



## **Food as Treatment: *Making the Links***

21st January 2004

Queen Elizabeth II Conference Centre, London

### **Contents**

<b>Chairman's Welcome and Opening Remarks</b>	2
<i>Lloyd Grossman, Chair, Better Hospital Food Panel</i>	
<b>Keynote Address</b>	2
<i>Lord Warner, Parliamentary Under-Secretary for Health (Lords)</i>	
<i>CHAIR: Rick Wilson, Director of Nutrition and Dietetics, Kings College Hospital</i>	
<b>Nutrition and 'Payment By Results'</b>	3
<i>Dr Gillian Morgan, Chief Executive, NHS Confederation</i>	
<b>Practical Strategies for Improving Nutrition</b>	4
<i>Dr Herb Meiselman, Senior Research Scientist, US Army</i>	
<b>Practical Strategies for Understanding &amp; Implementation of 'Food as Treatment'</b>	6
<i>Dr Michael Stroud, Consultant Gastroenterologist, Southampton General Hospital</i>	
<i>CHAIR: Prof. Alan Jackson, Director, Institute of Human Nutrition</i>	
<b>'A Duty of Care' – Practical Nutritional Screening in Action</b>	6
<i>Prof. Marinos Elia, Professor of Clinical Nutrition and Metabolism, Southampton University</i>	
<b>Embedding Nutrition into Clinical Governance: Getting Doctors on Board</b>	7
<i>Prof. Peter Kopelman, Professor of Clinical Medicine, University of London</i>	
<b>Embedding Nutrition into Ward Management – Getting Nurses on Board</b>	8
<i>John Badham, Programme Director, Essence of Care, Department of Health</i>	
<b>Preventing Undernutrition in Hospitals – Responses from Around Europe</b>	8
<i>Dr Lars Ovesen, Chair of the Expert Committee, Council of Europe</i>	
<b>Chairman's Closing Remarks</b>	9
<i>Lloyd Grossman, Chair, Better Hospital Food Panel</i>	



**“A year has passed since the last conference on the subject of food and treatment. In that year, there’s been an important shift in recognising the importance of food and nutrition, and the NHS has a major role to play in this.”**

Loyd Grossman  
Better Hospital Food Panel

## WELCOME FROM THE CHAIR

**Loyd Grossman**

### Chair, Better Hospital Food panel

Loyd welcomed delegates and opened the conference. “A year has passed since the last conference on the subject of Food as Treatment. In that year, there’s been an important shift in recognising the importance of food and nutrition, and the NHS has a major role to play in this.”

“Last year the PEAT team said the standard of food in about half our hospitals was good. That’s an achievement we should be very proud of, but I still think standards could be a lot higher across the board,” Loyd said. “We must keep up the track record of delivering what we promise, and we must also make sure the message of the significance of good food continues to get through to Board members, chairs, doctors, nurses and everyone else. I’m pleased to see those members of the hospital staff so well represented here today.”

Better Hospital Food is not a seismic disruption of everything currently happening, but a series of small, practical things that will lead to lasting improvements. This is becoming evident in patient satisfaction surveys and comments received from patients.

Loyd noted that there is “a big push under way to get the environment right”. All improvements must be seen in the context of the right environment for service. In designing a world-class hospital food service, attention must be paid to the whole system.

## KEYNOTE ADDRESS

### Lord Warner, Parliamentary Under-Secretary for Health (Lords)

Lord Warner began by thanking Loyd for his commitment to helping improve hospital food services. “Back in 2000, some people thought that trying to improve hospital food was just a gimmick. How wrong they were.”

Lord Warner noted the improvements in hospital food service over the past two and a half years, but said that improving food in the NHS was a long-term programme rather than a quick fix, and that continued efforts were needed to maintain and develop standards.

Last year’s conference made a number of key points, such as making sure the environment for eating is right; the crucial role of teamwork in providing patients with good nutrition; that food and nutrition must be embedded into the clinical governance agenda. “Without the wholehearted support of doctors and nurses, the improvements we want to see are not going to happen.”

Changes in the way people live their lives have given rise to diet-related illnesses such as obesity, salt-related hypertension, diabetes, heart disease and some cancers. These are a major public health

challenge. The Department of Health is leading the cross-government development of a Food and Health Action Plan that will focus on diet to drive action to improve public health. Key nutrition policies aim to increase the consumption of fruit and vegetables and reduce levels of fat, sugar and salt in the diet. The NHS has a key role to play: procurement of food in hospitals should consider these issues, and better use should be made of the opportunities afforded by a hospital stay to promote healthy eating options. The provision of clear information on the nutritional composition of food will help patients, staff and visitors to make healthier choices.

