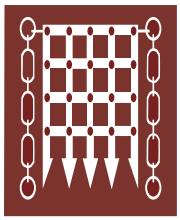

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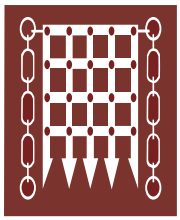
Food in Hospitals

The Westminster Diet & Health Forum Seminar Series



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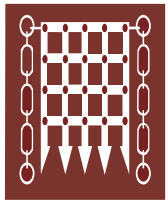

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About this Publication

This publication reflects proceedings at the Westminster Diet & Health Forum Seminar on Food in Hospitals held on the 8th December 2005. The speakers were asked for copies of their speeches made at the seminar, revised if necessary in the light of discussion on the day, or to approve transcripts. Further articles were also invited from interested parties who were asked to submit approximately 600 words each. These can be found in the Comment section.

Westminster Diet & Health Forum has not altered text apart from rationalising the spoken word for presentation in text form, checking for typographical errors and making minor production adjustments. The views expressed in the articles are those of the named authors, not those of the Forum or the sponsors, apart from their own articles.

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Session Chair's Opening Remarks

Professor the Baroness Finlay of Llandaff

Well, thank you very much and thank you all for coming today. I just want to start the day off with a few thoughts, and they are thoughts as a clinician who has also been a patient. I eat hospital food most days, most weeks – and for me it's fine – but I do think that we have to remember when we're talking about patients that they do have particular problems.

They often have nausea. Many patients have a heightened sense of smell, so the smell of food can be really very nauseating for them, it's often tied up with a disease, particularly patients who are having chemotherapy. The other thing is they often have mouth problems – dry mouth, sore mouth – and mouth care in hospitals often isn't all it might be. And then many patients have taste distortion, so things which taste nice or taste okay to you or me just taste like cardboard or tasteless to patients, particularly to those who have candida in their mouths.

So, if we're thinking about food in hospitals overall, we've got a huge challenge. In addition to the problems with smell and taste, people come in with an enormous range of types of food that they normally like to eat; if you're not well then you particularly will want to eat your type of food. That is not the time for you to try adapting your diet to somebody else's 'cardboard'. I always remember that when my own father was ill, the one thing he really liked was guacamole. Well, you don't get guacamole in hospital! But we were mixing up avocado and garlic and taking it in for him and he really enjoyed that. At one point, when he had swallowing difficulties, it was just about the only thing that he would and could get down.

And then, of course, we have patients from many different cultural backgrounds, and they may be used to having very spicy foods. So for them ordinary hospital food is particularly disgusting. And the other problem that we've now got – which, I have to say, I think is the bane of our life – which is so-called health and safety, where people say 'no, you can't let people pre-

"I eat hospital food most days … and for me it's fine – but … patients … do have particular problems. "

pare food in their kitchen for their relative on the ward and they can't bring it in and heat it up in the microwave'. Everyone gets completely obsessed and worried about organisms and food poisoning and so on. Meanwhile, we have *clostridium difficile* knocking around wards of hospitals giving patients dreadful, intractable diarrhoea. I do worry that we've just gone a bit too far in prohibiting food being brought in, because relatives do like to prepare food and bring it in, and obviously if you're used to having a hot curry hot, you want it hot, not cold and congealed, particularly when you're ill.

So those are just some thoughts about the challenges facing us. I'm going to go straight into the day now, and invite Professor Marinos Elia to give us our opening presentation this morning. And Professor Elia has a long history both at Oxford and Cambridge, so I don't know what you do in the boat race, but come and row us through nutrition.

"I do worry that we've just gone a bit too far in prohibiting food being brought in …"

Professor Marinos Elia
Professor of Clinical Nutrition and Metabolism
University of Southampton

University of Southampton

Latest Thinking on the Importance of Nutrition in Recovery

Malnutrition predisposes to disease, delays recovery from illness and has detrimental effects on individuals and society. It is common in hospital, affecting 10% – 60% of patients,[1] depending on age, type of hospital, medical specialty, and disease category. The main reason for the high prevalence of hospital malnutrition is that patients are already malnourished when they are admitted to hospital. Therefore, a broad conceptual framework is necessary to consider how policies in different settings and different phases of the patient journey can be integrated to optimise recovery from illness.[2]

Before Admission to Hospital

In people aged 65 years and over in the community, the prevalence of individual vitamin deficiencies can be as high as 20% [3] (and higher when any deficiency is considered). In addition, protein-energy malnutrition, according to 'MUST' ('Malnutrition Universal Screening Tool') affects 13% of those aged over 65 years. Such nutritional problems are less common in the southern than northern parts of England [4], where deprivation is more common. Recently, deprivation (multiple deprivation index) has been found to be related to malnutrition risk, and to in-patient mortality, even in subjects from the same geographical area. Treating/preventing malnutrition in the community, and abolishing major nutritional inequalities there, are important strategies for preventing disease, improving wellbeing, and aiding recovery of patients admitted to hospital.

During Admission to Hospital

Recent information continues to suggest that malnutrition is under-recognised and under-treated. The first step in management is to identify individuals at risk of malnutrition, using a simple screening procedure, such as 'MUST'[5]. But this in itself is not enough, unless there is an infrastructure with adequate policies, training facilities, and resources to deal with patients

"The main reason for the high prevalence of hospital malnutrition is that patients are already malnourished when they are admitted … "

identified as being malnourished. Interestingly, although most of the nutritional needs of hospitalised patients are met by food, virtually all the evidence base relating to clinically important outcome measures (e.g. mortality complications, length of hospital stay) concern other forms of nutritional support, which are provided to a minority of patients (artificial nutritional support, and oral nutritional supplements). Evidence also suggests that recent nutritional intake during critical phases of the patient journey (e.g. either shortly before or after a surgical, or other insult) can have important effects on physiological and/or clinical outcomes, independently of weight status [6].

"… treatment started in hospital can have beneficial effects in the community…"

After Discharge from Hospital

It is necessary to ensure continuity care because length of stay in hospital is frequently short (a few days only) and the time needed for repletion of malnourished patients is much longer. One of the last things to return to normal after an illness is the ability to undertake a full day's work, which has economic consequences. Nutritional factors that influence this through interventions in hospital and/or community require further study. Recent evidence from randomised controlled trials, e.g. for patients with fractured neck of femur, suggests that treatment started in hospital can have beneficial effects in the community six months later [2].

Lifecourse

Several bodily functions, such as bone and muscle strength, increase during growth and development, and generally decline between young adulthood and old age [2]. Patients may fall below their disability threshold, and become dependent on others, especially after acute disease. Strategies for speeding up recovery from disease and dependency include changing the disability threshold (e.g. modifications in the house, which can also prevent falls), and limiting/preventing the time spent below the disability threshold. This can be achieved by increasing the peak functional capacity and decreasing the rate of decline during the lifecourse. Nutritional factors operating even during fetal development have been reported to produce lifelong effects on bone and muscle mass, glucose tolerance, and immune function, all of which could influence predisposition and recovery from illness in later life.

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"Nutritional factors operating even during foetal development have been reported to produce lifelong effects on bone and muscle mass, glucose tolerance and immune function …

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Questions and Comments from the Floor with Professor Marinos Elia

Baroness Finlay:	Thank you very much. I think it would be good to take some questions now if we can. I would like to ask you about that graph with the two boxes on body mass index, what happened to the people who were grossly obese? Did they come out as a different group to the ones who just have a high body mass index in terms of how they fared?
Professor Marinos Elia:	It is possible for obese people to be malnourished. Firstly, depletion of lean tissue can be masked by the layer of subcutaneous fat. Secondly, reduction in dietary intake during key phases of illness can affect bodily function, for example peri-operatively. Therefore providing nutrients at key phases of an illness may produce benefits, even in those that are overweight.
Baroness Finlay:	Are there questions people have from the floor? Thank you.
Modi Mwatsama:	Modi Mwatsama, Heart of Mersey. You mentioned that malnutrition reflects similar inequalities to other diseases like heart diseases, etc. What can public health nutritionists do to prevent malnutrition occurring in the community? Are the underlying causes the same as those for obesity, for example?
Professor Marinos Elia:	Well, this is a complex issue and in terms of health inequalities we can tackle this from a clinical perspective and a public health perspective. From a public health perspective it has been argued that there are so many different inequalities with complex interrelationships with unclear causal pathways that one way to deal with the problem is to deal with them together. On an individual clinical basis, one can think of the factors such as poverty and a range of diseases that are linked to malnutrition. To tackle malnutrition, which is often hidden or unrecognised, it is necessary to raise the profile of malnutrition or at least so that, for example, GPs and health visitors look for signs of malnutrition, or to

consider that at least there is a component of an illness that could respond to some kind of nutritional support. I guess the most important thing from a clinical perspective is to think about malnutrition and increase awareness.

Baroness Finlay: I think what we'll do, if it is okay, is move on and pick up other comments later. Thank you very much. Your final graph made me begin to wonder whether that explained why people in the US who didn't go through the First World War are now very fit elderly people, compared with the elderly people in our population. It is really quite marked in that much older age group – the people who were *in utero* around the time of the First World War. I found that absolutely fascinating.

Professor Marinos Elia: I think that is very important and fascinating, and it is not just the in utero effects on muscle and bone, but also to diabetic risk and immune function which can have an affect on how we combat disease 50, 60 years later.

Baroness Finlay: On that note, thank you very much indeed. Thank you.

Our next group of speakers is – we now have three speakers, because unfortunately Sheila Dillon is unwell. We'll start with Professor Alison Kitson who is Executive Director at the Royal College of Nursing. Each of our speakers is going to give us a very short presentation, and then we'll have some discussion.

Thank you.

Professor Alison Kitson
Executive Director, Nursing
Royal College of Nursing

Good morning everyone. I'll start with a story, so I'll take one minute of my three minutes telling you a story about when I was a newly qualified Staff Nurse working in a hospital in Northern Ireland. I was working on a surgical ward and I was looking after a middle-aged, very educated, well-informed woman who had just been diagnosed with breast cancer. And one morning she sort of pulled me over and said, "*Staff Nurse, I would really like you to do something. Why is it that every day that I have been on this ward I sort of go through a ritual of filling in what I'm going to eat for the next day, and each day I have not got what I have ordered*?" She said, "*How can I have any faith or confidence in this hospital if I don't get a simple thing like the food that I order*?"

Now, that really taught me a very important lesson, because what I realised was that it is the very simple things that happen in hospital systems that really reflect some of the deeper confidence issues about us being able to deliver effective services. So you can guess what state of absolute anguish I was in whenever the dinner trolley came up the following morning, and I did personally go through and make sure she got the food that she ordered.

However, that is an example of a systems failure and I would like to actually just build on the suggestion of Profesor Elia, which was – and I think that what I'm about to say is a hypothesis rather than a statement – and my view is that the biggest thing that is wrong with hospital food at the minute is that food is no longer seen as one of the first interventions in the recovery plan for patients. So, it is relegated to the nether lands of hospital policy, and it is not given pole position as the first step to recovery. So not only does good food get people better, and we have got developing evidence to show that, but the story of my patient shows that psychologically food helps people feel better. It gives them more confidence, it gives them confidence in the system if they can actually get food when they want it, how they want it, and eating

"… the biggest thing … wrong with hospital food … is that food is no longer seen as one of the first interventions in the recovery plan for patients."

"… we need to … actually acknowledge … that food now becomes one of the top five priorities in transforming hospitals …"

it, as Baroness Finlay said, in a context that is conducive to making them feel better.

