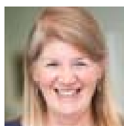
HOSPITAL FOOD STANDARDS: WHAT DOES THIS MEAN FOR DIETITIANS?

The Hospital Food Standards Panel's report on standards for food and drink in NHS hospitals was published by the Department of Health (England) in August 2014. Diane Spalding and Anne Donelan discuss the implications and opportunities that this national policy document gives to improving nutritional care in hospitals.



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Along with her current role in the NHS, Diane is Admissions Tutor, PG Dietetics at Leeds Beckett University and works as a Freelance Dietitian. She has always worked closely with patient catering services.

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Both Anne and Diane have extensive experience working as dietitians involved with hospital food and are passionate about the important role that dietitians have in delivering a high quality food and beverage service. Anne was a member of the Hospital Food Standards Panel and Diane has been working directly as part of the patient catering/facilities team within an NHS Trust. In this article, Diane asks Anne some pertinent questions about the Hospital Food Standards Panel and also gives her own views on implementation.

What was the Hospital Food Standards Panel and how did you get involved?

AD: The Panel was an independent group convened by the Department of Health (DH) on behalf of government by the Secretary of State for Health. The Panel worked with leadership from Dr Dan Poulter, Parliamentary Under Secretary for Health, and with excellent Chairmanship under Dame Dianne Jeffrey. Dianne has a breadth of relevant experience and her particular insight as Chairman of Age UK was fundamental to the good working, deliberations and outcomes of the Panel.

I was invited to join the Panel as Chair of the BDA Food Counts Group. I had 'met' DH lead Dr Liz Jones via a couple of conference calls she placed with me and DH colleagues, as she was keen to understand the impact of *The Nutrition and Hydration Digest*[1] in supporting the needs of nutritionally vulnerable patients. Their belief was that, within a whole hospital population, healthier eating was the key issue, as the percentage of people (including visitors and staff) who require a healthier 'eatwell plate' approach was higher compared to those who are nutritionally vulnerable on admission to hospital (approx c30%[2]). This key issue was ironed out during the Panel and ERG deliberations, but is still a thorny one for trusts when preparing their Food and Drink Strategy, and I will return to this later.

DS: *I think it was really important to have a dietitian with your level of experience involved in developing national policy on the Hospital Food Standards Panel. Working at this level gives opportunities for promoting good nutritional care in hospital and other care settings and so is a vital part of the role of a dietitian. I was involved in the Better Hospital Food Programme*[3] *and the interest at the time in the evidence base for nutritional standards for hospital food and meeting the needs of the diverse patient groups led to the formation of the BDA Food Counts Group. I remember that, prior to this time, the previous national policy documents were not always appropriate for the breadth and depth of needs of the current patient population in hospitals and, so, nutritional standards were not updated and defined until the BDA Food Counts Group published* Delivering Nutritional Care through Food and Beverage Services[4] *in 2006. Prior to this, the British Dietetic Association had published* The Dietetic

Interface with Food Service; A Professional Consensus Statement[5] *in 2002, which was aimed at drawing the attention of dietitians to the pivotal role that they play in ensuring the provision of appropriate and nutritious food in a patient focused food service, following the previous publication as part of the Health of the Nation public health strategy.*[6]

Who else was involved?

AD: The 'roll call' is transparent and listed within the report. In summary, the Panel was an eclectic mix of representatives from relevant government, professional, healthcare, patient, campaigning and charitable organisations, along with some key informants in the field of hospital food and beverage services and included a lay member. It was clear that, in addition to the overall expertise and experience provided by Panel members, a practical and academic focus was needed in three key areas to substantiate the Panel's requirements and recommendations.

Expert Reference Groups (ERG) were convened to explore these identified issues in-depth: patient nutrition and hydration; healthier eating across hospitals and sustainable food and catering services. Guided by DH, Panel members and invited experts within these fields met on a 'task and finish' basis to agree the evidence base and implications within these three domains that underpin the Panel's Report.

DS: *It is good to hear that a wide selection of people from different backgrounds and agendas were involved, including patients and their representative organisations, some of which have been very proactive in highlighting and helping to address some of the areas of concern about nutritional care in hospitals. Food, nutrition and hydration care requires a multidisciplinary approach, with the patient being a key player in this. Within my work in patient catering in the NHS, we have tried to ensure that patient feedback drives the direction of changes that we make and we have involved patient representatives so that they are influential in agreeing whether items are suitable to be added to the menus or not, as part of quality taste testing panels. We have also used this group to inform changes to the menu format and style, including the development of a bistro-style lunch, fish and chips on Friday, themed Indian/Chinese takeaway on Saturday evening and Sunday roasts.*

What impact do you think this will have on NHS Trusts?

