politics of the NHS: from creation to reinvention,* 6th edn. Oxford, Radcliffe Publishing

Kooiman, J. 2003. *Governing as Governance*, London, Sage

Lambert, H., Gordon, E. Bogdan-Lovis. E. 2006. Introduction: Gift Horse or Trojan Horse? Social science perspectives on evidence-based health care, Social Science and Medicine. 62(11) pp. 2613-2620

Lamy, P. 2012. Statement to formal meeting on revised Government Procurement Agreement, 30 March 2012, available from: http://www.wto.org/english/news_e/news12_e/gpro_30mar12_e.htm [downloaded 25.10.12]

Lane, A. and Jenkins, E . 2007. The Impact of NHS Re-Organisation on Service Commissioning Costs: A Welsh Case Study, *Journal of Finance and Management in Public Services,* 6(2) p.p.11-25

Lang, T. Heaseman, M.A. 2004*. Food Wars: the global battle for minds, mouths, and markets*, London, Earthscan

Langhelle, O. 2000. Why Ecological Modernization and Sustainable Development Should Not Be Conflated *Journal of Environmental Policy & Planning,* 2 pp.303–322

Langley, A. 1999. Strategies for Theorizing from Process Data, Academy *of Management Review,* 24(4) pp. 691-710.

Langley, A . 2007. Process thinking in strategic organization, *Strategic Organization* 5: pp. 271-282.

Langley, A . 2009. Studying Processes in and Around Organizations In: Buchanan DA and Bryman A . 2009. (eds) *The Sage Handbook of Organizational Research Methods,* London, Sage Publications

Lawton, A. 1998. *Ethical Management for the Public Services,* Oxford, Oxford University Press

Lee M. Koh, J. 2000. Is empowerment really a new thing? *International Journal of Human Resource Management* 12:4 pp. 684-695

Learmouth, M . 2009. Rhetoric and Evidence: the case of Evidence Based Management In: Buchanan, D.A. and Bryman, A . 2009.(eds) *The Sage Handbook of Organizational Research Methods*, London, Sage Publications

Lewis, M. Carey, S. Phillips, W. 2009. *Taking Forward Shared Services in NHS Wales*, Bath, University of Bath School of Management

Lukes, S. 2005., *Power: A Radical View. [online].* Palgrave Macmillan.

Lundqvist, L .J. 2001. A Green Fist in a Velvet Glove: the Ecological State and Sustainable Development, *Environmental Values,*10 pp.455-72

MacArthur, Phillips, C. Simpson, H. 2012. *Improving Quality Reduces Costs - Quality as the Business Strategy,* Improving Healthcare White Paper Series No. 8, 1000 Lives Plus [available from 1000livesplus.wales.nhs.uk]

Mannion, R. Davies, H.T.O. Marshall, M . 2005. *Cultures for performance in health care*, Maidenhead, Open University Press

Martin, S. 2010. Regulation In: Ashworth, R, Boyne, G, Entwistle, T. 2010. *Public Service Improvements: Theories and Evidence,* Oxford, Oxford University Press

Matthews, D. and Axelrod, S. 2004. Whole life considerations in IT procurement. *The international journal of life cycle assessment*, 9:6, pp. 344-348.

May, D. and Smith, L. 2003. Evaluation of the new ward housekeeper role in UK NHS Trusts. *Facilities* 21(7) pp.168-174.

May, D, Pinder,J. 2008. "The impact of facilities management on patient outcomes", *Facilities*, 26 (5/6) pp. 213 – 228

McCrudden, C. 2004. Using public procurement to achieve social outcomes, *Natural Resources Forum*, 28 pp. 257-267

McClelland, J. 2012. *Maximising the Impact of Welsh Procurement Policy,* available from
http://wales.gov.uk/topics/improvingservices/bettervfm/publications/mcclellandrevie
wsummary/;jsessionid=488CA530151655B037F1CAB803A4567B?lang=en

McWhirter, J.P. Pennington, C.R . 1994. Incidence and recognition of malnutrition in hospital, *British Medical Journal* 308, pp. 945-948

Meadowcroft ,J . 2007. National Sustainable Development Strategies, Features, Challenges, Reflexivity, *European Environment,* 17 pp.152–163