The significant number of undernourished patients in hospital is of great concern: “it is damaging to patients and to the reputation of the NHS. It is costing the NHS a great deal of money – perhaps more than it would cost to prevent it. And that, frankly, is a nonsense.” The situation is similar in other European countries. A study is under way to identify the impact that food can have in the clinical arena in relation to satisfaction, intake levels and outcomes; some results will be available in twelve months’ time.

Lord Warner acknowledged work currently under way in this area, including studies from the Institute of Human Nutrition at Southampton University, the Malnutrition Universal Screening Tool developed by the British Association of Parenteral and Enteral Nutrition (BAPEN), and work done by the Royal College of Physicians on doctors’ duties with regard to nutrition.

There is now a specific relationship between the NHS and the Royal College of Nursing to jointly promote programmes creating the right environment for food services at ward level, enhancing collaboration between nursing and facilities, and influencing the Modern Matron and other Leadership programmes.

Lord Warner launched the ‘Protected Mealtimes’ CD and video, saying copies will be sent to all Directors of Nursing at Trusts and PCTs this week, and a range of roadshows will be organised to promote the programme.

“I am pleased that the Commission for Health Improvement has once again included food and food services as part of this year’s performance indicator set,” said Lord Warner. He and Loyd Grossman are shortly to meet Professor Sir Ian Kennedy, the chair of CHAI, to discuss food and the patient environment.

London hospitals in particular face a wide range of challenges, including greater costs and difficulties in recruiting and retaining staff. London directors of estates and facilities have been invited to discuss these issues with Lord Warner. “We are hopeful that we will be able to work with and support them on their specific challenges.” Lord Warner will also meet leading commercial providers of food and basic care services, “with a view to speeding up the rate at which good ideas get adopted in London.”

Waste is still a concern. "Getting waste levels down to a reasonable level should be seen as an important issue in terms of investment and business plans for catering departments." Guidance being developed by NHS Estates, setting out best practice principles in identifying and managing the causes of waste, will be launched at the annual conference of the Hospital Caterers' Association in April.

Lord Warner moved on to consider the sustainability agenda. He welcomed the pilot scheme being run by the Soil Association and London Food Link to supply four London Trusts with organic and local food. The King's Fund has been asked to work with hospitals in Luton and Bedford to examine how local hospitals may support the sustainability agenda, and recommendations will be made later this year in the form of best practice and inclusion in PASA purchasing specifications.

Lord Warner emphasised his commitment to the principles of food as treatment. "We must continue to ensure that what patients eat does them good, and that our food and food service programmes are of a sufficiently high standard that citizens are well-disposed to hospital food before coming to our hospitals."

#### MORNING SESSION

**Chair: Rick Wilson**

**Director of Nutrition and Dietetics, Kings College Hospital**

Rick introduced Gill Morgan to give a presentation on the concept of 'payment by results'.

#### NUTRITION AND 'PAYMENT BY RESULTS'

**Gill Morgan**

**Chief Executive, NHS Confederation**

"Payment by results (PBR) is one of the mechanisms underpinning a number of the fundamental changes in the NHS," Gill said. She noted that the NHS had attempted to introduce a similar system during the reforms of the 1990s, but this failed: "This time, because of other changes in the NHS, and the philosophy of giving individuals more choice, there is more chance of making PBR a reality, as money follows the patient."

PBR has multiple objectives, the main one being efficiency. "If you pay people at the average cost, they will work hard to bring costs down – because the more efficient you are, the more money there is for your organisation," Gill said.

The Department of Health is behind the PBR initiative. In parallel, the Department is addressing years of underinvestment in the health service by investing in new capacity in both buildings and staff.

Payment of a set tariff will allow resources to be 'teased out' of existing services, said Gill. This is, however, more difficult with the complex care

needed by people with chronic diseases as a number of different providers may be involved in providing the integrated care needed. The tariff will need to cover a complete care pathway.

If this is the case then PBR could encourage the provision of care in more appropriate settings: "We manage people in easy-to-understand blocks; this often means they are kept in hospital as this is the only service available – this is often an expensive and inappropriate solution," Gill said. PBR provides incentives to establish a whole range of alternatives to hospital care, "and if you can manage somebody outside hospital, perhaps in the home, that will put resources back into the system," said Gill. This might encourage increased diversity, with private companies and other healthcare providers entering the market, giving more choice, as seen in the 'Treatment Centre' initiative.

"There is also an aim with PBR to exclude price from negotiations," Gill said. "This may not be possible."

"There is a lot of work to be done to realise the potential benefits of the PBR system," Gill said. "It's no good increasing capacity for elective surgery, putting in incentives to encourage operations and then finding that people have operations before they are needed." A Canadian review of cataract operations after the introduction of a similar scheme showed that a third of operations carried out after the introduction led to no improvement or to a deterioration in vision.