AD: As the requirements of the Report are integral to the 2015/6 NHS Contract agreed with commissioners, I hope the impact will be huge! This is the first time that such non-clinical activity is called upon to account for itself. But I also think that it may be too much too soon and a transitional learning curve must be anticipated, especially as some of the practical detail of the Panel's expectations was not published until six months after the initial report.[7] Several enabling complementary work strands are underway.

DH have published on their website a Food and Drink Strategy Toolkit[8] and a Prezi designed to engage and inform key trust personnel on how to go about working and delivering their interdisciplinary policy. In essence, this is a Trust's annual improvement programme based on their own gap-analysis specific to the challenges of their own sites, their own food and beverage services and their unique patient/staff/visitor populations.

NHS England is committed to enabling commissioners to understand what is required within the annual contract, which is legally binding. The Hospital Caterers Association (HCA), through its 'Last 9 Yards' multi-agency group (a term which arose from the final Panel meeting), has 'bitten the bullet' on behalf of its members and published their view of how a Food and Drink Strategy could be developed (accessible on the members section of the HCA website www.hospitalcaterers.org). The model envisaged is Trust Board-led (ideally by the Director of Nursing or equivalent), entailing regular reports to the Board and a formal annual report on the achievements in meeting the aspirations of their agreed multiagency Food and Drink Policy and plans for the coming year. Placing this level of importance and scrutiny is fundamental to ensure that commissioners are satisfied with the firm intent in delivering targets that the trust has set in the annual cycle of their Trust Food and Drink Strategy.

BDA Food Services Dietitians Specialist Group has developed a checklist for Trusts to use to check their compliance with the Digest, which DH is distributing via its website.

DS: *I have been involved in developing a Food and Drink Strategy within Leeds Teaching Hospitals NHS Trust. I agree that this needs to be an interdisciplinary approach and have an acknowledged status at a high level within an organisation. The Strategy also needs to involve other key players within nutritional care across the healthcare community in primary care and local authorities. We have found the sharing of ideas to be extremely beneficial. The Food and Drink Strategy can be developed using the work plans of a Trust's Nutrition and Hydration Care Steering Group (NICE Guidance, Nutritional Support for Adults[9]) and so much of the gap analysis and action planning may have already been documented, particularly for patient nutritional care.*

However, I do think that as dietitians we need to ensure that we take an evidenced and scientific approach to approving patient menus within our organisations. To do this, it is essential to use The Nutrition and Hydration Digest *as a reference for the nutritional targets to be met. In my work as a dietetic advisor to patient catering, I have found the Day Parts Approach referenced in* The Nutrition and Hydration Digest *to be invaluable and have been able to use this to define the nutritional targets for individual items on each section of the menu in order to achieve the targets in the Day Parts for both the nutritionally well and the nutritionally vulnerable patient. All items need to meet these minimum targets before being considered for inclusion on the menu. It is also essential to do a regular Nutritional Capacity Report in order to demonstrate the compliance required.*

I am aware that many nutrition and dietetic departments are not adequately resourced to undertake this work; however, I do feel that the requirement to produce a Food and Drink Strategy and also the requirement to be compliant with The Nutrition and Hydration Digest *gives a real opportunity for dietitians to evidence the need for this expertise and specialist resource, as we have the skills and expertise to give this assurance. The Checklist for compliance with* The Nutrition and Hydration Digest *will, therefore, be a useful tool in identifying gaps and should be included in Trust Food and Drink Strategies.*

What was it like being a dietitian on the panel and what were the challenges?

AD: The first meeting in early December 2013 was probably not my best! There was a landslip down-line from my mid-Kent station and, despite all my careful planning, I was late to the inaugural meeting held in the hallowed quarters of Church House, in Dean's Yard, Westminster. However, Dianne was welcoming and made me feel at ease, but I was pretty concerned to try and identify those I didn't know, i.e. who was who and from where. I recall that although I nervously contributing on several points, I felt comfortable that Panel members were supportive of my observations.

As the only food services dietitian, I was one of the few wearing a 'scientific hat' and I could sometimes apply this to my advantage within Panel and my ERG (the Defra-led Sustainability, Animal Welfare and Food Waste). Despite some qualms, I had decided to give this group my best shot and leave the more comfortable areas of patient and staff /visitor feeding to co-opted colleagues. I am glad I did; I learnt a lot and was fascinated by the passionate input of some others whose views I did not share, but which gave me food for thought.