Meadowcroft , J. Farrell, K. N. Spangenberg, J. 2005. Developing a framework for sustainability governance in the EU, *International Journal of Sustainable Development*, 8, pp. 3-11

Miemczyk, J. Johnsen, T. E. Macquet, M. 2011. Sustainable Purchasing and Supp.ly Management: a Structured Literature Review of Definitions and Measures at the Dyad, chain and Network Levels, *Supply Chain Management an International Journal,* 17(5) pp. 478-496

Miller, M. May, D. 2006. Patient choice in the NHS: How critical are facilities services in influencing patient choice?, *Facilities* 24(9-10) pp. 354-364

Mikkelsen, B.E. Kristensen, N.H. Nielsen, T. 2005. Change processes in large scale public foodservice – case findings from implementation of organic foods in a Danish county, *Foodservice Business Research*, 8(2) pp. 87-105

Mikkelsen, B.E. Sylvest, J. 2012. Organic Foods on the Public Plate: Technical Challenge or Organizational Change? *Journal of Foodservice Business Research*, 15(1) pp. 64-83

Mintzberg, H. Ahlstrand, B. Lampel, J. 2009. *Strategy Safari*. (2nd edn.). Harlow: Prentice Hall

Morgan, G. 1986. *Images of Organization.* London: Sage

Morgan, G. 1990. *Organizations in Society.* Basingstoke: MacMilllan

Morgan, K . 2007. *Greening the Realm: Sustainable Food Chains and the Public Plate,* BRASS Working Paper no 43. Cardiff, Cardiff University

Morgan, K . 2008. Greening the Realm: Sustainable Food Chains and the Public Plate: *Regional Studies* 42(9) pp. 1237-1250

Morgan, K . 2010. Local and green, global and fair: the ethical foodscape and the politics of care, *Environment and Planning A* 42, pp. 1852 - 1867

Morgan, K . 2011. The Green State: Sustainability and the Power of Purchase in: Pike A, Rodriguez-Pose A, Tomaney J . 2011. *Handbook of Local and Regional Development*, Abingdon, Routledge

Morgan, K. Marsden, T. Murdoch, J. 2006. *Worlds of Food, Place Power and Provenance in the Food Chain,* Oxford, Oxford University Press

Morgan, K, Morley, A . 2002. *Relocalising the Food Chain, The role of Creative Public Procurement*, Cardiff, Regeneration Institute

Morgan, K., Sonnino, R. 2005. *Catering for Sustainability: The Creative Procurement of School Meals in Italy and the UK,* The Regeneration Institute, Cardiff University

Morgan, K., & Sonnino, R. . 2007. Empowering consumers: the creative procurement of school meals in Italy and the UK. *International Journal of Consumer Studies*, 31(1) pp. 19-25.

Morgan, K, Sonnino, R. 2008. *The School Food Revolution, Public Food and the Challenge of Sustainable Development*, London, Earthscan

Morgan, R . 2008. Written Statement by the Welsh Assembly Government on One Wales Delivery Plan, 8 April 2008, downloaded from http://wales.gov.uk/about/cabinet/cabinetstatements/2008/delivery/?lang=en 25.7.12

Mosca, I. 2006. Is decentralisation the real solution? A three country study, *Health Policy*, 77 pp. 113-120

Mur-Veeman, I. van Raak, A. Paulus, A . 2008. Comparing integrated care policy in Europe: Does policy matter? *Health Policy* 85 pp.172-183

Murray, J.G. 2009. Towards a common understanding of the differences between purchasing, procurement and commissioning in the UK public sector, *Journal of Purchasing & Supp.ly Management*, 15 pp.198–202

NAO . 2005. *Sustainable Procurement in Central Government*, London, National Audit Office

NAO . 2006. *Smarter Food procurement in the Public Sector*, London, National Audit Office

NAW . 2001. *Improving Health in Wales: A Plan for the NHS and its Partners*, Cardiff, National Assembly for Wales

NEF . 2005. *Public Spending for Public Benefit*, London, New Economics Foundation,   available from www.neweconomics.org [last accessed 21.2.13]

Netherwood, A. . 2011. *Progress in Embedding the "One Planet" aspiration in Welsh Government*" available from wwf.org.uk [last accessed 25.7.12]