To make PBR work, a very sophisticated commissioning system is required, "and our commissioning organisations – the PCTs – already have an enormous workload and face major challenges," Gill said. Commissioning remains underdeveloped and much more investment is needed in PCTs and in the development of effective commissioning processes to deal with this "new and very complicated work".

Gill outlined the workings of PBR. Providers will be paid a set tariff for a given case as defined by Healthcare Resource Groups (HRGs). These give a single price for conditions that require the same levels of resource (such as different types of joint replacement). This is derived from an average of all hospitals' costs for these procedures, which means that half of all hospitals will be more 'expensive' than average, whilst the remaining half will be 'cheaper'. The theory is that 'expensive' hospitals cost more due to inefficiency, and these inefficiencies can be driven out of the system by PBR. But this is a fundamental flaw in the PBR concept: the tariff makes no distinction between inefficiency for no good reason, and higher costs due to unavoidable external factors. "Many hospitals have unavoidable additional costs. For example, if you serve a very poor area where there's no infrastructure to care for



**"The significant number of undernourished patients in hospital is damaging to patients and is costing the NHS a great deal of money – perhaps more than it would cost to prevent it. And that, frankly, is a nonsense."**

Lord Warner  
Parliamentary Under-Secretary for Health (Lords)

**NHS**  
Estates

**DH** Department of Health



**“Nutrition is one of the key ways to deal with efficiency and bring down costs. We must keep reminding people that the outcomes of good care don’t just depend on what doctors do to patients. Food and the environment is a critical part of the way people heal.”**

Gill Morgan  
NHS Confederation

people after their hospital stay, then inevitably costs will be higher,” said Gill.

The implementation of PBR is already underway: a current trial of 15 HRGs is due to finish this year, followed by a trial of 48 further HRGs due to finish in 2005. By 2006 most hospital specialities will be subject to HRGs, followed by all other areas by the end of 2008.

“One major result of PBR is that hospitals won’t be able to move costs around as much as in the past,” Gill said. “If you’re a hospital with costs above the average, this is really going to bite.” Hospitals without well-organised care need to be thinking now about their cost profile and, if they have not already done so, ensure they are working with the NHS Modernisation Agency to implement best practice in service delivery. Reducing the length of stay in hospital is the biggest way of reducing costs.

PBR will underpin the choice of individual patients about where to receive care. It is difficult to choose hospitals on the basis of clinical quality, as little useful information is available. In the US, this has led to ‘jacuzzi competition’, where patients choose hospital care on the perceived standard of facilities. “Issues to do with the provision of good food could be part of a competitive strategy,” Gill said. “The hospital management and its Board should become more interested in working out how to ensure patients leave satisfied.”

PBR may stimulate a focus on the significant variations in clinical intervention rates which have a major impact on the costs of organisations. “It will be really positive if these debates occur, but some organisations may want to avoid this as it means entering sometimes challenging debates with clinicians,” Gill said. “In this case, the focus will return to hotel services, and whether cost can come out of those to bring overall costs down. There are, however, some factors which may help protect hotel services, such as the CHI focus on food and cleaning.”

One very important point about PBR is that during its last incarnation, although hospitals were theoretically paid for cases coming in, departmental budgets bore no relationship to the derived revenue. “With choice, there will be an increasing drive to get the budget down to the clinical level. Clinicians must work smarter. It’s an opportunity but also a threat.”

Best practice is also an important aspect of PBR. Within the costs being averaged is a whole spectrum of hospitals, from the very best to the very worst. “We need a concentration on best practice, so the tariff can be based on that,” Gill said. In addition, 40% of current NHS capital stock has been written off and generates no capital charges; PBR will therefore be a disincentive to move to new buildings due to their associated capital charges.

Gill encouraged delegates to become advocates for nutrition with their Boards. “Nutrition is one of

the key ways to deal with efficiency and bring down costs: speed up healing and bring down length of stay. We must keep reminding people that the outcomes of good care don’t just depend on what doctors do to patients. Food and the environment is a critical part of the way people heal.”

### Question and Answer

**Q** How much will these changes affect foundation hospitals?

**GM** Completely. 85-90% of healthcare is funded by the NHS. This will increasingly be provided by a range of different organisations, of which foundation hospitals will be one type. If you get money out of that tax pot, you will have to use the PBR scheme.

**Q** How does this link in with mental health?

**GM** Over time, this will be a scheme for everybody. There will be HRGs for mental health.

**Q** Primary care isn’t getting backing and resources, and are finding it difficult.

**GM** There are two issues here. First, how do you provide adequate management for a growing task. Second, how to provide non-hospital types of care. In the past we’ve talked about developing alternatives, but admissions have risen inexorably. We need better commissioning mechanisms which link clinicians in both PCTs and hospitals with each other and with finance departments.