What opportunities do you think this gives to the dietetic profession in the NHS?

AD: As dietitians we have a raft of interpersonal and presentation skills that complement our professional expertise. We have an evidence-based clinical view of the importance and place of food as treatment. We understand 'food and figures', i.e. balancing the nutritional content of different foods within a multi-choice menu. We can assess quickly menu capacity and calculate the detail of nutritional delivery if required. In addition, we have a thorough knowledge of our trust sites, know many of our peers and personnel from board to ward and have a fair overview of the challenges from food production, transport and kitchen level to ward service. In our day job, we speak constantly with patients, their relatives and carers about food likes and dislikes, and often hear their unsolicited views about hospital food! So we have an overall appreciation of what people like to eat, coupled with the challenges in the logistics of providing appropriate 365-day/24-hour quality food and beverage services to patients, hospital staff and visitors - within a tight budget and frequently with stretched staff resources.

Table 1

THE 5 STANDARDS As required by the Hospital Food Panel Report
Three for patient catering
• 10 key characteristics of good nutritional care, Nutrition Alliance • The Nutrition and Hydration Digest, The British Dietetic Association • Malnutrition Universal Screening Tool (or equivalent i.e. a validated tool) (BAPEN)
For staff and visitor catering *(and applied as appropriate to patient catering; the specific nutritional needs of individual patients should always supersede the application of blanket principles)*
• Healthier and More Sustainable catering - Nutrition Principles (Public Health England)
For all catering
• Government Buying Standards for Food and Catering Services, HMG standards developed by the Department of Environment, Food and Rural Affairs

As a member of a multidisciplinary group - such as one that would develop a trust Food and Drink Strategy - dietitians have good team working skills and have the knowledge and language to identify and interpret the concerns of others who may not have the same understanding of the 'bigger picture' when it comes to catering for such a diverse population. They can work with catering and nursing colleagues in a way that fosters mutual trust and respect, agreeing and collaborating on shared goals so that the whole is more than the sum of the parts. They could also nudge their catering colleagues to provide cake - always a welcome enabler at meetings! It is so easy to talk about food when you are fit, well-nourished, not anxious and in decent health; we can help our team ponder on that and how patients and their relatives may perceive the same food and beverage services that we are all considering.

DS: *Many of the comments you have made are exactly the reasons why dietitians need to be an integral part of the patient catering service. At the start of our professional career path, dietitians were very involved in patient catering, often to the extent of being based in or near the catering department. Times have changed and, as a profession, we have generally moved away from the close involvement with patient catering services and yet this involvement now seems to be becoming more important as it gives us an opportunity to impact on every inpatient's nutritional care - not just the small percentage who require specific dietetic intervention.*

One of my concerns is the diversity of nutritional needs of patients in hospital - how has the Food Standards Panel addressed this?

AD: One of our major tasks was to wade through over 50 publications relevant to public sector/ hospital food services and focus down to a few robust 'required' documents. Through scrutiny and agreement by Panel and ERG members, this was reduced down to the five key documents **(**see table 1**)** that are the evidence base to underpin NHS food and beverage services. Whilst references to all five are essential, there is scope for each trust to tailor their strategy to meet the nutritional and food and drink needs of their unique patient and staff population.

The thorny issue of how to meet patients' diverse nutritional, therapeutic, texture and cultural food and beverage needs is far more demanding than the straightforward 'healthier eating' for staff and visitor catering. The Panel and ERGs addressing this challenging inconsistency through the Healthier Eating Across Hospitals and Patient Nutrition and Hydration teams, were very clear on this point. Tackling this diversity of practice is key when it comes to a Trust cross-professional team agreeing their approach and making sure that the span of needs from nutritionally well to nutritionally vulnerable patients is covered.

DS: *I believe that the Hospital Food Standards Report covers these diverse needs very well, describing 'healthy eating' for the nutritionally well patient and 'eating for health' for the nutritionally vulnerable.* The Nutrition and Hydration Digest *also covers the diverse range*

Figure 1

A toolkit to support the development of a hospital food and drink strategy

of nutritional targets for these two extremes of patient nutritional situations and an organisation needs a nutritional capacity report to be able to demonstrate that all patient needs are covered. However, we should be aware that, although across the whole hospital population (patients, visitors, staff), the nutritionally vulnerable patients are the minority (c30%), these are the patients who require greater consideration and attention in terms of their food and drink requirements and not getting this right could be more costly both for the patient, their carers, their relatives and for the organisation (due to longer hospital stays, readmission rates, increased mortality). Although they are a smaller percentage, they will, therefore, justify more resource to address their needs.