Nettleton. 1995. *The Sociology of Health and Illness*, Cambridge, Polity Press

NHS Wales. 1998. *Putting Patients First*, Cardiff, NHS Wales

NHS Wales. 2000. *Access and Excellence, Acute Health Services in Wales*, Cardiff, NHS Wales

NHS Wales. 2007. Healthy Sustainable Wales: the NHS Contribution, available from http://wales.gov.uk/docs/phhs/publications/100527technicalen.pdf [last downloaded 8.1.13]

NHS Wales. 2010. *Model Standing Financial Instructions*, Cardiff, NHS Wales/ Welsh Assembly Government, Cardiff, NHS Wales

NHS Wales. 2010a. *Model Standing Orders*, Cardiff, NHS Wales/ Welsh Assembly Government, Cardiff, NHS Wales

NHS Wales. 2010b. *Service, Workforce and Financial Strategic Framework for the NHS,* Cardiff, NHS Wales

NHS Wales. 2010c. *Quality and Safety Committee Handbook,* Cardiff, NHS Wales

NHS Wales . 2011. *Terms of Reference and Operating Arrangements*: *Shared Services Partnership*

NHS Wales . 2012.   Conditions of Contract for the Purchase of Goods Version: 2.0 Issued: February 2012.

NHS Wales . 2012a.   Model Standing Financial Instructions for Local Health Boards, July 2012

NHS Wales, 2012b*. NHS Wales Audit Committee Handbook, July 2012*, Cardiff, NHS Wales

NHS Wales. 2012c. NHS Wales e-governance Manual, available from http://www.nhswalesgovernance.com/display/home.aspx

NLIAH . 2005. *Integrated Care Pathways: A Guide to Good Practice*, Cardiff, National Leadership and Innovation Agency for Healthcare

Noddings, N . 2003. 2nd Edn, *Caring : a feminine approach to ethics & moral education* Berkeley, University of California Press

Nussbaum, M. 2000. *Women and Human Development: The Capabilities Approach.* Cambridge, Cambridge University Press

NWSSP. 2012. *Annual Review, 2011-2012*, Cardiff, NHS Wales Shared Services Partnership

NWSSP-FS . 2012. *The NHS Estate in Wales, Facilities Performance Report 2011/12*, Cardiff, NHS Wales Shared Services Partnership, Facilities Services

NWSSP-PS. 2012. *Instructions to Tenderers and Specification for the Direct Delivery of Yoghurt to the NHS in Wales: AW4160*, Cardiff, NHS Wales Shared Services Partnership, Procurement Services

NWSSP-PS1 . 2012. Welsh Government Food Purchasing Survey 2012, Procurement Services Response

NWSSP-PS2 . 2012. Personal Communication LFR3 data, Cardiff, Procurement Services

NWSSP-PS. 2013. *All Wales Menu Framework, available from:*
http://www.whs.wales.nhs.uk/allwaleshospitalmenu [accessed, 30.1.13]

NWSSP-PS. 2013a. Meat Origin Update 18 February 2013 available from
(http://www.whs.wales.nhs.uk/30894) [last accessed 8.3.13]

NWSSP-PS. 2013b. Public Sector Sustainable Procurement Assessment Framework,
WHS SPAF.smt calcs [provided by NWSSP_PS, 20.12.12]

Ogbonna, E. Harris, L.C. 2002. Managing Organisational Culture: insights from the
hospitality industry, *Human resource management Journal* 12(1) pp.33-53

OGC . 2003. Joint Note on Environmental Issues in Purchasing, available online
http://www.ogc.gov.uk/documents/Environmental_Issues_In_Purchasing.pdf [last
accessed 20 June 2011]

OGC . 2006. Social Issues in Purchasing, available online from
http://webarchive.nationalarchives.gov.uk/20100503135839/http:/www.ogc.gov.uk/d
elivering_policy_aims_through_public_procurement_social_issues.asp [last
accessed 21.2.13]

OPC . 2011. *Dignity in Care? The Experiences of Older People in Hospital in Wales,*
Cardiff, Older Peoples Commission

OPC, 2012, *Dignified Care? One Year On*, Cardiff, Older Peoples Commission

Orme, J. Jones, M. Kimberlee, R. Weitcamp, E. Slamon, D. Narges, D. Morley, A.
Morgan, K. 2011, *Food for Life Partnership Evaluation*, Bristol, UWE

Ovretveit, J. Hansson, J. Brommels, M. 2010. An integrated health and social care
organisation in Sweden: Creation and structure of a unique local public health and
social care system, Health Policy 97 pp.113-121.