And, I believe that the consequences of us not acknowledging the pole position of nutrition and food in our hospitals is that it is given a low priority, from the boardroom to the bedside. Every step in every decision chain, food is given a low priority. That consequently has an impact on trying to get systems improvement, and you can't actually improve the food on just one ward or with one group of patients. If you want to improve food in a hospital you have to improve the food of the whole hospital. You cannot have protected mealtimes in ward X and try to change things if ward Y is not saying food is a priority.

So, my suggestion is that what we need to do is actually acknowledge, with the knowledge of the Chief Exec or the Director of Nursing, at the top of the boardroom, that food now becomes one of the top five priorities in transforming hospitals, improving patient experience, actually moving things on. That would mean that the really good work around protected mealtimes that is happening in many hospitals across the country can actually be given more impetus, more ideas for how to make things better, so we can actually begin to introduce more choice, more variety in our food, and most importantly we can begin to realistically look at the investment and education needed to sustain the changes that we've made.

Thank you.

Royal College of Nursing

Dr Karen Jochelson
Research Fellow in Health Policy – Public Health
The King's Fund

Some of the things I am going to say are very similar to my predecessor. That's probably a good thing that we're going along the same path, making similar arguments.

I've got two problems I want to talk about. The first is similar to what Professor Kitson was talking about, but slightly broader, and that is the lack of holistic food policies for hospitals. The focus on patients is important – but I think that we need to go far broader than that. We need to look at food throughout the hospital and that means looking at the food that's in the retail outlets and food that staff, patients and visitors are going to eat. A hospital should be a beacon of good health in the community. It should be an example of all the messages the Department of Health is trying to get over about good health. And one of those message is about the kind of diets we have, so, if people go into retail outlets in their hospital, what they should see on offer are the kinds of foods bearing the kinds of messages that the Department of Health is trying to get out to the public.

And why might we want to do that? Well, firstly, we already know there's a lot of information about the cost of poor diets. These are costs borne by the health service in terms of having to treat people, and the economic costs in terms of lack of productivity, and days off work. So they are the costs borne by everyone in society. For example, coronary heart disease costs £1.66bn for treatment and £8.9bn in loss of productivity. Obesity costs £0.5bn in treatment and £2bn in productivity.

Secondly, providing good-quality, nutritious food also brings operational benefits to a hospital. Malnourished patients take longer to recover and occupy beds for longer. For staff, a meal at the hospital may be their main meal of the day. What you eat and how you're feeling is going affect how productive you are. There are issues about food quality, regardless of whether it's for

"… good-quality, nutritious food … brings operational benefits to a hospital."

"We need to have a new look at catering and, menu design and how this might support healthier eating …"

patients or in retail outlets. If food is poor quality and is wasted, then you're basically putting money directly into the bin.

Finally, hospitals can have a public health role. We don't normally see hospitals in this way, but I do think that health organisations sell health messages by the way they present themselves. This may well become far more important as we move towards foundation trust hospitals, and also as patients have the right to choose. Patients may not be able to judge one clinical skill against another, but what they can do is see the quality of the food, the aesthetics of the hospital and whether it's clean. And it may be that people make decisions on where they want to go on these factors.

The second problem also arises from looking at a whole food policy for the hospital, and that's how does the food get there? I would argue that food procurement in the hospital is unsustainable, and has an effect on health, although it may seem indirect. Based on data we collected from a few Trusts and a few cook-chill producers, we found that food is sourced internationally. The ingredients for steak and kidney pie, for example, travel about 31,000km. It's coming into Britain by boat, plane and a lot of it by road travel, and food is going up and down the country in lorries. Why is this important to health? Well, we all know that transport results in all sorts of air pollutants and these are implicated in respiratory diseases, and there's also an economic issue in terms of congestion, which we also pay for.

And then there are other issues related to how food is produced. Regulations about food production in Britain may not be matched in other food-producing areas. There are issues around pesticides and who is exposed to pesticides, about the cocktail of pesticides and the unknown effects that these might have on health, about antibiotics that may be used in production of food and about food additives and the impact that might have on health, particularly in children.

So, what are the solutions? I thought I'd quickly get my word in here. One, I think, is looking at corporate policies, and again like Professor Kitson, I think there has to be a whole-food approach, but I would want to extend it back to look at the supply chain, looking at where you get food as well as what you serve, where you serve it and how you serve it. I think this means looking at purchasing, much clearer attention to what goes into your tender specifications, and who you're buying from, and how you're buying. We need to have a new look at catering, and menu design and how this might support healthier eating, and how it might support buying seasonal food which might

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be both cheaper and fresher. We also need to look at vending machines, and what kind of messages they are offering and see them as a food source.

"We also need to look at vending machines … and see them as a food source."

King's Fund

Andy Kemp
Group Sales Director
3663 – First for Foodservice

Well, good morning ladies and gentlemen, and thank you to my fellow speakers who have already raised some very interesting points. My name is Andy Kemp, I'm group sales director of 3663 – First for Foodservice. I'm also chairman of Arena which is the industry networking body, and I'm also a fellow of the Hotel and Catering Institute. For those of you that are not aware, 3663 – First for Foodservice is the UK's leading wholesale distributor and we provide more frozen food, fresh food, chilled and ambient food, grocery and provisions to caterers in the UK than any other company. As the supplier of choice we offer an extensive selection of leading food service brands, and provide an excellent quality and value with our successful own brands. And we believe we have an unmatched understanding of all of our customers, one of which is the NHS. In both roles, I believe I represent and inform the hospitality industry of some of the wider issues that affect all of us. Healthcare and the role that food plays within it, and its distribution, are considerations for all of us within our marketplace. And, on a personal note, my wife has been in healthcare for over 30 years so this is an issue that is very close to my heart, and indeed one that 3663 believes in and sees that it can have an instrumental part to play within. We are delighted to sponsor today's seminar, and as a business we are passionate about wanting to raise the profile of food and its role within hospitals. Since the launch of the Better Hospital Food programme in 2001, 3663 has committed to its remit, so today our sponsorship and my attendance is to reaffirm our commitment to the project. We aim to work very closely with the NHS Purchasing and Supply Agency (PASA) to meet the challenges, and to ensure that staff, patients and visitors have an enjoyable, high quality, and most importantly, a nutritionally balanced food within hospitals.

This is a hugely sensitive social issue, and I would like to embrace what we see is best practice, where we can share through highlighting the opportunities for improvement and contributing to the thought leadership that this seminar will provide. The role that food plays in welfare, care, physical and

"The role that food plays in welfare, care, physical and emotional wellbeing … in hospitals is still very undervalued…"

emotional wellbeing for all of those in hospitals is still very undervalued, and we believe that food is a key part of the moral component. Interestingly, our first speaker talked about the effects of malnutrition, highlighting the impact that between 15% and 50% of patients admitted to hospitals being negatively affected in their speed of recovery, and their moral association to this, the clinical outcome and the cost implications, and here we are, a leading and First World country, and we are allowing this to happen. The cost implications and people implications are enormous.

We also aim for solution-driven outcomes in our approach, and we're constantly seeking to improve and innovate our offering to our customers. For example, we have a dedicated care team who provide menu solutions for care homes and packs for caterers, with information about specific nutritional needs of the elderly, meeting the current guidelines for meals provisions and a range of nutritionally balanced menus with a library of recipes that each have a nutritional value per serving. All of this with the specialist knowledge of our dedicated nutritionist, who happens to be here today.

So, in summary, we believe that there is a great deal to be done to integrate food and nutritional care into everyday activity and the wards of our hospitals. More importantly, it is about encouraging all parties to treat patients as guests and taking that extra step and caring way in all that we do.

Thank you very much for your attention.

"… it is about encouraging all parties to treat patients as guests …"

Questions and Comments from the Floor

Baroness Finlay: Thank you. Well, you have our panel, and comments please from the floor.

Peter van Gelder: Thanks very much, Peter van Gelder from the Westminster Diet & Health Forum. We've heard the three speakers essentially agreeing with each other about what the issues are. I'd be interested to know if you have a view on the way forward for improving things. I'm sure we'll get on to that later in the seminar as well, but I'd be interested to know why we are in the position that we are at the moment perhaps, and anything that you think should be done in the future, with perhaps a call to action for people who are in charge of policy at the Department of Health or elsewhere.

Baroness Finlay: Who would like to start?

Andy Kemp: Shall I answer that one? I think, at this moment in time, the competitive tendering process prohibits the movement forward on quality food. I think that one of the previous speakers talked about nutritional balance, making it a part of the tender, and today any distributor is really very restricted to tendering for products that are required by a government body. For example, if an NHS tender suggests that we supply baked beans and they are to be Heinz, we don't have an ability to operate or suggest low-salt baked beans. Or, if we want to talk about products such as the steak and kidney pie or whatever's been shown on the slides, we can't talk about reduced fat, salt or sugar in some of the products that are readily available. And this is the first status, and I think that any supplier of food into the NHS needs to have a range portfolio that meets that aim. And interestingly, in food distribution all of us carry between 12,000 and 15,000 products, and those products are as wide-ranging as supplying someone like Buckingham Palace down to a greasy food café on the A2. And one of the areas that we supply is the MoD

who are superb in ensuring that all of our forces when they're eating abroad are eating nutritionally balanced food, and I think this is a lesson that we should start to learn within the NHS. There is a cost to bear within that, but I'm quite sure that, if someone did a calculation on the additional cost of bad care within our marketplace and within our communities versus probably an increase cost of maybe 30p or 40p per meal occasion, the benefits are huge.

Professor Alison Kitson: I think it is an issue of value and priority. I think the debate has to be had at a higher policy level about the value we want to place on making sure that our hospitals and our patients in our hospitals have high-quality food. And I think it is a matter of prioritising that. We know we can do it if we want to do it, and the fact that we haven't done it yet means that we haven't put our energy into making it happen. And I think that that is the first debate for me. Then it goes down to getting the system working in an integrated way, having the right checks and balances, making sure we know where we can save money, where we have to invest more. And then, from a nursing point of view, it's looking at what actually happens when you are delivering food. And we're still faced with paradoxical situations like, when do the staff go and have their mealtimes? Mostly they have their mealtimes when the patients are having their mealtimes. Can staff actually get good quality food at 3 o'clock in the afternoon or at 11 o'clock at night? No. So there's loads of very practical, logistical things that we then need to work through.

Another example is when do people suggest that you do drug rounds? At lunchtime. When do registered nurses have to give out the drugs? Well, they have to prioritise. Do they sit with the patient and help them feed or do they give out a drug? So many very simple, simple decisions that have to be made, but if you keep making the priority against food you end up in the state that we're in and we don't want to stay here, so let's move on.

Dr Karen Jochelson: I support what the previous two speakers have said. I think, for me, one of the issues is that food is seen as a cost, rather than part of the clinical service and so immediately it's an add-on. How can you cut costs, how can you shave a cent off this, a cent off that, whereas it should be given an importance equal to its role as part of clinical treatment. I was pleased to hear what you were saying about tender specifications, and I think there it works on both sides. Whether you have your own kitchen or buy cook-chill, you need to be clear about what you're specifying.

Because you're only going to get what you write down, what's in the contract. And I know when we did some of our interviews, one of the things we heard back from the cook-chill companies was around whether they were sustainable? And they said, 'we don't know what it is we're being asked to do, so you need to be clear in terms of asking us'. This means clarity about the nutritional make-up of food and if you're going to use sustainability as a criteria, being clear about exactly what it is you're looking for, and have that built into the contract.