However, the higher energy choices suitable for the nutritionally vulnerable patient should not be just higher in calories - the types of food items chosen for the menu should be appropriate for a healthcare environment, giving an impression which is associated with wholesome and healthy food.

As well as the nutritionally well and the nutritionally vulnerable patients, there will be others who have specific dietary or clinical needs and this also needs to be addressed (e.g. patients requiring texture modification for dysphagia, renal conditions, neutropenic diets). From my experience we need to work closely with the clinical teams to ensure that specific patient needs are met and a dietitian working in patient catering is an ideal person to establish and ensure this joint working takes place.

Dietary coding is also important and in the past has often been developed for staff guidance rather than for the patient. Dietary coding should be focused on aiding the patient to make appropriate choices for their own specific needs. It should be minimal, non-technical and not confusing. I remember James Martin asking the question in his TV programme, "What does Reducing mean?" We should not assume that the patient will understand the terminology that we as healthcare professionals use. Hospital menus are hard enough to understand when you are unwell, apprehensive and in a strange environment without having professional jargon and confusing codes.

How should NHS Trusts practically implement the recommendations in the Food Standards Panel report?

AD: One of the exercises undertaken by the DH when finalising the Panel's report was to undertake a cost benefit analysis of the recommendations. *Nutrition and Hydration Digest* Team Leader, Maxine Cartz, and I were invited to meet with a DH economist to see how *The Digest* 'shaped up'. This was initially an alarming idea, but one that was most rewarding when we saw how useful *The Digest* is for underpinning developments in nutrition and dietetic services. In particular, promoting multidisciplinary menu planning, dedicated catering liaison time, weekly malnutrition screening, snack provision, improving patient safety and waste policy and audit. So, these are the areas that are likely to be monitored in the future and to which dietitians

can have positive influence in a team role. Note that they are not necessarily leading in these areas, but have firm intention from the Digest to be involved in areas that they may currently not be, e.g. waste audits (uneaten food has no nutritional benefit); patient safety discussions (case for appropriate textures, therapeutic diets); business case for a level of waste to energy dedicated dietetic/catering liaison.

Within *The Digest*, there are tools to enable qualitative and quantitative assessment of patients' nutritional needs through a day parts approach and for assuring nutritional adequacy through simple or detailed menu capacity checks. As mentioned, both the Financial Sustainability Strategy Group (FSSG) and HCA Last 9 Yards groups have developed guidance or checklists for their members to monitor their progress. Patient-Led *Assessments* of the Care Environment (*PLACE*) and in-house satisfaction questionnaires provide constant rigour.

During these early days, it is likely that these will be quite enough for dietitians and their cross-professional team colleagues to contend with, to develop and monitor their fledgling strategies without recourse to more demanding audits. This is a period of acquiring a new way of thinking and working together to improve food and beverage services trust wide, and will doubtless benefit for some bedding down time before taking flight to tackle more demanding audit programmes.

DS: *From my experience, taking time to develop a Trust Food and Drink Strategy is a good place to start and working through the Toolkit to support the development of a Food and Drink Strategy*[8] *(see figure 1) gives a useful process for this. The Strategy can be written in the three sections suggested:*

1. *Patient nutrition and hydration.*
2. *Healthier eating for the hospital community, especially staff.*
3. *Sustainable procurement of food and catering services.*

We have found that much of the patient nutrition and hydration section has already been covered by the work of the Trust's Nutrition & Hydration Steering Committee, with a gap analysis and action plans already identified, so this has mainly involved referencing and signposting to this work. It is important to recognise that this is not just about the catering service, but all the people involved, policies, guidelines and systems in place to provide good nutritional care (service skills, attitudes, encouragement given to patients, protected mealtimes, nutritional screening, support and help given at mealtimes, including mealtime volunteers, discharge processes and communication on discharge). Working through the 10 key characteristics of good nutritional care and The Nutrition and Hydration Digest *checklist is a good way of working through the Patient Nutrition and Hydration section as well as using feedback from PLACE assessments (NHS Choices website).*[10] *This will also require some dedicated dietetic time linked to the Patient Catering Service.*

The third section on 'Sustainable procurement of food and catering services' can also use the Government Buying Standards as a checklist to undertake a gap analysis and action plan. However, it is more difficult to cover the second section 'Healthier eating for the hospital community, especially staff', because a standard format has not yet been developed for this, although this would be beneficial to ensure a standardised approach across organisations.

Some of the areas in the Government Buying Standards (GBS) do not seem to be appropriate for the 'nutritionally vulnerable' patient in hospital - how did the Food Standards Panel address this?