PAC . 04. – 04-11: *Hospital Catering and Nutrition, submission by Ruth Marks*
available from
http://www.senedd.assemblywales.org/ieIssueDetails.aspx?IId=1252&Opt=3

PAC . 04. – 06-11: *Hospital Catering and Nutrition, submission by Welsh
Government* available from
http://www.senedd.assemblywales.org/ieIssueDetails.aspx?IId=1252&Opt=3

PAC. 4.-07-11 – Paper 3 – *Welsh Government evidence: Hospital Catering and
Patient Nutrition* available from
http://www.senedd.assemblywales.org/ieIssueDetails.aspx?IId=1252&Opt=3

PAC. 4. 08-12 Paper 2 – *Welsh Government's response to Hospital Catering and
Patient Nutrition* available from
http://www.senedd.assemblywales.org/ieIssueDetails.aspx?IId=1252&Opt=3

PAC. 4. 08-12 (a) Paper 3 – *Advice from the Auditor General for Wales on the
Welsh Government's response to Hospital Catering and Patient Nutrition* available
from http://www.senedd.assemblywales.org/ieIssueDetails.aspx?IId=1252&Opt=3

Paisley, C.M. Tudor Smith, C . 2001. Food and Catering Policies in NHS Hospitals
in Wales, *Health Education Journal* 60 pp. 327-338

PC, 2002, *Farming & Food: A Sustainable Future*, London , Cabinet Office

Peckham, P. Petts, J. (eds). 2003. *Good Food on the Public Pate,* Sustain; East Anglia Food Links

Pettigrew, A. 1987. Context and Action in the Transformation of the Firm. *Journal of Management Studies* 24(6) pp. 649-670

Pettigrew, A. 1997. What is Processual Analysis. *Scandinavian Journal of Management* 13(4) pp. 337-348

Pettigrew, A.M. 2012. Context and Action in the Transformation of the Firm: A Reprise, *Journal of Management Studies,* 49 (7) pp.1304-1328.

Pettigrew, A.M. Ferlie, E. McKee, L. 1992. *Shaping Strategic Change.* London: Sage
Pfeffer, J . 2006. Bringing the Environment back in: The Social Context of Business Strategy.

Power, M. 1997, *The Audit Explosion*, London, Demos

Preuss, L. 2007. Buying into our Future: Sustainability Initiatives in Local Government Procurement, *Business Strategy and the Environment* 16 pp. 354–365

Preuss, L. 2009. Addressing sustainable development through public procurement: the case of local government, *Supply Chain Management: An International Journal* 14(3) pp. 213-223

Preuss, L. and Walker, H. 2011. Psychological barriers in the road to sustainable development: evidence from public sector procurement. *Public Administration*, 89(2) pp. 493-521.

PSLG . 2012. (04)15-03 Working Paper 3i.AMP Procurement Workstream Update, available from
http://wales.gov.uk/topics/improvingservices/pslg/pslgmtgs/120315psjlgmtg/?lang=en [last accessed 2.4.13]

PSLG . 2012a. . WG PSGL . 04.-15-03 Working Paper 2, AMP Procurement Workstream – National Procurement Service Project Discussion Paper
ttp://wales.gov.uk/topics/improvingservices/pslg/pslgmtgs/120315psjlgmtg/?lang=en [last accessed 2.4.13]

PWC. 2011. *Understanding Commissioning Behaviours: Commissioning and Competition in the Public Sector, A report for the Office of fair Trading*, available from
http://www.oft.gov.uk/shared_oft/reports/comp_policy/commissioning%2Bcompetition.pdf [last accessed 21.2.13]

PWC. 2011a. *Effectiveness review of the Sustainable Development Scheme: A Report to Welsh Government*, available from www.wales.gov.uk

Pye, A. and Pettigrew, A.M. 2006. Strategizing and Organizing: Change as a Political Learning Process, Enabled by Leadership, *Long Range Planning*, 2006, 39 pp. 583-590