And the other issue is, I think, recognising that having better quality ingredients is not always a cost. Now, admittedly, my information is anecdotal but I found it quite interesting that – I think you're going to hear about Cornwall and the London Project later today – but certainly what I've heard from the chefs involved is that, if they bought high-quality meat there was less shrinkage in the meat, so they actually needed to use less. When they bought higher-quality bread rather than the bread that sticks to your palate, patients found it more filling, so they ate less. And then, when you looked on the retail side, there was a hospital using powdered soup and they started making their own soup with proper vegetables and they found they sold it and they were making more money out of soup. So there is a realisation that 'if I put something into food it's not throwing money away. I'm getting something back'. And some of that will be a cost saving because you use less or you're selling more, and some of it is in the more hidden things, like people recovering more quickly.

The final issue is, why is it so hard for things to happen? I think that relates to issues to do with, how do you get organisations to change? There's a kind of inertia that's built into organisations. Things work fine as they are, they could be better, they could be worse, but it's really, really hard to get people to figure out how to do things differently and be willing to put the extra time and effort into doing that.

Baroness Finlay: Thank you. You make me think that we're so obsessed with the balance sheet and cost yet attitude makes a huge difference. And prioritisation of making sure that patients are eating is staff making sure that food is accessible, that patients can use the knife and fork supplied, that they have the company they need. And that is very much about the staff attitude as a lot could be done without incurring any more expenditure.

Dr Karen Jochelson: The other thing that I'm also concerned about – and I keep pushing it because it doesn't fit easily on the agenda – is a whole food approach in

the hospital. Why aren't we putting equal thought into what's served in those retail outlets and vending machines? It seems silly to go on and on about it, but if you're in A&E and you're waiting for your appointment that may be your only source of food. And if you're a staff member trying to get food on the run, again there's not much choice there. The school examples are showing us that it is possible for us to run vending machines that offer people a range of healthier, proper food, and that those are profitable. One of the things we did for our project was we went into supermarkets and took a whole range of things off the shelf and started looking at their nutritional breakdown, just to prove to ourselves really that there are things that are commercially available that you can put into vending machines that would be healthier for people to eat.

Andy Kemp: I think you're absolutely right, and one of the key issues the NHS needs to address is the total income for food within an NHS Trust, where does that income go? And if you look at certain areas such as universities, they use their total income to subsidise and manage their student welfare. Within hospitals often you've got retail outlets where the cash is going elsewhere, – and vending is incredibly easy today – there are thousands of products that are available that are nutritionally balanced that can be microwaved, regenerated, by literally putting a code into a vending machine and putting in your £2.50. I think what most people forget about is that there is no difference between catering and retail. Most of the food manufacturers are trading for both ourselves in food distribution and for caterers, and are also supplying Tesco and Sainsbury's and everybody else. It is just that often the demand in certain sectors – and I believe the NHS sector is one of the areas that is guilty of this – does not demand that standard. And some of it is about cost restrictions, some of it certainly is about kit, some of it is about quality of training, and most of all it is about profile and being the number one thought, as you rightly said, in total patient care.

Professor Alison Kitson: Can I just add another thing, which is we do have to take account of the whole societal attitude to eating and food, and the symbolism of it. I know that recent statistics show that most people graze now, and it isn't so common to have family meals and people sitting down and spending time at mealtime. And one of the things that we have found in research that we've done at the Royal College of Nursing is that even nurses themselves feel as if they're on some sort of conveyor belt and graze through the day; so even the staff are not taking time out to sit down, relax and have food. Now, consider the impact that has on your

either implicit or explicit attitude to the importance you put round an event called a mealtime for patients. And we also know both the symbolism and the importance of people just having a rest and taking time out. We know that day rooms in hospitals have vanished. We know of the difficulty and challenges of actually having a conducive atmosphere to have people enjoying a meal, and we also know again in the symbolism of people and relatives actually asking, 'is so – and – so able to eat yet?' And loaded in that question is that, if you're able to eat, if you're getting your appetite back, you actually are on the road to recovery. So there's a lot of stuff in there that we do have to go back and talk about. Because, whether we know or not, the systems within the hospital are actually working against some of the fundamental healing processes, some of the fundamental recovery processes, and our hospitals are not places of safety and welfare. They feel more like race tracks that people are rushing through. And we are all victims of that as well, and it is about us actually seeing what is happening.

Professor Marinos Elia: Thank you. I was just going to ask you whether you think that grazing is necessarily always a bad thing? I'm just reminded that some patients may have early satiety, they may eat a little, they get full, and if they're not given food, if food is not available until the next meal then they're not actually making use of the intervening time for snacks or additional things. So, whilst I fully agree with you on the importance of mealtimes as an absolutely key factor here, there may be situations where the intervening periods might be used as well.

Professor Alison Kitson: Absolutely, and the point was that, given focus on protected mealtimes, we have to understand that within that construction in the system there has to be that appropriate response to people who have small appetites and can only take a small piece of food at a time. And we have to acknowledge that as well.

Jackie Smith: I'm a dietician but I've spent 100 days in a hospital this year, and I can honestly say that nothing was further from my mind. As regards my food, all I wanted was something that I could actually eat, that was acceptable, was at the temperature that I required it, and at the time I wanted it, and with a spoon that was a reasonable size – I had a tube feed in at one point – and somebody there to actually feed me. None of those things occurred. My two sons came from home, my family were there to feed me at mealtimes, otherwise you would not see me here today. And frankly, healthy eating doesn't necessarily have a role. I see it as having a role when feeding the staff and I sympathise with the staff

because I know that the nursing staff on my ward were overworked. They rushed down and grabbed a box of chips or existed on the chocolate biscuits that patients gave them, and then their actual eating was appalling. But as far as patients were concerned I think we have to consider that yes, there are patients who do need to be eating healthily, but there are a hell of a lot of patients who just really want good food, well served, well presented, and, yes, you do need a snack and a drink. Drinks are very, very important too, and sometimes they didn't appear at all. And when you're paralysed, lying in bed, with no way of feeding yourself, you are relying on somebody else to come and do these things for you. And I think a menu has to bear in mind the whole range of patients that you've got there. But as far as finance is concerned you haven't unfortunately got any Chief Executives or anybody here who actually holds the purse strings, and that's the most important thing. My campaign will continue. I'm seeing the Chief Executive of the hospital where I was a patient in January to talk about these issues.

Baroness Finlay: I think I'd like to take some comments from the floor and then have the panel respond en bloc. The gentleman back there, yes.

Steve Bloomfield: Steve Bloomfield from the Eating Disorders Association. I just wondered how much in Andy's experience of the tendering and purchasing process was actually a dialogue with organisations such as yours, and how much of it was simply a one-sided specification.

Andy Kemp: I think it is a mixture of both. But essentially under our legal requirements into any government-funded body the dialogue tends to be quite minimalistic against the specification, and then we would be standard tendering into certain trusts. And I have to say as well that there are trusts around the UK in some areas that are doing brilliant jobs, who are looking at sustainable farming, who are looking at environmental issues, who are looking at nutritional standards and are really doing some fantastic work. And there are other trusts that are very clearly underfunded and literally go down the straight square line, and I think they are hampering their opportunities.

Tony Bishop-Weston: Tony Bishop-Weston, Foods For Life. In the panel's experience, I'd like to ask the panel, who is it that is making the decisions about the food that is available in hospitals? Because I can't see that it is anyone like a nutritionist or anything like that, because the choices that are available just are incredible. I was in hospital the other day and I couldn't even get water. I finally managed to get water from Burger

King, and it was over £1 for a tiny little bottle of water, and that's the most basic of needs. Nothing much more than crisps. So who, in your experience, is making those decisions?

Baroness Finlay: I'm going to hold the panel. Let's have some more comments from the floor because some more hands went up.

Toni Osmane: Toni Osmane, Chief Dietician for Food Policy. In answer to your question, I was heavily involved with the design of our menu, along with our contractors who I'm very happy with. What I would like to say is to Professor Kitson. One of the main problems that I have is exactly what you were speaking about, and it is engagement with nutrition by nurses at ward level. There's a commitment at board level right down to the Modern Matrons, but as soon as you get to the ward this is where we have difficulty engaging the nurses. It is an important issue. With regard to water, 25% of all patients dehydrate in hospital quite simply because they cannot reach their cup, and that to me is a nursing issue. It is not the fault of catering.

Baroness Finlay: Other comments from the floor? I'm going to chip in with a follow-up to two people, because we've audited in our teaching hospital how many patients could reach their glass or cup, and it was just appalling. We had a lot that were put on the blind side of patients, on the paralysed side of patients, cups of tea that developed that skin on them which makes them even less appetising than the stewed brew that was in the cup even when it was hot, and fluid intake was a problem. And then in the hospice when we looked at what the patients had, the favourite was the home-made soup. The tragedy was that the kitchen, as it was, got condemned for various reasons and so there was no more home-made soup. I think the patients have suffered since, because we did have a cook who just chopped up vegetables into different vegetable soups every day and that was the most popular item amongst all the patients who were really sick.

Nick Ellins: Nick Ellins, Water UK. I work with a team of people called the Water For Health Alliance. I thought you might be interested given the comments that have been made, that the World Health Organisation described water as an important nutrient for the body, critical for life, and yet it doesn't appear in any of the nutritional standards for hospitals at all. It was missed by the Better Hospital Food panel, it isn't in the Essence of Care. And the Water For Health Alliance is a large group of health stakeholders, which includes the Hospital Caterers Association

by the way, and loads of other caterers too are trying to get this sorted. And there are lots of clever people who are trying to invent things like hospital jugs you can get access to, wheelchair access water coolers where wheelchair users can actually access and press the button, all sorts of things going on; but one of the principle problems is that it isn't recognised in policy. The only obligation in a hospital is to actually have fresh water into the building. The efforts to get it to patients and to staff tends to come from goodwill of the hospitals, and there are some very good examples of that. But interestingly, I think I'm right in saying that the NHS now has a £6m a year procurement contract on water coolers, but it is not very widely advertised in the NHS. So actually there are ways and means, but it doesn't even feature in the dietary records plans yet, and, as somebody pointed out, it is actually the critical nutrient.

Anne Macalpine-Leny: My name is Anne Macalpine-Leny and I represent the Anaphylaxis Campaign and I was going to bring it up later on, but I think perhaps it is appropriate to bring it up now as well – to address special diets and special needs for diets in hospitals and the entire environment. Because, of course, when you're dealing with – anaphylaxis is severe allergy which leads to anaphylactic shock – when you're dealing with patients with anaphylactic reactions of course they are susceptible to their entire environments, not just to dietician-set meals. So I wonder if any of you could address that.

Baroness Finlay: Thank you. Are there any more comments from the floor before I let the panel have their say. Would you like to start?

Dr Karen Jochelson: I thought there were two issues I would pick up on. One, was there was the mention of the relationship with suppliers and producers, and this issue of the cooked soup in your example. And to me there is a bigger issue that lies behind it. What we're seeing at the moment is basically a running down of capacity within NHS hospitals and their ability to run their own kitchens, so there are a lot of the new, privately financed hospitals which are not building their own on-site kitchens because their assumption is that they're going to bring in cook-chill food. I don't want to use this as an opportunity to hammer you, but I think there's a political issue there, because what you're losing once you lose your kitchen is your ability to be flexible in how you respond to patients. In the example of severe allergic reactions it is hard to know that that is what you have on your books and it takes a while to go through

your system. You're more easily able to respond if you've got a kitchen on site.

It is widely accepted that outsourcing catering is more efficient – but I have visited hospitals who have their own on-site, industrial, properly managed kitchens that are very effective in producing food for their institution. Where hospitals are trying to source food differently, it has involved a lot of time and resources. I won't talk about the London Project because Emma will talk to you later today, but Cornwall won several grants to develop their own regional food processing unit and have had time and money to put into understanding their local markets and making links with producers, and cutting down the number of middle men. And again somebody has to think that that is important and put money into developing that kind of expertise.