### PRACTICAL STRATEGIES FOR IMPROVING NUTRITION THROUGH THE NON-FOOD ASPECTS OF THE ENVIRONMENT

**Dr Herbert L Meiselman**

**Senior Research Scientist, US Army**

Dr Meiselman began by presenting the results of a survey on the expectations of individuals on where food will be best. At home and in a restaurant were seen as the best, and hospitals were seen as the worst.

To address any eating problem in an institutional context, three aspects are to be considered: the food, the person and the environment. The environment is often overlooked.

There is a relationship between how much an individual likes a particular food (acceptability) and how much of it s/he eats (intake). Both should be measured, because the relationship is a complex one. “In some situations, liking doesn’t necessarily predict intake,” said Dr Meiselman.

Often there is a dissociation of eating and liking – in other words, these two factors do not change together. In one study, the same diet was given to a group of soldiers in training and a group of university students. In this study, the subjects who ate less food rated the food more highly, and vice versa. In a second study, the same group of soldiers was tested

in two different locations – training outdoors, and inside in the army canteen – with the same food. The results showed that when the soldiers were outdoors they ate much less than when indoors, but their liking rating was the opposite to the first study. “This is because the environment was controlling their eating,” said Dr Meiselman. “So when people are in an uncongenial environment, the effect of liking is diminished.” Food must be continually improved to keep intake at the same level.

Studies done by Dr Meiselman and colleagues over a number of years have yielded a list of the environmental factors that might be significant in decreasing food intake. These might include a monotonous diet, food quality, stress, and a disturbed sleep pattern.

Does isolation in a hospital setting depress intake? A 1980s study gave a seven-day pocket diary to a group of subjects and compared people who ate meals alone to those who ate socially; those who ate alone ate fewer and smaller meals, whereas the meals eaten socially were larger. This effect is known as the social facilitation of eating.

A further study showed that, for social meals, as the size of the eating group increased, individuals stayed at the table longer and therefore consumed more. The study then independently varied group size and eating duration; this showed that eating duration produced the effect. “This produces two possibilities for implementation: either put patients in groups to eat together, or give them a longer time to eat,” said Dr Meiselman.

Studies done with the American company McCormick Spice consider the ‘meal context’. Two tests compared food eaten in a taste test environment to food eaten in a ‘real’ meal environment; the same food was rated more highly in the ‘real’ meal environment.

Choice is also important. In a study at Bournemouth University, students were first offered the chance to select food items to make up their meal; they were then offered a pre-composed meal with a reduced price. Asked to rate their meals, students gave a higher rating to the chosen meal, rather than the pre-composed meal, even though the price of the latter was less.

In a further study, an identical chicken and rice dish was served in a variety of locations from a restaurant to an institution. Results showed a clear preference for the food served in the restaurant rather than the institutional setting.

Breaking down the data from this study by age shows that younger people consistently give the lowest scores. “We don’t know why this is,” said Dr Meiselman. “Are younger people found more in the locations that tend to produce lower ratings? Or are they just more critical?”

Dr Meiselman compared these location data to the expectation data shown earlier. “It appears that part of the location difference effect is a difference in expectations. People who go to different places to eat have different expectations of what the food will be like. Expectations have a strong effect.”

There are four theories that predict how expectations work. The most important of these are assimilation (the belief that certain products will have certain sensory qualities such as taste or colour) – this predicts that product performance lies between a ‘blind’ rating and an expectation rating; and the assimilation/contrast theory, which predicts that when the discrepancy between an actual and expected result is small, assimilation theory can predict the outcome, but where the discrepancy is large, the consumer rejects the product. Expectation theory provides a quantitative way of taking into account where people expect lower- or higher-scoring food to predict the outcome.

Dr Meiselman introduced the theory of restrained eating, the tendency of people to control food intake to control body weight. This is not the same as dieting. “If you have a large group of people who are undereating, it’s worth considering whether they have traits and attitudes that lead them to consume less.” He showed a questionnaire designed to determine whether people may practise restrained eating.