RCN. 2012. Policy Briefing 2012, available from
http://www.rcn.org.uk/aboutus/wales/time_to_care [last accessed, 15.1.13]

RCN. 2012a. We're Transforming Care, March 2012 edition, downloaded from
http://www.1000livesplus.wales.nhs.uk/sitesplus/documents/1011/Were%20Transfo
rming%20Care%20FINAL%20Version.pdf [accessed3.12.13]

Reed, M. 2009. Critical Realism: Philosophy, Method or Philosophy in Search of a
Method? in: Buchanan DA, Bryman A . 2009. eds. *The Sage Handbook of
Organizational Research Methods*, London, Sage

Richmond, J. 2007. Developing the role of a ward housekeeper within a
multidisciplinary team , *British Journal of Nursing,* 16(1) pp. 56-59

Rimmington, M Carlton Smith J, Hawkins K . 2005. Corporate Social Responsibility
and Sustainable Food Procurement , B*ritish Food Journal,* 108(10) pp. 824-837

Ringwald, K. Lee, C. Williams, H. Cahill, D. Cifford, G. Evans, C. 2009. *Barriers to
Procurement Opportunity Research*, Llantrissant, University of Glamorgan

Russell, C. 2007. *A Fresh Approach to Hospital Food*, Bristol, Soil Association

Savage, J. Scott, C. 2005. *Patients nutritional care in hospital: an ethnographic
study of nurses' role and patients' experience.* NHS Estates

Sayer, A. 2000. Moral Economy and Political Economy, *Studies in Political
Economy* 62 pp. 79-104

Sayer, A. 2000a. *Realism and Social Science*, London, Sage

Sayer, A. 2004. *Moral Economy*, published by the Department of Sociology,
Lancaster University, available from
http://www.comp.lancs.ac.uk/sociology/papers/sayer-moral-economy.pdf

Sayer ,A. 2010. *Method in Social Science*, (revised 2nd edn.) Abingdon, Routledge

Schein EH . 2010. *Organizational Culture and Leadership: A Dynamic View*, (4th
edn.). San Fransisco, Jossey-Bass

SDiG 2004 Sustainable Development in Government: Thirds Annual Report, 2004,
available from
http://collections.europarchive.org/tna/20080530153425/http://www.sustainable-
development.gov.uk/publications/report2004/fore.htm [last accessed 21.2.13]

Seddon, J. 2008. *Systems Thinking in the Public Sector: the failure of the reform
regime and a manifesto for a better way* Axminster, Triarchy Press

Sen, A. 1993. Capability and Wellbeing in: *The Quality of Life*, Nussbaum, M. Sen,
A. (eds). Oxford, Oxford University Press

Sen.A. 2009. *The Idea of Justice*, London, Penguin

Senge, P.M. 2006. *The fifth discipline: the art and practice of the learning
organization*, London, Random House Business

Seuring, S. Muller, M. 2008. From a Literature Review to a Conceptual Framework for Sustainable Supply Chain Management, Journal of Cleaner Production 16(15) pp.1699-1710

Sminia, H. 2009. Process research in strategy formation: Theory, methodology and relevance, *International Journal of Management Reviews* 11(1) pp. 97-125

SI 2003 No. 154. WSI. 24. *Health, Social Care and Wellbeing Strategies . Wales. Regulations*

SI 2009 No. 779 . WSI, 79.*The Local Health Boards . Constitution, Membership and Procedures. . Wales. Regulations*

SI 2011 No.13 National Health Service . Wales. Act 2006 the NHS Wales Shared Services Directions 2011

Smith, P.C, Anell, A. Busse, R. Crivelli, L. Healy, J. Lindahl, A.K. Westert, G. Kene, T. 2012. Leadership and governance in seven developed health systems. *Health Policy* 106 pp. 37-49

Soil Association . 2011. *First Aid for Hospital Food*, Bristol, Soil Association

Sonnino, R. 2009. Quality food, public procurement, and sustainable development: the school meal revolution in Rome, *Environment and Planning A* 41 pp. 425 - 440

Sonnino, R. 2010. Escaping the Local Trap: Insights on Re-localization from School Food Reform. *Journal of Environmental Policy and Planning*, 12(1) pp. 23-40

Sonnino, R. and McWilliam, S. 2011. Food waste, catering practices and public procurement: A case study of hospital food systems in Wales. *Food Policy* 36(6) pp. 823-829.