And the final issue was the one raised by the woman in purple. I was sad to hear of your experience, but what I found interesting was that, to me, healthy food is nutritious and tasty, and it is not an either/or. I've spoken at conferences before and talked about healthy food and people say 'oh, well, that's boring'. And yet I think that my favourite meals are tasty and they are nutritious, and there is something that has happened culturally where that true link has gone. So there's a bit of a cultural issue for me as well.

Professor Alison Kitson: I would just like to pick up the challenge about the responsibility of nurses to be part of an effective team to deliver good food, and I would absolutely support that nurses have a key role to play, and that this isn't a blame culture. It is about seeing how systems fail and where the weak links are in complex processes and systems, and it is totally frustrating if the endeavours of the nutritionists and dieticians, caterers and every-one else in the team get it right, and then it falls at the last hurdle. There is no excuse to have the water sitting on the wrong side of a patient. There is no excuse for not having the right utensils, and there is no excuse to have food that comes to a patient warm and appetising and it is left there without anyone helping the patient eat it. Those are all symptoms of a system that needs putting right. I know that nurses who have been involved in the protected mealtime initiative will talk about how much negotiating and changing of the routines and the systems in their own wards they've had to undertake in order to prioritise mealtimes; how they've had to change drug rounds and other sorts of services in and out of their ward. So we take responsibility for it, we

want to see improvements and we acknowledge that it is a whole systems issues.

Andy Kemp: There's lots of things in there. First of all, with the procurement of food from large operating distributors you can buy fresh or pre-prepared foods today very, very easily and you can also do that using sustainable farming techniques where we would have linking into us local farming, or local product into local regions. To me, I think the whole issue is about money. I think it is about a clear understanding of the work that goes on in the kitchen. I know that by note the Hospital Caterers Association are here today and I'm sure they will feel for their membership that, number one, they're undervalued, number two, they're underpaid, and number three, they're under-resourced. And actually you can put in good kitchens. The Jamie Oliver experience has a seen a lot of changes across a number of authorities doing exactly that. Being a caterer I can honestly say that there are people out there thirsting to come into our industry, provided they can get paid the right money. And if you've got staff employed on minimum wages using archaic kit then we're not going to attract the right people into the industry, particularly in the NHS area, and we're not going to keep our employees working there. So it is about cash. It is about investing in patient care and hospital care, and a holistic approach.

Baroness Finlay: We've got one more comment – go on, you can have the last word, from the back.

Finlay Nelson: Hi, I'm Finlay Nelson, I'm the managing director of Geest Anglia Crown. I, like Andy, am a supplier of prepared foods into the NHS. I'd like to pick up on a couple of things. Professor Kitson, in support of what you said. I have a sister who is a nurse in a large hospital. She works 12 hour shifts and very often has two cups of tea, that's all she gets to sustain her because of the work pressure. I also think it is quite difficult for the nursing staff because they cannot taste the food, they're not allowed to eat patient food. As a company we've done a number of initiatives around some of our customers where we've had Supported Nurses Days or Modern Matron Days, where we've actually gone in and fed the nurses so they can understand what we're supplying in to patients. Dr Jochelson, I'd like to comment on something that you said about prepared, delivered meals. I'm fairly new to the NHS and healthcare – my background is supplying big retailers like Marks & Spencer and Sainsbury's – but I've come in and found that the food that we supply now as part of a large group of suppliers to retailers is equally as

good as what is going to the retailers, and in some cases, I think, better. I do think, and I have evidence particularly in care homes that, because we have a standard range of products that are supported by –

Baroness Finlay: I'm going to ask you to be quick because we're moving into other peoples' time now.

Finlay Nelson: Okay, sorry – it is possible to supply delivered meals that are actually a better service to some units who struggle with turnover of staff. And the last point I'd like to make in support of what Andy is saying, I've got a copy of the Equity this morning and two newspapers over the weekend saying a lot about price pressure on the NHS. I'm seeing massive pressure on buying decisions, where the buying decisions are currently made by the finance director, not made by the people who really should be making the decisions in the NHS.

Baroness Finlay: I'm going to ask you all to just thank the panel for their brief presentations.

Thank you.

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Rick Wilson
Director of Nutrition and Dietetics
King's College Hospital

Thank you very much, ladies and gentlemen, for this opportunity to come and speak today. By way of background, I've come from King's College Hospital, it is 4 miles away from here. It is a typical inner London teaching hospital –1,000 beds, 70,000 admissions every year, 55% of which are unplanned admissions through A&E. Food service comes courtesy of a private finance initiative. We have a cook-freeze system which is regenerated, reheated and served at ward level. King's College Hospital has an illustrious history with regards to food, and those people who have a nutrition background will undoubtedly be familiar with McCance and Widdowson's 'Composition of Foods', the first food composition tables in the world. And Elsie Widdowson met Ray McCance in that building in the 1920s. I've been at King's College Hospital since 1979, in the 'winter of discontent'. It has been alluded to today already that compulsory competitive tendering has been detrimental to food service in hospitals and I would support that contention. In the early 1980s it came in, and also in the late 1980s we had the terrible incident of 19 people dying of food poisoning at Stanley Road Hospital in Wakefield. As a result of that, Crown immunity was lifted. Up until 1987, hospitals could not be prosecuted under the food hygiene regulations because they were the property of the Crown. That changed in 1987 and my own hospital had to spend nearly £2m bringing our kitchen and catering facilities up to 20th-century standards, they were still in the 19th century. All that at a time of severe financial constraint, and there was a headline at the time: 'NHS puts patients on sick list'. It was not a good time to be an NHS caterer. Many of my colleagues in catering were losing their jobs and it was very, very difficult, and certainly the emphasis very much was on cost.

Dieticians and colleagues across the region in South East Thames were very concerned that nutritional standards of hospital food were declining, declining to a point where it was unsustainable. It was impossible to provide adequate nutrition to patients in those circumstances, and we tried to discover whether or not there were minimum nutritional standards that hospitals had

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to deliver and, believe it or not, in the early 1980s, there were none. There was no requirement for hospitals to feed anyone at all. So we set about writing some, and in 1992 a group of dieticians and nurses and some doctors and some health promotion colleagues in South East Thames region wrote two sets of guidelines. One called the food chain which we regarded as being best practice: how to get food delivered to the patient and, more importantly, how to get it eaten. And secondly, one called menu planning; how to get the right mix of nutrients, the right balance between nutrients for our patients in the menu planning process. In 1995, as part of the Health of the Nation exercise, the Government at the time produced these nutritional guidelines for hospital catering.

Many other people were concerned about this issue of malnutrition in hospitals and it is a nut we've yet to crack. In 1999, two reports were published by the Nuffield Foundation at the Hospital Caterers' Conference in April, and by the British Association for Parenteral and Enteral Nutrition at their conference in June. The bottom line is that if you don't provide a healthy person with adequate amounts of food, and this is before we go into the nutritional balance of food, its micronutrient content, its health giving effects or otherwise, if you provide inadequate food, zero food or less than enough, what happens to all of us is that we starve, and eventually we starve to death. And that doesn't take very long, it is days. This was clearly illustrated by David Blaine hanging over the Thames not so long ago. A fit and healthy young man, 40 days later he was not fit and healthy. People getting inadequate food are only going one way.

In 1999 and 2000, the Better Hospital Food project came along as part of the NHS plan. It is what the public, the voter and the taxpayer wanted, and I think that is still the case. I think the public will use patient's choice and use their greater consumer power to choose hospitals which provide better food and which are cleaner. No one wants to see relatives struggling to eat and everyone knows that patients do not get better if they don't eat. Better Hospital Food was launched on the 8th May 2001. 1,200 NHS personnel attended the post-launch road shows during that year making it a fantastic opportunity to promote food as treatment, and it certainly did raise the standard of food provision.

At the time, the health service in England was given some 'must dos'. Six of these related to hospital food and were to meet or exceed a new menu framework, and one of the key things about that was moving the main meal to the evening. 2001 is not very long ago, only four years ago, but there were some hospitals who were not providing a meal in the evening for patients. They

were getting soup and a sandwich at 4.30 in the afternoon and then no more food until 7.30 the next day. Quite a ridiculous situation, and this idea of moving the main meal to the evening I think put an end to that kind of practice. Snacks, mid-pm and evening had to be provided, and in terms of added calories and added nutritional content, these snacks are probably the greatest improvement. They add 300 calories and 4g of protein to every patient's provisions every day. Include three other new signature dishes, use the new menu design and improve the availability of food 24 hours a day though snack boxes and the ward kitchen. And also, the nutritional goals must be met and approved by a state registered dietician which was a big improvement.

So, what's happened? Well, there has been good uptake of those initiatives – the ward kitchen, the snack box, the additional snacks, the main meal in the evening and leading chef dishes. Between 2002 and 2004 there has been a greater uptake across the 500 or so Trusts in England. There is another independent view of whether or not we're succeeding or whether or not the Better Hospital Food initiative succeeded, and that's the Patient Environmental Action Team (PEAT) reports. This was part of NHS Estates and part of the Department's project looking at what was happening and it was set up to assess cleanliness in 2000. The teams looking at cleanliness realised that it was a good opportunity to also look at food and in 2002 they first assessed whether the food was good or not in the patients' view. Only 17% of hospitals managed to achieve a good rating in 2002, one year into the Better Hospital Food project, which meant that 83% didn't. By 2004 the figure had risen to 58%, though 42% are still not there, but only 7%, were assessed as being less than acceptable. So I think things have moved forward as a result of the Best Hospital Food project over the last four years. The National Patients Survey has a couple of questions about what the patients think about food within it also. It is slightly less convincing than the report from the PEAT survey, but nonetheless there is an indication of improvement.

I think that having the Better Hospital Food project has led to a few initiatives that have been very successful; we've heard already about protected mealtimes. I think protected mealtimes is an excellent initiative and something that has put food higher up on the agenda and higher up in the minds of not just the ward staff, but all the other departments in the hospital. You can't really do protected mealtimes unless you do it as a whole organisation. In my own organisation we had to negotiate protected mealtimes with all the diagnostic departments to make sure that patients were actually there when

"I think protected mealtimes is an excellent initiative …"

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the meal happened! I think it is something of a success story which we need to build on further.

At the back of house, as we'll hear from the procurement people NHS procurement has moved on an awful lot and the NHS recipe file has now got over 300 recipes. The recipe file was last reviewed in 1975. So that's a big improvement; and, on procurement initiatives, product and quality control has improved and there is improved inspection and due diligence, and better and more accessible product information than there ever has been. The British Dietetic Association has worked hard on recipe and menu analysis techniques to develop consensus within our profession and standardise the ways in which we judge them adequate nutritionally or not.

There is a huge amount still to be done. Hospital food is still not a good news story. We're all discerning diners, and the nutritional value of food not eaten, food we're not happy with or service we're not happy with, is nil. Good service, I would emphasise is at least half of the issue. There has been a lot of discussion about how much we're spending on food, but I think we must spend if we're going to invest. We need to invest in food and we need to invest in service. I think there is a level of hospitality that has been lost in hospitals; being hospitable is somehow beneath our professional day-to-day activity. That hospitality is at least half of whether the food service is going to be successful, we need to win over hearts and minds. The column I reproduce here was written by Dee Burkett for the *Health Service Journal* and it was published in October 2005. She had a quite awful experience with her daughter in hospital and I'm sure in this audience there are a few people who've had not a good experience. Until we can turn that situation around I think we've still got a lot of work to do!

"We need to invest in food and we need to invest in service."