Dr Meiselman showed two slides of recommendations for action (Figures 1 and 2). These were originally shown at the 2003 conference on Food and Healing. On the slides, the underlined items represent changes in emphasis in the recommendations since the 2003 conference. Dr

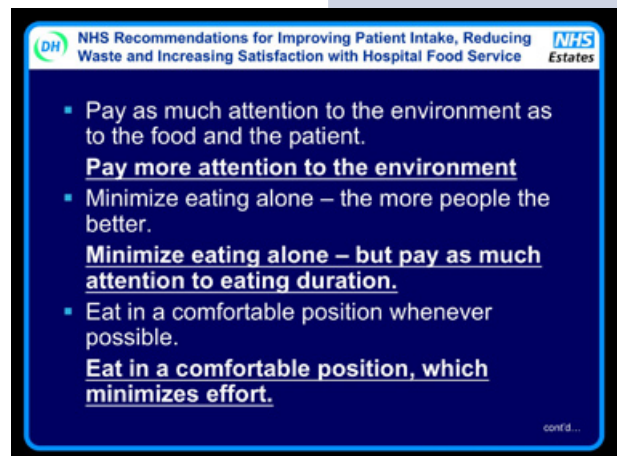


Figure 1



Figure 2

Meiselman concluded: "We cannot improve the perceived quality of institutional food until we address people's expectations of it."

### PRACTICAL STRATEGIES FOR BETTER UNDERSTANDING AND IMPLEMENTATION OF 'FOOD AS TREATMENT'

**Dr Michael Stroud, Consultant Gastroenterologist, and Senior Lecturer in Medicine and Nutrition Southampton General Hospital**

Why are patients malnourished in hospital, and what can be done about it? Dr Stroud began by

looking at the prevalence of being malnourished (over or under weight) on admission: "This stands at 40% across the range of different patient groups." The incidence of low vitamin levels is also increasing.

Malnourishment makes a difference to whether the patients progress through their hospital journey swiftly and without complications; this leads to an average of 50% increased costs to the hospital. Patients are more vulnerable to hospital-based infections if they are malnourished; likewise, wounds heal less quickly, and the kidneys may not excrete salt and water properly if the patient is undernourished.

"Patients can go from normal weight to death in three weeks," said Dr Stroud. He described a common patient journey (Figure 3).

A patient who is experiencing abdominal pain and so is not eating very well visits his GP, who takes some blood for tests. The test results show the patient is anaemic. Because the abdominal pain has continued, the patient is still not eating well. A consultant appointment is made for three weeks' time, during which the patient continues to eat poorly. The consultant diagnoses stomach cancer

and the patient is admitted to hospital the next day, "by which time he's already in the concern zone. The trouble is, at this point, they almost invariably stop eating poorly and begin not eating at all, because of anxiety, disrupted routine, and so on." By the time surgery is prescribed, the patient is "on a very steep descent. After surgery, you rarely eat much for a few days, and if at this point you don't act you've only got about ten days before the patient dies of malnutrition," said Dr Stroud.

Studies have shown that the nutrition levels of patients whose dietary needs were assessed by dietitians did not deteriorate. Patients at risk were offered higher-protein menus and in some instances supplements. Another study shows that offering patients a vitamin supplement reduces the average length of stay by 0.4 days during a six-day stay; sip feeds reduce length of stay significantly. "If a vitamin supplement or a sip feed can do it, then better-quality food ought to do it too," said Dr. Stroud. "It's relatively low-cost, and has significant benefits." He showed a slide detailing a model for dealing with patients' nutritional needs (Figure 4).

The BAPEN report highlighted the cross-disciplinary working and structures that must be in place before hospital food can properly be used as part of the patient's treatment. These include non-food environments, dietitians and nutrition support teams, management structures and a commitment to teamwork. "Everyone in the organisation must recognise that it's as important as the drugs on the chart that patients are getting meals and consuming them."

### AFTERNOON SESSION

**Chair: Professor Alan Jackson, Director, Institute of Human Nutrition, Southampton University**

Professor Jackson introduced Professor Marinos Elia to discuss the new MUST nutritional screening tool.

### A DUTY OF CARE: PRACTICAL NUTRITIONAL SCREENING IN ACTION

**Professor Marinos Elia, Professor of Clinical Nutrition and Metabolism, Institute of Human Nutrition, Southampton University**

Nutritional screening should aim to identify patients both with and without special nutritional support. However, there are problems with existing nutritional screening tools: there are at least 50 in existence, some of which have been developed for particular environments. It would be of advantage to develop an integrated nutritional screening tool to help patients as they move from one environment to another.