AD: As already discussed, the Hospital Food Standards Report clearly differentiated between 'healthier eating' for staff, visitors and patients and catering for the needs of nutritionally vulnerable patients and the ERGs were very clear about these differences. The Hospital Patient Nutrition and Hydration ERG created an 'island' for catering for hospital patients by requiring three patient-focused standards (see table 1) to be met (10 key characteristics, compliance with *The Digest* and use of a validated nutritional screening tool). So, as long as patient food and beverage services can demonstrate that the three standards are met with compliance with GBS *where appropriate*, the key nutritional driver that underpins patient catering is *The Digest*, which does, of course, tackle both ends of the spectrum.

The Sustainability, Animal Welfare and Food Waste ERG took a similar view and were keen on the 'balanced score card' approach that Defra was then developing for public sector catering. Helpfully

The Digest starred here as well, as in Chapter 4 it reminds dietitians to be mindful to support and develop patient food services (for example, range and choice of menus and snacks) in a sustainable way that provides 'good value for money'. So, overall the ERGs allowed a degree of weighting of pertinent factors so that food, beverage and snack services for in-patients that include a good choice of familiar and comforting foods with plenty of energy from fats and carbohydrates is quite acceptable where this is clearly evidenced and also underpinned by the Panel's required documents.

DS: *Many of the Government Buying Standards which relate to nutrition are also appropriate for and/or can be applied to nutritionally vulnerable patients and can easily be incorporated into the higher energy choices on the menu and, therefore, do not conflict with their nutritional care. This includes the use of fresh seasonal produce, fruit-based higher energy desserts, vegetables, higher fibre cereals and provision of fish, including oily fish on the menu. It is more difficult to achieve the same salt restriction in higher energy choices as it is for the 'healthier options'; however, it is possible to limit this and I have ensured that the higher energy choices of the menus at Leeds are within a maximum salt limit. Restrictions in fat, saturated fat and sugar may be more difficult and inappropriate for the nutritionally vulnerable patients, but there can be adequate justification for this.*

For many patients, including those who we need to encourage to eat, it is more important that the menu contains some locally produced, fresh and wholesome food which patients can recognise and associate with quality. Using local dishes and familiar dish names can help to encourage the more nutritionally vulnerable patients to eat and take an interest in their meals. At Leeds this has worked well with locally produced and well recognised dairy ice cream and freshly baked, locally produced cakes which are served with afternoon tea on the older adult wards, providing a valuable higher energy snack.

What do you think dietitians should do and where can they find out more?

AD: Don't try to 'go for gold,' i.e. 100% compliance, straight away. The strategy is a plan for regular improvement based on your own Trust's identified areas of weakness. Fix one and another will likely come along…and that's for next year's strategy. The same applies to dietetic developments - not looking for full-time dedicated catering dietitians, just some funded and ring-fenced hours. Build on this as the benefits become apparent to the wider trust team. Seek to apply GBS where comfortable and plan to extend on that next year where there is sound opportunity. Choose areas where there are some 'quick wins' for healthier and sustainable catering in beverage, accompaniments/ snack services, e.g. stand-alone dairy items like cheese portions, yoghurt and milk, rather than wading straight into the more challenging areas.

When it comes to complete dishes, focus on the overall nutritional delivery and in maintaining flavour and appeal, rather than every ingredient being a good fit with GBS. As the Report states, '…it is not enough for hospitals to deliver food that meets the letter of the standards if its flavour and presentation are poor…it must taste good as well'. Amending tried and tested costed standard recipes is a lengthy task which can be a transitional aspect of your food strategy.

The panel was clear that food should crucially be a source of pleasure and enjoyment within the patient experience. As dietitians who are trained to be objective and fact-based, we can take an impartial perspective of the whole process. To allay the fears of Hospital Food Standards critics, our eye for detail means that we fully appreciate the demands inherent in meeting the complex and detailed requirements of the five required standards and the binding power of the NHS Contract in making that mandatory.

DS: *As a dietitian with experience of working within a patient catering team in an NHS organisation, I would suggest that in order to find out more, dietitians need to be aware of:*

- *BDA Food Services Specialist Group - the work programme and the membership as a valuable network*
- *HCA website and get involved - join them and go to Branch Meetings!*
- *DH website - particularly related to hospital food*
- *NHS choices website ratings for hospital food in each NHS organisation*
- *Work within their Trust (PLACE assessments, Food & Drink Strategy, etc)*

For article references please email info@networkhealthgroup.co.uk.