I'm not going to dwell on this, but malnutrition is still common in hospitals, and Professor Elia has given us a lot of the statistics; it is common in hospitals across Europe, and there is concern about this. The Council of Europe published a report in 2002 on food and nutritional care in hospitals and 19 participating nations recognised the problems that we've already discussed. There are between 10% and 60% of patients admitted to hospital who are poorly nourished and a significant number get worse whilst they are in hospital. Solutions to improve this will require improvements to food and improvements to hospital environments. We need to build in good food to our buildings as well as to the rest of the hospital environment. We need improvements in the patient's experience; we need improvement in hospital procedures, and improvements in staff attitudes, training and education.

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There is an important, and I think very useful, adjunct to the Council of Europe report, and that is that a resolution was passed by a committee of ministers as a result of the report. There are a hundred odd recommendations for improvement in there, which ministers have signed up to.

Food service needs investment. If patients don't eat they won't get better, and we need to invest in staff on the ward as well as food. The population is ageing. I was recently at a University of Surrey day where the statistic was given that in every decade in the years to come the number of people over the age of 80 will double. As we get older and frailer our needs for better nutrition and to maintain our function and to keep our independence are greater, and we need to make this a priority. The food bill at King's College Hospital, including the staff and all the food that we buy for patients, is around about £3m a year, and for the last five or six years that has been virtually zero inflation. It is not going up so we're having to do more for the same amount of money. The drug bill is £26m and inflation on drugs is running at between 10% and 15%. And a lot of those drugs are drugs which maybe we could avoid using if we fed patients better or if we hydrated patients better. A fair chunk of that £26m is spent on laxatives.

One day in hospital – our hospital – even if somebody does nothing to you, if you just lie there and nobody does anything to you, will cost £270. If you're in a high dependency area it will cost nearer £1,900 or £2,000 per day, so we've got to get all of this in perspective. We had a young man in intensive care who had been shot in the neck and he was paralysed from the neck down. He needed to go to Stanmore to the spinal injuries unit at Stanmore but he couldn't be found a bed, so he spent over a year in intensive care at King's College Hospital, a fit young man but paralysed from the neck down. He had an enormous appetite because he was a fit young bloke, but he needed help and assistance with eating and we had all sorts of trouble trying to get adequate amounts of food for him. All sorts of arguments, – you can't have this for him, you can't have that for him, it's too much, everybody will want that. And at the end of the day, this young man, whether he ate or not, was costing us £1,900 a day to sit there, so £10 on extra food is really a drop in the ocean, these are attitudes which need to be challenged.

One admission through A&E, even if you are not admitted, costs £750, so if you can keep somebody at home by identifying their nutritional needs earlier and meeting them then you're going to save money. Common sense in these things is not commonplace. Evidence obviously is needed to support investment, but randomised controlled trial evidence on food and the interventions with food are very difficult to get and, as Marinos has pointed out, there

"We need improvements in the patient's experience, improvements in hospital procedures and improvements in staff attitudes, training and education."

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aren't very many of them. Starving people as controls is not ethical! Common sense dictates that inadequate food and/or fluid is harmful. We all know it is. If you go without a meal today – I hope we're going to be fed after this actually – but if you go without a meal and have to wait until you get back home you're going to feel a bit wobbly, so missing out on one meal when you're feeling fit and well makes you feel poorly, and if you're ill on top of that it is going to cause more problems. If you count all the visitors and staff – there are 1.3m staff and all the patients that come as out patients or as day cases or as in patients of the NHS – the NHS, it is estimated, feeds 1 in 50 of the entire population in any given year, so it has massive influence on the nation's diet and we do need to capitalise on this.

Food service needs champions at high levels, and it is not just the quality of food, it is the whole service, it is the whole idea of regarding food as an important part of treatment, as that first part in your recovery. It is not defended at high levels, it is not there from the boardroom to the bedside, and it needs to be. And the quality of food loses out to price in market testing. I'm sorry to say doctors and nurses do have low awareness and training on nutrition and there is an urgent need to improve that situation. Consequently, food provision has a humble profile in the perennial struggle for resources and that is something that we need to change. Food is good value for money; Marinos has already said that artificial nutrition is not the answer. It is not nutritionally complete; it is as complete as our knowledge will allow it to be but it is not food.

There are exciting developments happening. The British Dietetic Association (BDA) and the Hospital Caterers Association (HCA) are working together to get an alliance of professional organisations together to improve hospital food using the recommendations of the Council of Europe report. There are new initiatives from the Department of Health and the National Patient Safety Agency which we'll hear about later, and there is a new core standard which is a requirement for all hospitals whether they are in the public or private sector to provide good nutrition. It is as broad as that, so in defining it we have plenty of opportunity. But it is there as a core standard for improvements in our hospitals.

"… the NHS, it is estimated, feeds 1 in 50 of the entire population in any given year, so it is a massive influence on the nation's diet …"

Food is the best means of nutritional support. It is the most nutritionally complete, the most physiologically appropriate, the most psychologically supportive and the most socially acceptable and I commend it to you as the best way forward.

Thank you.

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Questions and Comments from the Floor with Rick Wilson

Baroness Finlay:	We've got time for a couple of questions if people do have questions or comments to make. Okay.
Finlay Nelson:	It's Finlay Nelson again from Geest Anglia Crown. Thank you, I think that was a fantastic presentation. I would just like to make one comment about back in 2001 there was no evening meal, and that was soup and sandwich. Although I'm reasonably new to this part of the food industry I have a team made up of NHS caterers, or ex-caterers. They are shocked currently at the number of hospitals that are talking to us about going back to the soup and sandwiches option. I myself was in a hospital on Monday, where I was talking to the buyer and catering manager, where they are currently in debate about making exactly that decision and it is about cost. I have been really impressed by the number of initiatives I've seen coming through the NHS and how hard people genuinely are working on making the life of the patient better, but I think there is a danger at the moment where there is a big disconnect between policy and intent, and some of the realities.
Rick Wilson:	Very brief comment. I think that there is a long way to go and we need to maintain the momentum. There has been a bit of a hiatus this year in England, we've had a general election, there has been a fair bit of deck-chair shuffling at the top and now I think everybody is in their seat and I'm sure we'll hear later today where we're going, but I think it has not dropped off the agenda and it is up to us to keep it there.
Baroness Finlay:	Thank you, Rick, thank you very much indeed.

Session Chair's Closing Remarks

Professor the Baroness Finlay of Llandaff

Just a few closing remarks from me. The morning has triggered off some thoughts in my mind: we've got this chain right from outside – with the farmers – right on through the supply chain, then into hospitals, and on site getting things to ward level, and then getting them from ward level to the patient. And then when they've got to the patient, actually getting them into the patient. Fluids – again I'm back to soups – I think have enormous nutritional value. No one must underestimate constipation in hospitals; it is a massive problem and it puts you off your food and it makes you uncomfortable, it is degrading and it is just awful. And it is all made worse by the fact that hospital toilets are just grim. There's no privacy, and the worst of all is if you're stuck with a commode by the bed. How many people in this room would like to have their bowels open if we put a commode at the back with a screen round it? I don't think anyone would volunteer, not even someone with diarrhoea.

So we've got a huge problem, we need a Jamie Oliver. Hand-washing has had such a high profile that now you'll see soap dispensers, alcohol dispensers, around on all the wards and it has got there. It has taken a huge push, a huge attitudinal push to begin to get there, but there is something about saying, for each patient, who is going to help this patient eat? What about the post-operative patient when they come back? Who is going to timetable in the time?

Now, while I was in France, looking at some units, I was very impressed by a very simple system where they have just a whiteboard on the wall with the patients' names and the times against it, and the times for those patients to be encouraged to eat was marked on there, and the times to make sure that they had managed to get to the toilet was marked on there. Now, you could say it's not very confidential, but it meant that whenever any of the nurses went past that whiteboard, it was there, and if it was noon and the things for 10 o'clock in the morning hadn't been struck through as having been done for

"… I think the nutritional value of fluids is absolutely enormous … "

patients then somebody had to go and do it. I know that would seem to be task-orientated, but there are some important 'tasks' such as helping patients get food and fluids in. Patients often need small frequent sips, as they can't drink a lot in one go when feeling unwell. Let us not forget that the 'monochrome' meal is unbelievably unappetising, so presentation, at the end of the day, is key to making it appetising.

Just a little plug for Marie Curie – I don't know how many of you remember Bill Cotton of *Wakey, Wakey*. Kate Cotton, his wife, has worked with Marie Curie for years and she has been a real champion of food in hospices. In the Marie Curie centres she has been adamant that presentation is key, and has raised awareness up the agenda, which has been very important. It is thanks to her that, within the Marie Curie centres, food has been high priority, food and its presentation has been a high priority. We have a drinks trolley as well, taken round before a meal and people can have a glass of sherry or a beer or wine; they are a good appetite stimulant, and get fluids in while having some food. It seems illogical that no one in hospitals can have any alcohol, when it is actually quite an appetite stimulant with a meal.

So, a few thoughts about how we look at everybody. Relatives and families are often happy to come in and help if they're encouraged to do so, feel valued and appreciated, and they know their help is wanted, is useful, and appreciated by all the staff. Relatives are often frightened of doing the wrong thing, of somehow hurting somebody who's sick, uncertain how much they should give them – for example, is it safe to let them have a yoghurt or a caramel dessert, or whatever? So the way that we approach food should be as we would if we were entertaining a guest in our own home, because, at the end of the day, whatever you think, hospitals are there for the patients. They're not there because of the staff, because of the builders, because of the contractors. They're here because of the patients.

So, go and enjoy your coffee break. I wanted to ask you all: how many in this room have tasted those supplements from cartons? Yeah, great. Now, how many of you enjoyed the taste of them?

Thank you all.

"… presentation, at the end of the day, is key …"

Chris Bryant MP

Session Chair's Opening Remarks

I'll start. It is very good to welcome you – well, not to welcome you, we've already been here some time – but to welcome me. I'm Chris Bryant, I'm MP for the Rhondda. There is absolutely no reason why I should be chairing this session at all. I haven't been in hospital since I was 4, somewhat differently to Claire who has rather more experience than I. I am a Welsh Member of Parliament which means I have no responsibility for the health service, and nor has anybody else – I'm not allowed to make that comment, it gets me into trouble! And the only connection with the food industry that I can drag out of my own past is that my father's best man – and I want to you to know that I wasn't there at the time – my father's best man is called Keith Preston and he owns a company called Preston & Thomas, and you will all pretend you know nothing of Preston & Thomas but if you've ever been in a fish and chip shop, the big fryers will actually have been made by Preston & Thomas – unless they were the rubbish lot that were made by the other company.

So, I know absolutely nothing about healthy eating. But the one introduction point I want to make is that I have recently decided that I must become healthier. I've been to the gym for years and years and years, but that doesn't seem to get you healthy, does it? It just sort of makes you look better, so I've started training for a triathlon, and of course the first piece of advice you're always given is don't think about your nutrition last. Your nutrition for any sporting activity is one of the absolutely key elements, and I think it is all too often true in the past that nutrition in hospital was just thought of as part of the accommodation, rather than part of getting somebody back into full health. So, that is the only interesting, or semi-interesting, thought that I had on the matter.

So, without further ado, I think we'll move over to our panel. We've got an excellent panel, they do know considerably more, you'll be glad to know, than I do about this matter. We've got Emma Hockridge, who is the Hospital Food Project Officer from the London Food Link. We've got Peter

"I think … in the past that nutrition in hospital was just thought of as part of the accommodation, rather than part of getting somebody back into full health."