BAPEN has recently launched the 'Malnutrition Universal Screening Tool' ('MUST'). This attempts to be a general tool for use in all care settings by all types of health worker on all types of adult patients,

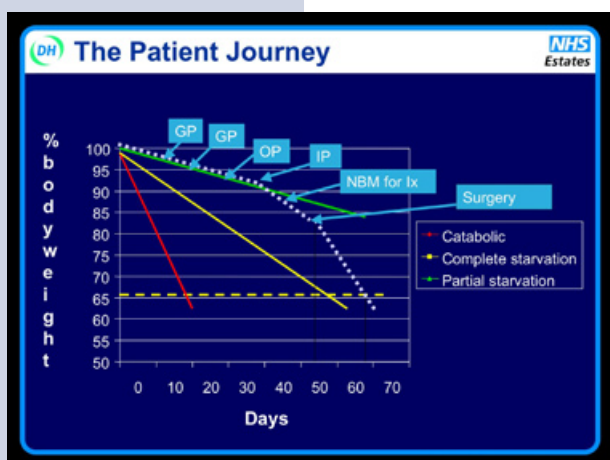


Figure 3

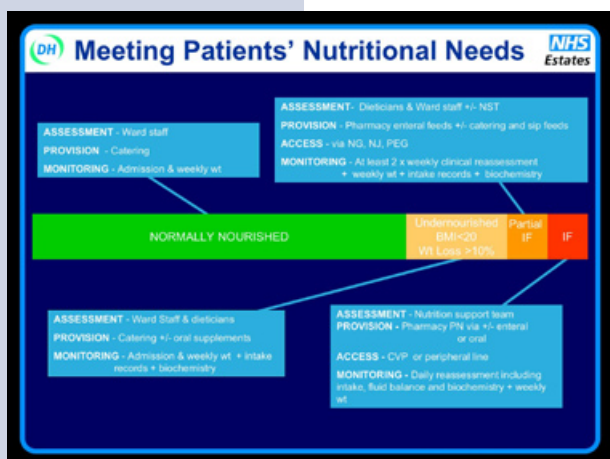


Figure 4

for clinical and public health purposes, and can be adapted according to local policy (Figure 5).

'MUST' includes factors for weight loss and for body mass index and together they provide a rating for overall risk of undernutrition. These three indices can be considered in different ways, such as over time for the individual patient, or as a predictive tool. Using 'MUST' criteria, Professor Elia has carried out a secondary analysis of the national diet in people aged 65 years or over, and this clearly shows the number of GP visits increasing, with higher malnutrition risk.

In the community, 'MUST' can be used to show a three-fold increase in the percentage of patients of 65 years or over admitted to hospital as malnutrition increases from a low to a high risk. Each patient's number of admissions also increases over time. Elderly care wards can be predicted to show a seven-fold increase in mortality.

The 'MUST' tool has been shown to be reproducible and reliable, so that different observers can take measurements and get the same results. Ten studies were done, in which the same patients were assessed by different observers; their agreement was between 92% and 100%. 'MUST' has also been shown to be easy and quick to complete, easy to understand, and acceptable to patients and health workers alike; and has been field-tested in over 200 centres throughout the UK. It is recommended and supported by the Royal College of Nursing, the British Dietetic Association and the British Care Homes Association amongst others.

It is now mandatory that all patients admitted to Scottish and Welsh hospitals must be nutritionally screened. This is not yet the case in England, but may become so.

It is necessary to bring together all individuals involved in education, clinical governance, catering, communication and nutritional science, in order to implement an integrated policy of nutritional care.

**EMBEDDING NUTRITION INTO CLINICAL GOVERNANCE: GETTING DOCTORS ON BOARD**

**Professor Peter Kopelman, Professor Clinical Medicine and Deputy Warden, Barts and the London, Queen Mary's School of Medicine and Dentistry, University of London**

"It is not the intention of doctors to allow patients to starve," said Professor Kopelman, "but they aren't familiar with the need to take nutrition seriously. My presentation is a wake-up call to doctors. Just as we routinely listen to heartbeats and take blood pressures, we should be checking nutritional status."

Obesity is now officially recognised as an epidemic in the UK. A survey repeatedly carried out in Professor Kopelman's hospital shows an increasing percentage of patients in elderly wards are obese: "This is a trend we'll see increasingly over the next few years."

The working party that Professor Kopelman chaired recently with the Royal College of Physicians has provided compelling evidence that provision of clinical support for patients with malnutrition improves clinical outcomes.

To ensure that nutrition is well-established in clinical governance, every PCT or Trust should have a nutritional strategy and steering group equivalent to its Medicines Committee.

"The cost is not equivalent to drugs, but it may make substantial savings on the drugs bill," said Professor Kopelman. The committee should include personnel from across the hospital (Figure 6).

It is also necessary to set standards for the recognition of nutrition in clinical governance. Nutritional assessment should be mandatory. Performance monitoring should also be in place.

"The only way to ensure nutrition remains a high-profile issue within Trusts is to engage doctors," said Professor Kopelman. "We can only do that if we make sure nutrition is embedded in training and education: both undergraduate training and continuing professional development."