STATS Wales: 025417: Hlth1707: H&CHS Complaints by Subject, available from http://statswales1.wales.gov.uk/TableViewer/tableView.aspx .

Stoker, G. 1998. Governance as Theory, Five Propositions, *International Social Science Journal* 50 (155) pp. 17–28

Stratton, R. Eliah, M. 2000. How much undernutrition is there in hospitals? *British Journal of Nutrition* 84 pp. 257–9

Sustain. 2009. *A decade of hospital food failure*, *a review of ten years of failed voluntary initiatives to improve hospital food:* Sustain, http://www.sustainweb.org/publications/?id=182 [accessed 18.2.13]

Sustain. 2010. *Yet more hospital food failure: the bill rises to £54million and still counting*, Sustain, http://www.sustainweb.org/publications/?id=181 [accessed 18.2.13]

Sustain. 2013. *Twenty Years of Hospital Food failure, Why we need mandatory standards, not more ineffective voluntary initiatives*, Sustain, available from http://www.sustainweb.org/publications/?id=265 [last accessed 22.2.13]

Teeman, D. Featherstone, G. Sims, D. Sharp, C. 2011. *Qualitative Impact Evaluation of the Food for Life Partnership*, Slough, National Foundation for Education Research

Thatcher, J. Sharp, L. 2008. Measuring the local economic impact of National Health Service procurement in the UK: An evaluation of the Cornwall Food Programme and LM3, *Local Environment* 13(3) pp. 253 -270

Toth, F. 2010. Healthcare policies over the last 20 years: Reforms and counter-reforms, *Health Policy*, 95 pp. 82-89

Tronto, J. 1993. *Moral boundaries, a Political Argument for an Ethic of Care*, Routledge, New York

Tsoukas, H. 2009. Craving for Generality in Small N Studies: A Wittgenstein Approach towards the Epistemology of the Particular in Organization and Management Studies In: Buchanan, D.A. and Bryman, A. 2009. (eds) *The Sage Handbook of Organizational Research Methods*, London, Sage Publications

Van de Ven, A.H. and Poole, M.S. 2005. Alternative approaches for studying organizational change *Organization Studies*, 26, pp. 1377–1404

Vion (2013) Welsh Country Foods Announces Site Closure, Press release 11 April 2013 available from http://www.vionfoodgroup.com/en/news-press/news/post/welsh-country-foods-announces-site-closure/show.html [accessed 22.4.13]

WAG. 2000. *'A Better Wales', a 10-year plan with targets for improving life for everyone in Wales*, Cardiff, Welsh Assembly Government

WAG. 2000a. *Learning to Live Differently*, Cardiff, Welsh Assembly Government

WAG. 2001. *Better Value Wales A Review of Procurement in the Welsh Public Sector*, Cardiff, Welsh Assembly Government

WAG. 2002. *Wellbeing in Wales*, Cardiff, Welsh Assembly Government

WAG. 2002a. *Nutrition and Catering Framework for NHS Trusts*, Cardiff, Welsh Assembly Government

WAG. 2003. *Fundamentals of Care: Guidance for Health and Social Care Staff*, Cardiff, Welsh Assembly Government

WAG. 2003a. *The Review of Health and Social Care in Wales*, Cardiff, Welsh Assembly Government

WAG. 2003b. *Wales a Better Country: the Strategic Agenda of the Welsh Assembly Government*, Cardiff, Welsh Assembly Government

WAG. 2004. Food for Thought – A new approach to public sector food procurement, Cardiff, Welsh Procurement Initiative

WAG. 2004a. *Making the Connections: Delivering Better Services for Wales,* Cardiff, Welsh Assembly Government

WAG. 2004b. Starting to Live Differently, Cardiff, Welsh Assembly Government

WAG. 2005. *Designed for Life: Creating World Class Health and Social Care for Wales in the 21st Century*, Cardiff, Welsh Assembly Government

WAG. 2005a. Healthcare Standards for Wales: Making the Connections Designed for Life, Cardiff, Welsh Assembly Government