Mansell, Director for Patient Experience at the National Patient Safety Agency. We've got Claire Rayner who is sitting here next to me and has the most glamorous fingernails I've seen for some time. We've got Alison McCree, who is Chairman of the Hospital Caterers Association, and Mike Tiddy, who is the Category Manager, Fresh Produce and Nutrition at NHS Purchasing and Supply Agency.

So, I think we'll move straight on to Emma. Some are going to speak from the platform, some are going to speak from here, and I hope you'll be prepared for questions and answers because people are only going to be speaking for three to four minutes each. Emma, over to you.

Emma Hockridge
Hospital Food Project Officer
London Food Link

I will briefly describe a practical approach which has been taken in a pilot project to improve hospital food. The project aims to provide benefits to health, local economies and the environment and, on the basis of the project's results, I will conclude with some policy recommendations.

The two-year project is a partnership between Sustain: the alliance for better food and farming, as part of its London Food Link programme of work, with the Soil Association. The project works with four hospitals in London to increase the amount of local and/or organic food being served in the hospitals' routine catering systems.

The aims of the project are to:

- Improve the health of staff and patients by providing more fresh, appetising and nutritious food;
- Enhance the viability of local economies by providing new business for local companies; and
- Protect the environment by reducing long distance food transport and buying food produced organically.

The pilot project will end in January 2006, and has been successful on a number of counts:

- We have improved food quality within hospital catering budgets by, for example, using ingredients that are cheaper because they're in season;
- We have worked within the existing NHS Purchasing and Supply Agency (PASA) framework contracts, for example by including sustainable producers in lower tiers of the supply chain; and
- There is increased enjoyment of, and knowledge about, the food being provided amongst patients and staff. This has also helped to improve staff motivation.

"We have improved food quality within hospital catering budgets by, for example, using ingredients that are cheaper because they're in season."

New products in the hospitals now include: organic and local milk, beef and fruit juices, an organic fruit and vegetable 'box' scheme, local seasonal fruit and vegetables, and local free range eggs.

The benefits of more local and organic food in hospitals could be substantial. For example, the environmental damage caused by the current farming system is estimated at £2.3bn, and estimates of the costs to the country of an unhealthy diet range from £6.6bn to £7.4bn per year.

As well as helping to reduce these costs, there may be other benefits from more sustainable food in hospitals, such as the following:

- As a result of patients and staff enjoying, and therefore eating the food in hospitals, waste is reduced, which is beneficial both economically, and environmentally;
- If food provided to NHS staff is attractive and nutritious, there are possible long-term benefits in the form of less sick absence. This could be particularly important for low-paid employees who may have less access to a healthy diet; and
- Buying food from local businesses can contribute to regeneration by creating employment. Regeneration can, in turn, improve the long-term health of the population.

Unfortunately, despite this range of potential benefits, there is no clear mechanism through which hospitals can incorporate sustainable food into existing policies. Therefore it is unlikely that this agenda will be pursued unless there is personal motivation from staff. This is despite the fact that there is government enthusiasm to make public sector catering more sustainable.

A number of valuable lessons were learned in the course of the two-year project, which lead us to recommend the following:

- Funding is needed for the kind of practical help this project offered. This funding will not be needed indefinitely. Once potential purchasers and suppliers have been 'matched' and any practical problems ironed out, the systems should continue to work; and
- Investment is needed to ensure that a wide variety of sustainable food is available everywhere in the country, that the transport and distribution infrastructure is adequate, and that hospitals have the kitchens, equipment and skilled staff to create attractive and sustainable meals.

"The benefits of more local and organic food in hospitals could be substantial."

London Food Link
ENVIRONMENT. HEALTH. ECONOMY.

I would like to finish with a quote from Mike Duckett, catering manager at the Royal Brompton hospital which is part of the project:

" We want to provide the best fresh foods that we can for patients – as they get the best in medicine, so too should they get the best in food. We want to show that hospital food can be good food."

"Unfortunately, … there is no clear mechanism through which hospitals can incorporate sustainable food into existing policies."

Peter Mansell
Director for Patient Experience
National Patient Safety Agency

NHS
National Patient Safety Agency

So, this is just a little bit around patient safety. Public expectations around safety quite often assume that there is a lot less error and harm in the NHS than actually exists. And you know, one of things that I've learned in the three and a half years that I've been with the Agency is that error is systemic in healthcare. It has to be, it is a high risk industry. So if we pretend that it isn't systemic then we will deny the risks that we're having to deal with. And if you look at other high-risk industries – North Sea oil, chemical industries, airline industries – they all freely admit that it is a high-risk industry, and then they do something about them; so that's the first point.

So, the National Patient Safety Agency (NPSA) aims to capture information around patient safety incidents when things go wrong and harm patients, and look at the information, not on an individual case – by – case basis, but looking thematically. So, at the moment for example, we have been working on, methotrexate errors, cross matching of blood, errors in anti-coagulants, looking thematically, understanding the root causes of the errors and harm, and then doing something about it. That's our primary function.

I want to talk to you a little bit about the 'clean your hands' campaign because I think this encapsulates for me what I think the agency tries to do. Lots of patients have said to me, and say to the agency, and say to the NHS, 'why don't we just tell people to wash their hands?' And of course all of us know that cleaning our hands is an important thing to do. So the question for me isn't 'why don't we just tell people to wash their hands?' We know they don't. So then the question is, what is it that makes clever, bright people who are committed to making us healthier not wash their hands? What is it about the context that they find themselves in that stops them? What are the barriers? And in this campaign – there's a couple of the posters – we try to do this at a multi-layered approach in addressing 'clean your hands', so the alcohol gel rubs that are now at the end of patients' beds. I used to be Chair of a hospital and I can remember that the loos were at one end, the sinks

"… what is it that makes clever, bright people who are committed to making us healthier not wash their hands?"

"… it is very simple what we're trying to do, but it is very complex to get there …"

were at the other end and the patients were in between! So, when the doctors were doing a ward round, the idea was that they would walk to the end of a ward for every single case and then come back. So, while we thinking that we're dealing with very simple things, quite often they are not, they are very complex things. And until we open our minds to the idea that we need to understand these issues in the whole, from a multi-faceted point of view then we can't start addressing them.

What kind of things go wrong in food? Well, patients given food when they're nil by mouth, food delivered to patients at bedside tables but they're not able to eat it. I think I'm a bit of a personal expert, I've spent three years in hospital and one year was continuous, so we're not talking about the mean of six days in hospital, we're talking about what I'm being fed in February I'm going to see repeatedly until October, November. The issue again is around not taking any one of the single points that have been raised this morning – although I think we're talking to a converted audience – but understanding all of them in the context that you work in and then trying to address them at a whole series of different layers in a holistic systematic way.

So, the next 12 months it is establishing the cost of malnutrition – that's a very important thing – and delivering a quality of service: just looking at all the other areas, really reviewing them and putting them together so we get a clear picture of what the barriers are, what we need to do, and how we need to do it. There's lots and lots of stakeholders in delivery of food, and again it is not about a silver bullet. It is not about just trying to answer one particular question at one point in time. We have to deal with the complexity and that will take some doing and we're putting a team together as we speak to do that. The Chief Nursing Officer has the policy lead, we have the implementation, but that's again a too simplistic construct of it. there's all these stakeholders involved in it. And it is very simple what we're trying to do, but it is very complex to get there, and that's to ensure that the delivery of food with the correct nutritional value to the patient takes place and that they eat it, and they want to eat it.

Thank you.

NHS
National Patient Safety Agency

Claire Rayner
President
The Patients Association

As you heard, I have a lot of patient experience as an individual, but I've also a lot of experience about what goes on about hospital food from the people who write to, phone up, talk to the Patients Association. They're not very pleased, most of them. And I don't know, I never actually left Lloyd Grossman's Food in Hospital committee, you may know about that, and he's been producing all sorts of materials, but I sort of fell off, I think, in 2003 when I had a slightly – I can't say botched – unfortunate anaesthetic which put me in ICU for a month and damn near killed me, so ultimately the recovery period was a very interesting time. When I drank water it tasted like boiled swimming pool, heavily reduced, or sometimes it tasted just of dust. It somehow never tasted of what I wanted, which was cold, clean water. That's just a detail.

But let me start at the very beginning, which is how much is spent on the ingredients of a patient's meal, each patient per day, just the ingredients. Not the equipment, not the staff around it or the delivery, none of that. It is only £2.50 a meal. I think at a pinch, and it would be a hell of a pinch, I could produce a fairly nutritious meal for a sick person out of £2.50, but I feel it would be heavily dependent on very solid soup, well 'whooshed', because it would be nice to taste. Beyond that I might have some difficulties. I mean, £2.50 isn't really going to go very far, let's face it. Those of us who run a family and push our loaded trolleys know what it costs. So that's the main issue, I think, behind a lot of this.

Second is the lack of willingness to recognise that people who are well do very well on breakfast, dinner, lunch and tea. This is what the human frame requires; I'm quoting Hilaire Belloc. Ill people want to graze. You can't just eat breakfast, wait four or five hours, eat another big meal. You just want what you want when you want it. Florence Nightingale made it very clear that, as a support, food and drink are of a huge importance and it comes first. She recommended porter quite a lot, I don't think I'd drink Guiness for

"Ill people want to graze. You can't just eat breakfast, wait four or five hours, (then) eat another big meal …You just want what you want when you want it."

"… the delivery of the meals is appalling."

anybody – that's what it is, isn't it, porter …? She thought a little alcohol would help, and I must confess, one of the most constructive suggestions I made to the Lloyd Grossman committee was that there's no reason why people who are beginning to feel better shouldn't have a little drink before dinner if they feel like it, if it is their normal thing. A soupçon of sherry can do a lot for your appetite; it does a lot to mine. We need snack lists, we need small, tasteful, nicely presented snacks, not only for people who suddenly think, 'I actually could eat something now', but had sent away their lunch uneaten, but also for people who are stuck in X-ray or another department when the mealtime comes, or worst of all has been interrupted by doctors who don't give a damn whether the patient is eating. I remember that with rage. They just walk in, take your tray away – I was left just holding a fork once – they just took the tray away and un-bandaged my knee and I thought, my knee is important but there is a person here, I'm a person! But still, that is one of the things that is desperately important, snack meals. Difficult sometimes; a lot of hospitals now refuse to use anything but pasteurised egg which means you can't have that delightful boiled egg and soldiers. I waited until I got home and it was heaven. They can't do it, and I can understand the fear of salmonella, but most of us have been pretty much exposed to it for donkey's years and I suspect would cope, but there we go. So it is omelettes or scrambled eggs or nothing.

The next thing which I feel is important is that the delivery of the meals is appalling. It comes up from a distant kitchen in a hot trolley. Now, hot trolleys – the food may look quite appetising, indeed be appetising at the point of departing the kitchen. By the time it gets to the ward, has stood there until the people who are going to give it out are ready to give it out, it has turned into that slightly congealed, 'your dinner's in the oven, love' look, you know what I mean. It is not attractive. In my nursing days food was a nursing issue. The food came to us indeed from kitchens in hot plates but Sister was very, very strong on this. She made sure everything was right, and if it wasn't it had to be urgently re-done and there was a lot of fuss. She served, we the nurses delivered, made sure the patient was comfortably seated, had the food in front of him or her and could cope, and if not we stayed there and fed them. It was a nursing issue. Now it is regarded by some of our highly trained, academic BSc nurses as menial – one of them actually wrote that in a letter to one of the nursing journals. I exploded like Krakatoa, I was so angry when I saw it. It is a pure nursing issue. Thank God we've got healthcare assistants, some of whom do it beautifully, though some of whom just shove it in, and that is cruel.