The latest edition of the General Medical Council's guidance for undergraduate doctors includes material about the role of diet and nutrition in promoting health. "This is the Bible for doctors, and it is now very difficult for doctors to avoid taking this on board." Doctors have a very important responsibility with regard to the education of the public. Their role is advisory, organisational and investigatory in terms of research into nutritional topics.

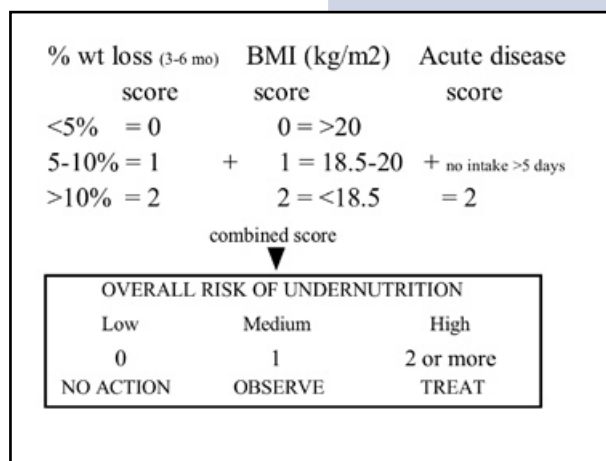


Figure 5



Figure 6

**Question and Answer**

- Q** What do you think of pharmaceutical companies looking at nutritional care?
- PK** I welcome them to the extent that they could sponsor education days and meetings. It's our responsibility within the NHS to put our house in order, but any sponsorship would be useful.
- Q** The BAPEN guidelines make no mention of the ward housekeeper on the nutrition committee.
- PK** They are a very important part of getting food into patients, but they're not in all Trusts just yet.

**EMBEDDING NUTRITION INTO WARD MANAGEMENT: GETTING NURSES ON BOARD**  
**John Badham, Programme Director, Essence of Care, Department of Health**

"The question of accountability has driven the changes in the healthcare we deliver," said John. "Patients are becoming the hub and spoke of all we do." It is important that a representative from the Royal College of Nursing is attending the conference today: "We can take this forward with the RCN's support."

The Essence of Care is the bedrock of clinical governance. It was published in 2001, when it was not seen as policy. It identifies eight areas of basic care, and in all of these areas is an element of food and nutrition.

Essence of Care may be used to improve some of these elements, including screening, planning, implementation and evaluation of care for those patients who need nutritional assessment. The environment should be conducive to eating, and those patients who need it should be assisted to eat and drink, and food should be easy

to obtain. The Essence of Care benchmarking process can be used to improve those factors.

The Department of Health has indicated some benchmarks of best practice, using the Essence of Care framework. These include nutritional screening programmes, progressing to further assessment for all 'at risk' patients; plans of care based on ongoing nutritional assessments; and an environment conducive to eating. "I'm delighted to see Protected Mealtimes being implemented in many hospitals."

It is important to ensure that mechanisms are in place to support the Essence of Care. There must

be systems to ensure that lessons are learned, and there must be measurable outcomes to demonstrate sustained improvement in patient care. Effective multidisciplinary and interagency working must be in place, and there must be Board accountability for the fundamentals of care.

Whose responsibility is food and nutrition? Is it part of the Trust's Business Plan? It can underpin widespread change for a Trust. "There has been a surge in the last eighteen months of Trusts who are seeing the Essence of Care as part of the delivery of quality improvements."

The Essence of Care has received tremendous support from nurses. "We should be celebrating the contribution of the patient and the carer," said John, "and the partnership between the two."

**Question and Answer**

- Q** We're just about to relaunch the Essence of Care programme. Should Trust Boards have the programme as part of their agenda and targets they must meet – as with waiting times?
- JB** On its original launch in 2001, the Essence of Care programme was never really seen as a core programme. That is improving now, with the co-operation of clinical and non-clinical professionals.
- Q** You need evidence. What is the Department of Health doing to fund studies that will scientifically answer the question of what the Essence of Care is achieving?
- JB** Patients don't always look at scientific evidence. But there's lot of anecdotal evidence that we can collect that says we are making that change.

**PREVENTING UNDERNUTRITION IN HOSPITALS: RESPONSES FROM AROUND EUROPE**

**Dr Lars Ovesen**  
**Chair of the Expert Committee, Council of Europe**  
 Dr Ovesen began by introducing the Council of Europe, an organisation that exists to reinforce democracy, human rights and the rule of law, and to lead responses to political and cultural change in member states.

A Partial Agreement in the social and public health field has led to a report from the Ad Hoc Group on Nutrition Programmes in Hospitals. Thirteen member countries participated in the report (of a total of eighteen member countries).