WAG. 2005b. *Food for Thought – A New Approach to Public Sector Food Procurement - Case Studies*, Cardiff, Welsh Assembly Government

WAG. 2006. *Beyond Boundaries, Citizen-Centred Local Services for Wales: A Review of Local Service Delivery,* Cardiff, Welsh Assembly Government

WAG. 2006a. *Making the Connections: Delivering Beyond Boundaries: Transforming Public Services in Wales*, Cardiff, Welsh Assembly Government

WAG. 2006b *National Service Framework for Older People in Wales,* Cardiff, Welsh Assembly Government

WAG. 2007. *One Wales: A Progressive Agenda for the Government of Wales*, Cardiff, Welsh Assembly Government

WAG. 2008. *Free to Lead Free to Care,* Cardiff, Welsh Assembly Government

WAG. 2008a *Free to Lead, Free to Care Empowering ward sisters/charge nurses ministerial, Task and finish group, Final Report*, Cardiff, Welsh Assembly Government

WAG. 2008b. *Opening Doors: The Charter for SME Friendly Procurement* , Cardiff, Welsh Assembly Government

WAG. 2008c. The Strategy for Older People in Wales 2008-2013, Cardiff, Welsh Assembly Government

WAG. 2009. *Better Outcomes for Tougher Times,* Cardiff, Welsh Assembly Government

WAG. 2009b. *Local Sourcing Action Plan: Food and Drink for Wales Our Healthy Future*, Cardiff, Welsh Assembly Government

WAG. 2009c. *One Wales: One Planet the Sustainable Development Scheme of the Welsh Assembly Government*, Cardiff, Welsh Assembly Government

WAG. 2009d. *Our Healthy Future*, Cardiff, Welsh Assembly Government

WAG. 2010. *Adding Value II: Showcasing examples of good practice in procurement and delivery* Cardiff, Welsh Assembly Government

WAG. 2010a. *Buying Safe Food for the Public Plate*, Cardiff, Welsh Assembly Government

WAG. 2010b. *Doing Well Doing Better: Healthcare Standards for Wales* Cardiff, Welsh Assembly Government

WAG. 2010c. *Economic Renewal Programme* Cardiff, Welsh Assembly Government

WAG. 2010d. *Setting the Direction*, Cardiff, Welsh Assembly Government Strategic

WAG. 2010e. *Action Plan for the Welsh Horticulture Industry*, Cardiff, Welsh Assembly Government

WAG. 2010f. *Health at Work, the Corporate Health Standard*, Cardiff, Welsh Assembly Government

WAG. 2011. *All Wales Nutrition and Catering Standards for Food and Fluid Provision for Hospital Inpatients*, Cardiff, Welsh Assembly Government

WAG. 2011a. *Together for Health*, Cardiff, Welsh Assembly Government

WAG. 2011b. *Fairer Outcomes for All*, Cardiff, Welsh Assembly Government

WAG. 2011c. *Invest-to-Save: short term investment for long term benefit*, Cardiff, Welsh Assembly Government

WAG. 2011d. Response to the EU Consultation on Modernisation of the Procurement Directives, letter from Alison Standfast to European Commissioner for Internal Market and Services dated 18 April 2011

WAG. 2011e. *Fairer Outcomes for All: Our Healthy Future Technical Working Paper 2* available from http://wales.gov.uk/topics/health/ocmo/healthy/?lang=en [last accessed 8.1.13].

Walker, A . 2012. Letter to LHBs and Trusts Dated 17 July 2012

Walker, H. Di Sisto, L. McBain, D. 2008. Drivers and barriers to environmental supply chain management practices: Lessons from the public and private sectors. *Journal of Purchasing and Supply Management*, 14(1) pp. 69-85.