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And may I tell you – I mustn't take too much time – I came across one ward in one hospital when I was on that committee long, long ago on this mixed geriatric ward, they weren't separate bays for men and women and they were all elderly. Someone had choked during his lunch when he was unsupervised; there was no nurse there. Happily for him, there was a patient's visitor present who knew how to do a Heimlich's manoeuvre who actually saved his life. But they have never forgotten it, and the current Sister's remedy for that problem was for virtually every single patient to have their food whizzed up to a sort of khaki gunge and put in via a tube. They were tube-fed whether they wanted it or needed it or not, and I still don't know what to say about that. It is outrageous.

Now you're lucky if your food, when it is brought to you by the ward maid, she looks for somewhere to put it. If the bedtable in front of you has been left cluttered in any way and you are not able to clear it yourself, she will put it wherever she can, and you say 'please, can't you just put it … ', and she says, 'oh no, that's not my job', and she goes. They're not allowed to touch anything else. I find that extraordinary and that is a major problem. As I said, I get these complaints from many of our members. Actually, what kept me going when I got into high dependency after all the weeks in ITU was my darling aunt's best chicken soup, which was smuggled in to me in flasks because there was a rule that no outside food may be brought in: the salmonella fear again. And people from other ethnic groups who frankly can't eat and loathe what they are offered, even if it is made to be suitable for an ethnic diet; Halal food often comes up so bland that it doesn't taste of anything to the people who are used to something with a little more robustness about it. So I was very grateful for my aunt's chicken soup. It is true you know, my aunt is Jewish and made the most fabulous chicken soup. Get her recipe and we'll cure most of these problems I think.

I've got an extra note here about water. Do you remember that heatwave in 2003? I was in high dependency for most of that. All I wanted was iced water, and I couldn't always have it because the ice kept running out. They just couldn't provide enough ice for a row of single-bedded rooms. It was appalling, it really was, and again the family helped with flasks.

I lost 100lbs in weight. As you will gather, as I have only put around 30 or so back on. I was glad to get rid of the other 70lb. I was altogether too cuddly! Mind you, my husband said I kept a draught off better on a cold night then. However, he's getting used to it. But seriously, I was over-fed. I suppose that's how I produced a son who is a restaurant critic. But so many people go in of frail weight, they're already frail, they're already thin, and some of them

"… so many people go in of frail weight … (and) some of them come out looking positively skeletal. They've lost weight they can ill afford to lose."

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come out looking positively skeletal. They've lost weight they can ill afford to lose. In the best of worlds they would do what they used to do when I was nursing. Many patients would say to us when they finally left to go to a home or to go out or whatever, 'do you know, I feel much better. I've put on a stone since I've been in here!'. We kept them in a bit longer but we fed them well in the 1950s. It's a long time ago, I'm an old bird, but they did well, they did better with us. Mind you, we couldn't do anything else, we had none of the modern techniques, only basic nursing care – and that is important.

I'm going to finish right now, I think I've said all I want to say. Basically, it is a big, big problem and we've got to do something about it, and above all, can we do something about ward kitchens and snacks and grazing? That is the thing I think is most important.

"We kept them in a bit longer, but we fed them well in the 1950s."

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Alison McCree
Chairman
Hospital Caterers Association

Good morning ladies and gentleman. In this session I'm going to share with you the views of the Hospital Caterers Association (HCA) on 'Nutrition in Hospitals: The Way Forward for Policy'.

First, it's important that we recognise and understand that no food is nutritious unless it's consumed, food will only be consumed if it is tasty and well presented and patients receive assistance to eat when required.

Whilst it is widely recognised that the Better Hospital Food programme has significantly raised the profile and the importance of hospital food, the HCA believes there is still a long way to go in relation to food service, food consumption and nutritional intake at ward level.

Food is, without doubt, the cheapest form of medicine and, with, clear evidence supporting the fact that good nutrition aids a patient's recovery, we need to sustain the achievements of the Better Hospital Food Programme but switch our focus more on targeting our patients with an appropriate level of food service that meets their needs.

"Food is, without doubt, the cheapest form of medicine …"

Improving standards is about more than just the quality of the food on the plate – it's about enhancing a patient's whole mealtime experience – and we recognise that the current levels of under-nourishment are totally unacceptable.

It has to be recognised that market testing and the privatisation of catering services lead to food being driven by price over value and quantity over quality, we need to turn this situation on its head as value and quality need to become the key drivers.

"In hospitals we provide … a range of specialised diets … often with a daily ingredient budget that is less than the price of a 'high street' cup of coffee."

It's also important to understand that catering for patients in hospitals is far more complex than catering for children at school, residents in nursing homes and guests in hotels and restaurants.

In hospitals we provide three meals a day for patients ranging from infants to the very elderly – providing a range of specialised diets that you would never come across in any other hospitality setting and often with a daily ingredient budget that is less than the price of a 'high street' cup of coffee.

Why is good food so important? Good food contributes directly to recovery. Many patients are malnourished on admission and hospital caterers play a key role in partnership with nurses and dieticians to address this issue.

Good food promotes a sense of wellbeing. Served at the right times, good food makes being in hospital more bearable, enhances patient satisfaction and performs a major function in the healing environment.

Good food improves efficiency and cost-effectiveness. Malnutrition can delay discharge and is associated with costly side effects such as pressure sores and infections. The NHS spends a considerable amount of money on supplements and feeds. In the right format, 'normal' food is more appropriate and can be cheaper. Caterers need to play their role in ensuring that 'normal' food is always available when required.

Good food can be used as a proxy measure of the health of the NHS. We know that patients can judge food quality more easily than they can judge the quality of their care. Patients may well use non – clinical services such as food and cleanliness to discriminate between trusts when exercising choice.

It is also important to remember that fluid intake is also an essential part of a patient's diet.

Good food is no good to anyone unless it actually gets into the mouths and stomachs of patients and to achieve this it requires greater communication and collaboration between dietetic, nursing and catering teams.

It is a straightforward argument but one that is difficult to deliver with our present NHS systems and policies and procedures. To improve nutritional intake and deliver a better food service to our patients these have to change.

Good food needs to be enhanced with 'good food service' – if we are not providing a 'good food service' at ward level we undo all the good work undertaken in producing 'good food'. It's important to reinforce that good training and education underpins 'good food service'.

If we get 'good food service' right it creates a win-win situation for all concerned.

It is the HCA's view that ministers and healthcare professionals should now examine, on a wider and more in-depth scale, how patients receive their food. The HCA strongly advocates that food should be provided by ward 'housekeepers' or 'hostesses' working alongside nursing staff on every ward. As laid out in the NHS Plan, many trusts already have ward housekeepers on at least some of their wards and it's our view that the rest should now follow. We would like the Chief Nursing Officer to consider the important role ward housekeepers undertake and assess how this service can be implemented across all hospitals.

The provision of ward housekeepers would play a key role in ensuring that hospital food becomes an integral part of a patient's clinical care, which will enhance patient satisfaction and play its rightful part in the healing process.

My key message is that the hospital catering manager cannot improve patients' nutritional intake alone. It requires greater communication and collaboration between nurses, dieticians and caterers.

I would like to end using the same message I started with. No food is nutritious unless it's consumed, food will only be consumed if it is tasty and well presented and patients receive assistance to eat when required.

Thank you.

"The provision of ward housekeepers would play a key role in ensuring that hospital food becomes an integral part of a patient's clinical care …"

NHS Purchasing and Supply Agency

Mike Tiddy
Category Manager – Fresh Produce and Nutrition
NHS Purchasing and Supply Agency

Effective purchasing will ensure the NHS makes efficient use of its resources. The Department of Health set up the Commercial Directorate (CD) in June 2003 to gain the best value for money from particular areas of spend and to drive negotiations with the private sector. After a thorough review of the NHS supply chain, the CD launched the Supply Chain Excellence Programme (SCEP) in March 2004. Collaborative purchasing between trusts and groups of trusts will produce greater savings through effective and efficient supply chains.

NHS PASA works with the Department of Health in implementing the DH work programmes. The 5 A DAY programme encourages consumption of fruit and vegetables to reduce the risk of heart disease and some cancers. The School Fruit and Vegetable Scheme delivers a fresh piece of fruit to nearly 2m children every day in 16,500 schools. Today is banana day when all these children will consume a banana at about 10 o' clock this morning, tomorrow is a soft citrus day and each day a different product is available. The object is to encourage healthy children and keep them out of hospitals in both the short and long term.

NHS PASA is also an active member of the Public Sector Food Procurement Initiative, part of the Strategy for Sustainable Food and Farming Programme. One of the key objectives is Health and the Choosing Health White Paper, and subsequent Food and Health Action Plan gives targets on how to achieve and measure the success of the initiative in the NHS. Definitions on the maximum recommended salt intake, for example, have been announced and new nutritional guidelines will be published for the NHS in 2006. The Food Standards Agency has published a consultation document on multiple traffic light indicators for food packaging to aid consumers to make decisions on food purchases.

"The object (of the School Fruit and Vegetable Scheme) is to encourage healthy children and keep them out of hospitals…"

A tool has been developed by NHS PASA for all food items, which will allow all NHS trusts to compare the nutritional content of products by brand so that trusts may make informed decisions on the make-up of their recipes and menus. This tool will also aid NHS PASA, along with other criteria, to award contracts based on trust requirements and track changes in producer levels of salt, sugar, fat or saturated fats. An example is as follows:

Product (1 of)	Supplier	Salt	Fat	Sat. Fat	Sugar
Italian / Traditional / Other – meal centres					
Baked steak kidney 184g	Brakes	Medium	Medium	High	Low
Chef's steak & kidney pie	N. H. Case	Medium	Medium	High	Low
Chef's steak & kidney pie	Apetito	Medium	Medium	Medium	Low
Steak kidney pie	Anglia Crown	Medium	Medium	High	Low

Figure 1

The next stage is to work with suppliers to reduce products with high levels of salt, sugar, fat and saturated fats. We will also work with suppliers to increase the consumption of dietary fibres and fruit and vegetables.

The work on the Strategy on Sustainable Food and Farming continues but the subject is clearly set in a global economy and the sustainable virtues must be similarly employed from Cameroon to Croydon.

"The next stage is to work with suppliers to reduce products with high levels of salt, sugar, fat and saturated fats."

NHS
NHS Purchasing and Supply Agency

Questions and Comments from the Floor

Chris Bryant MP:	I thought the Cameroon was Notting Hill now. Right, it is time for questions. And I think there is somebody up there, and a microphone is on its way up to you.
Fausta Cerezo-Gomez:	Hello, my name is Fausta Cerezo-Gomez from Consensus Action on Salt and Health. And my question is, why isn't there a specification in hospitals for nutritionally balanced foods that are low in fat and salt for patients? It just seems crazy that patients who have suffered a stroke or heart attack and are particularly susceptible to a high salt diet are being fed foods that are high in salt and fat.
Chris Bryant MP:	I think that was a question about salt and sugar for obvious reasons, yes?
Fausta Cerezo-Gomez:	Well, there was some discussion that they were working towards setting the standards, but what I am asking is why aren't there specifications about the foods that are served in hospitals, to be low in fat and salt?
Mike Tiddy:	There's a couple of answers to this one. Number one, the product availability, whether is it high in salt or low in salt, the product availability is still there and available for the Trust to take up. Secondly, it is not always required by patients that they need a low/high level of salt or sugar, particularly in something like milk. There's often a requirement for caterers to provide whole fat milk rather than semi-skimmed milk and that is available and will remain available throughout the process.
Chris Bryant MP:	Alison?
Alison McCree:	Yes. Actually, work has commenced and I attended a meeting yesterday with the Department of Health and there is a stakeholders' meeting next week which is being led by the Department, and this is about

developing nutritional standards for food in the NHS. My point would be, I actually think, don't underestimate it, but I think that is the easy part, developing the standards. What my sort of focus will be is how we implement those standards and how we monitor those standards, because, as I've said, it is fine having the food there but if it is not being consumed then it is of no benefit. Stage one is developing the standards, but we've got to implement and monitor those standards.