The aim of the Group was to review current practices; to consider how governments, hospital administrators, catering and healthcare professionals might work together to improve nutritional care; and eventually to issue recommendations to ensure food and nutritional status were regarded as important elements of care.

Country	Routine Nutritional Screening
Denmark	No
Finland	Varies
France	No
Germany	Varies
Italy	No
Netherlands	No
Norway	Yes
Portugal	No
Slovenia	No
Sweden	Probably No
Switzerland	No
UK	Varies

Figure 7

The report produced by the group, entitled 'Food and Nutritional Care in Hospitals: How to Prevent Undernutrition' is available online at <http://book.coe.int>.

The Group formulated a questionnaire to all the participating countries' hospitals. It asked about matters such as education, food service practices, nutritional practices and costs.

Most countries have no nutritional screening (Figure 7). "This is definitely a target for improvement," said Dr Ovesen. The post-graduate education of physicians is also highly variable between countries, from a few hours in Germany and the Netherlands to 60 lessons in France.

The report identified five barriers to good nutrition in European countries. The first of these is the lack of clearly-defined responsibilities in planning and managing nutritional care. The report made recommendations for nationally-developed standards of practice for assessing and monitoring nutritional status and risk, which should extend into the community as well as in hospitals.

The second barrier was the lack of a sufficient educational awareness on nutrition among all staff groups. The report made recommendations for a continuing education programme in nutritional support techniques, with a focus on training non-clinical staff.

The third barrier was a lack of patient influence: "Patients are somehow without a voice, right across Europe," said Dr Ovesen. The report recommended that patients should become very influential and be involved in planning their meals, with the possibility of ordering food and extra food.

The fourth barrier was the lack of co-operation between different staff groups. The report recommended that administration should give priority to co-operation, and that there should be some kind of organised contact between hospitals and primary care organisations.

The fifth barrier was a 'striking' lack of involvement from hospital administration. The report recommended that administrators should acknowledge responsibility for food service and the nutritional care of patients, and take account of the costs of complications and lengthened hospital stay due to malnutrition.

The resulting resolution (ResAP(2003)3 on food and nutritional care in hospitals is available online from <https://wcm.coe.int/rsi/CM/index.jsp>.

The resolution makes three basic recommendations (Figure 8). Governments should draw up national recommendations on food and nutritional care in hospitals, based on the agreement's principles; they should promote the implementation of these; and they should ensure the widest possible dissemination among the parties concerned.

The resolution's signatory countries must now consider these recommendations. There is a need for research, especially on the clinical outcomes. Dr Ovesen called for studies on the healing effects of ordinary food, meal patterns, menu choice and meal ambience on food intake and patient well-being. He also called for organisational research to improve co-operation between different groups of staff.

It is hoped that the Council of Europe report will raise debate in member countries. "This is extremely important. If you can gather public opinion around your case, you are much better off," said Dr Ovesen. In Denmark, there are directions for the nutritional care of patients; patients may complain, and the hospital can be held responsible. Also, there are public funds available for research. All patients have the right to insist that their personal needs are met in hospital, "which is a patient rights issue rather than an administrative or clinical issue," said Dr Ovesen.

**Question and Answer**

**Q** It's hard to collect data that's robust enough to be used in pursuit of policy change. Were you successful in Denmark?

**LO** It's still under consideration at this time. Data collection is ongoing. But it's very important to work at this area.

**CONFERENCE CLOSE**

Lloyd Grossman took the stage again to thank the speakers for their "excellent and profoundly important" presentations, and the chairs for their input and enthusiasm. He thanked delegates for attending. "I sincerely hope that you have heard enough today to carry the message back to your Trusts. Food is an essential part of the treatment programme, and may no longer be ignored."

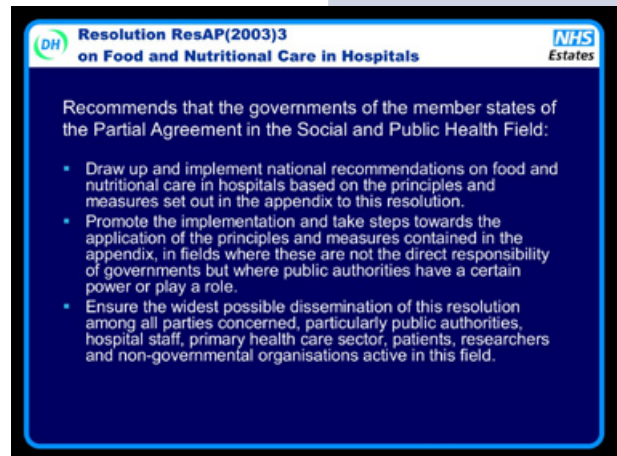


Figure 8