Walker, H. Brammer, S. 2009. Sustainable procurement in the United Kingdom public sector, *Supply Chain Management: An International Journal* 14(2) pp.213-223 pp. 128-137

Walker, H. Preuss, L. 2008. Fostering sustainability through sourcing from small businesses: public sector perspectives, *Journal of Cleaner Production*, 16 pp.1600-1609

WAO. 2010. *Sustainable Development and Business Decision Making in the Welsh Assembly Government,* Cardiff, Wales Audit Office

WAO. 2010a. Individual LHB Hospital Catering and Nutrition Audit Reports, available from http://www.wao.gov.uk/reportsandpublications/localhealthboards_2855.asp

WAO. 2010b. Hospital Catering Audit Guide, Cardiff, Wales Audit Office

WAO. 2011. *A Picture of Public Services: The Key Financial Challenges Facing Welsh Public Services*, Cardiff, Wales Audit Office

WAO. 2011a. *Hospital Catering and Patient Nutrition*, Cardiff, Wales Audit Office

WAO. 2011b, *Eating Well in Hospital - What you should Expect*, Cardiff, Wales Audit office

WAO. 2011c, *Hospital Catering and Patient Nutrition - A Checklist for Board Members*, Cardiff, Wales Audit Office

WAO. 2012. Health Finances, Cardiff, Wales Audit Office

Weale, A . 1992. The Politics of Pollution, Manchester, Manchester University Press

Weick, K E. 1995 Sense-making in Organizations, Thousand Oaks, CA, Sage

WG. 2011. *Programme for Government*, Cardiff, Welsh Government

WG. 2011a. *Food Strategy for Wales*, Cardiff, Welsh Government

WG. 2011b. *Supporting healthy Food and Drink Choices for Staff and Visitors in Hospitals*, Cardiff, Welsh Government

WG. 2012. *All Wales Fundamentals of Care Audit: A summary of the NHS organisations' compliance with the standards based on 2011 audit* Cardiff, Welsh Government

WG. 2012a. All Wales Menu Task and Finish Group, Report to Minister, April 2012 . unpublished.

WG. 2012b. *Food for Wales, Food from Wales*, Cardiff Welsh Government

WG. 2012c. *Programme for Government, Annual Report,* Cardiff, Welsh Government

WG. 2012d. *Healthcare Standard 10: Dignity and Respect, Supporting Guidance*, July 2012, Cardiff, Welsh Government [available from http://www.nhswalesgovernance.com]

WG. 2012e. *Healthcare Standard 2: Equality, Diversity and Human Rights, Supporting Guidance*, July 2012, Cardiff, Welsh Government [available from http://www.nhswalesgovernance.com]

WG. 2012f. *Healthcare Standard 14: Nutrition, , Supporting Guidance*, *February 2013* Cardiff, Welsh Government [available from http://www.nhswalesgovernance.com]

WG. 2012g. *Achieving Excellence: The Quality Delivery Plan for the NHS in Wales,* Cardiff, Welsh Government

WHC 2006. 67 *Nutrition in Hospital – Importance of Welsh Risk Pool Standard No. 23* Cardiff, Welsh Assembly Government

WHC. 2007.034 "Healthy Sustainable Wales The NHS Contribution – A Sustainable Development Toolkit for NHS Bodies in Wales

WHO. 2007. *Everybody's business: strengthening health systems to improve health outcomes. WHO's framework for action*. Geneva: World Health Organization.

WHS. 2007. *Annual Report Welsh Health Supplies*, Cardiff, Welsh Health Supplies

Wood, S. 1998. Full-service nutritional aspects of nursing, *Nursing Times*; 94(32) pp. 24-6.

WPI. 2004. *Food for Thought*, Cardiff, Welsh Procurement Initiative

Yin, R. . 2010. *Case Study Research, Design and Methods.* (4th edn.) Thousand Oaks CA, Sage

Yeung, HW. 1997. Critical Realism and realist research in human geography: a method or a philosophy in search of a method? Progress in Human Geography, 21(51) pp. 51-74

Zokaei, K., Elias, S. O'Donovan, B. Samuel, D. Evans, B. Goodfellow, J. 2010. *Lean and Systems Thinking in the Public Sector in Wales*, Cardiff, Lean Enterprise Research Centre, Cardiff University

Internet Resources:

NHS Wales e-governance manual:
http://www.nhswalesgovernance.com/display/home.aspx

1000 Lives Plus: http://www.1000livesplus.wales.nhs.uk

ERAS: http://www.1000livesplus.wales.nhs.uk/tv
        May 2012, Cardiff and Vale
        May, 2012, Abertawe Bro Morgannwg
        November, 2010, Hywel Dda