Chris Bryant MP: Claire?

Claire Rayner: Yes, I agree with what they've said, but I've always wondered, why it isn't possible to be given pepper if you're not allowed salt? I mean, pepper is harmless. I'd like to lift a salt-free meal if that is what you have to have. I had eclampsia once and I was told I mustn't have pepper or salt. And the other thing is, why can't we use in hospital more nil or low sodium in flavouring? There's plenty of it about.

Alison McCree: I think another point as well is that we have to do it gradually, because we've already heard about patients' taste buds, they do change when they are having treatment. So, to suddenly cut out all salt etc, then they're just not going to eat anything, so I think it is a gradual approach as well.

Chris Bryant MP: Right, there was a gentleman there, in the third row.

Tony Bishop-Weston: Thank you, Tony Bishop-Weston from Foods For Life. I was interested in what Alison was saying about different categories. You have to try and please all these different categories, not only just in what people prefer but also allergies and things like that. I was very encouraged to see what the NHS has been doing about five a day, and trying to get people to think about healthier food from the beginning. But from the point of view from a vegetarian and vegan thing, the ethics study – somebody identified earlier on that Coronary Heart Disease (CHD) and heart disease and obesity cost the NHS £12.5bn a year, and the ethics study showed that the vegetarians and vegans suffer far less from that. So as far as I'm concerned, I can see that vegan can be a very easy solution to this because you can please a vast range of people, and also different allergy groups, with just one simple meal. I was involved with the hospital food programme right from the beginning and trying to do this and get it sorted out, and you have to have less options if you just make one tasty and delicious food.

Alison McCree: I think we've got to give patients choice. You could not say to patients …

Tony Bishop-Weston: No, no, I'm not suggesting that for one minute …

Alison McCree: … it is about choice and patients have to choose what they want to eat.

Tony Bishop-Weston: I wasn't suggesting for one minute that that was the only thing.

Chris Bryant MP: Claire?

Claire Ranyer: Thinking about patient choice I agree with you totally, but it is a bit difficult when they bring you a menu immediately after you've had lunch to ask you what you'd like for breakfast next morning. It doesn't help. You don't want anything for breakfast next morning at that moment, and when the next morning comes and you think, 'why did I order that?' it makes it very difficult. It would be easier if it were better planned so that menus were collected at more logical times.

Alison McCree: And I think that is about our systems, our policies, our procedures, and that is what we need to change.

Peter Mansell: The biggest difference to me personally was snacks. One, two years ago, I had to spend three months in the hospital having a heart valve replaced and the biggest difference to the quality of my food intake, apart from the Kentucky brought in – well it is really, it is true, I'm not saying that flippantly – was the fact that I could say to any member of staff, 'can I have a snack', and what I would get was either a ham sandwich, a packet of crisps, an apple or a banana. And that did make a big difference.

Claire Rayner: Hear, hear.

Chris Bryant MP: Right, another question. I've got a gentleman here in the front row. I can't see any hands at the back. I don't know whether that's because you can't hear anything – there will be one in a minute.

Professor Marinos Elia: Marinos Elia, Professor of Nutrition at the University of Southampton. Apart from patient preference there is variation in patients' requirements, so that, if you look at a spectrum of patients in hospital, following the healthy eating guidelines might not be appropriate for them and in some cases may well be detrimental. (Applause)

For example, patients that have increased losses, gastro-intestinal losses, may require more salt rather than less salt. People that have poor appetite may increase their intake at least over a limited period of time by high energy dense foods rather than the low energy dense foods that might be recommended for public health purposes. So the requirements of different patients vary, the requirements, the recommendations for staff as opposed to patients may be different, and the question I wanted to ask you is, how do we go ahead with trying to avoid conflicting messages coming across?

Chris Bryant MP: If you don't mind, because we're slightly short of time I'm going to take the various questions that I can see and then I'll come round to everyone on the panel to finish us off. So, there's one right at the back and then over here.

Anne Macalpine-Leny: My name is Anne Macalpine-Leny and I represent the Anaphylaxis Campaign, and we represent patients with severe allergies. I'm afraid I'm going to pose the question again to this panel as I did earlier this morning, and ask what provisions are made for severely allergic patients within the catering environment in hospitals? And how can the total food environment in hospitals be altered to limit the risk, particularly with children?

Chris Bryant MP: And the gentleman over here.

Delegate: Yes, thank you. Very much talking about acute hospitals, I'm here representing a mental health trust, in fact one of the largest in the country, and there we can actually make a difference where patients may be there for two or three years, so we can actually make quite a difference to their nutritional intake. The point I was going to make though, very much within the trust, coming back to Alison's point and Claire's, where we used to have the Ward Sister who made sure everything was fine in the ward, we're now starting to introduce housekeepers. On those wards, we have a housekeeper, everything is shipshape, people order, and they make sure they're fed. The areas where we don't have housekeepers, we do have problems. The question was, as we're looking at policymakers hopefully around the room and perhaps will read the context of this, when are housekeepers going to be mandatory as part of that ward regime? I think if we get to that all the others will fall into place, they will eat the food, they will eat the nutritional intake and they will be fed. So that's a question really to get some support so we can actually drive this one home.

Chris Bryant MP: There's one right at the back there, then I'll take the panel fairly swiftly, you'll have about a minute each.

Martin Forsyth: Thank you Mr Chairman. I just wanted to ask the panel, bearing in mind some of the questions here about serious allergenic risk and problems with nutrition in general, do the panel think that the sustainability and local food procurement is a distraction from these other serious food issues in hospitals today? My name's Martin Forsyth from 3663.

Chris Bryant MP: Thanks very much. So I think we'll go along the panel in the previous order. Emma.

Emma Hockridge: I want to address the first point and the last point. We talked about being able to address the needs of patients across the board. We found in this pilot project that hospitals need to have the flexibility to be able to supply a whole range of meals. Therefore, the hospitals that actually have kitchens on site, or ward kitchens, and are therefore having the necessary infrastructure to address those different needs is very important. Also, issues of staff training there have been vital, for example promoting the skills necessary to cook meals from fresh food. Such training has had a number of knock-on benefits; for example in raising staff morale, which in turn has decreased employee turnover. In terms of the gentleman's comments regarding sustainability, we don't feel that this is a separate add-on that is in some way distracting from issues including nutrition. We are working with catering managers looking at the supply behind the scenes. We feel that it is part of a whole hospital approach, for example in promoting healthy eating to patients, staff and visitors, and that it needn't be distracting in any way.

Chris Bryant MP: Thank you. Peter.

Peter Mansell: Well, I wanted to disagree with the speaker that said about housekeepers. I think that if we reduce this problem to any one single solution we'll fail, because that is what repeatedly happens. We try to find overly simplistic answers to – we've mapped out the problem today, we know what it is but it needs to be addressed in a multi-faceted way at a number of levels. And if you look at the cleaning your hands campaign that's what that tried to do, so I think that we won't come up and go away from this morning's exercise by saying there's one thing we can do; it is a whole series of things.

Chris Bryant MP: Claire.

Claire Rayner: Right, well, I do agree with your point about, you know, we can't have food – about one size fits all. One size never fits all, and there must be flexibility. Really that's the message we've got, isn't it? We've got people who want to graze, people who can deal with the need to graze, people who have special diets, all of that. And a good housekeeper would be useful but I agree with my colleague, it is not the only answer. It is a good way forward, but I just wish nurses would take an interest again, I really do. It is ingrained in us, I'm a nurse. So my message is flexibility, all the way through.

Chris Bryant MP: Thanks very much. Alison.

Alison McCree: Right. On the conflicting advice, it is about education, isn't it, and flexibility. And we have patients who say 'I can only have semi-skimmed milk' because it is all they've ever had when they actually need the full cream milk, so it is very much education and flexibility. On the allergies, again that is about training, education and communication between the three parties – caterers, nurses and dieticians – and we are doing some work in the Association around that issue. I do support housekeepers and I do think they would make a difference. They're not the sole answer, but they can make a difference and we have seen the difference they've made. And sustainability, I don't think it is a distraction but we've got to look at all of these things and see how we can get the best from them.

Chris Bryant MP: Thank you very much. Mike?

Mike Tiddy: I'll pick up the last one about sustainable issues. I really do not see that being an issue to what we're trying to achieve in this manner, providing we look at sustainability as a global environment. I think it is too simple to look at it from a UK or a regional perspective. And on the other issue, I do very much think that we have to look at whole hospital approaches. I think there is no doubt in the education sector that the whole school approach is having a significant benefit in the way that people see schools, and in the way that they're endeavouring to promote healthy issues. I think hospitals are going to be forced to review their policies to show they are looking at the healthy environment throughout their sites.

Chris Bryant MP: Right, thanks too. Can we say thank you very much to all our panellists. Some of them are off to telly now so we've got to let them go. Thanks very much.

Dr Liz Jones
Head of Patient Environment
Department of Health

Almost 20 years ago, I was working as a researcher in a small elderly care hospital. The patients we cared for were frail and dependent – over three-quarters required help with feeding and a third needed to be fully spoon-fed. We tried to give colour and interest to their lives, but we did not always do as well as we might have wished.

One highlight of each day was lunch. The food was good and the patients enjoyed it. Yet we seemed to rush through feeding – we got patients up and dressed quickly so they were waiting at the table before the food arrived, and then we seemed to hurry them through eating for no apparent reason.

When I asked why we did this, I got the answer, "*we have to finish quickly because the domestics need to wash up before they go for lunch.*" This didn't seem too sensible, so I asked the domestic staff why they didn't go for lunch first, and wash up when they got back. The answer? "*We have to wash up early because the porters come for the trolleys at 1.30.*" When I asked the porters if they could come later, I was told, "*We can't, because the trolleys have to be back in the kitchen in time to be cleaned before tea.*"

Somewhat daunted by this, I went to talk to the catering manager, to ask why he needed the trolleys back so early. His reply was short and to the point. "*We don't. As long as they are back by 4.00, that's fine by me.*"

So there we were – a whole system in which nurses helped domestics, domestics helped porters, and porters helped kitchen staff – who didn't need any help. A whole system in which the staff were so focused on helping each other that we forgot about the needs of the patients.

We weren't bad people. We cared about the patients and we cared about our colleagues. Our only crime was that we didn't think through our actions, but this affected our patients' food experience and, I am sure, their food intake.

"(We had) a … system in which the staff were so focused on helping each other that we forgot about the needs of the patients."

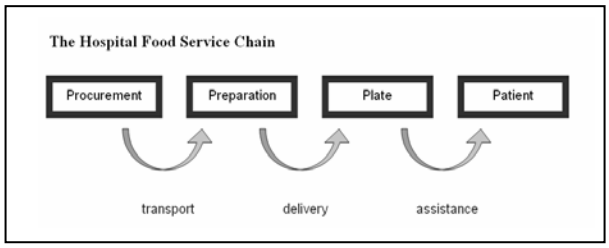

Figure 1

We have come a long way in the last 20 years, but there is still much to do. And much of it still focuses on those issues of teamwork that typified my experiences back then. What we must at all costs avoid is the charge of 'good food spoiled', where the efforts and investment of people early in the food delivery chain are wasted by inadequate services at the end.

Hospital food has long had a poor press, but real improvements have occurred in the last five years. The NHS Plan allocated an extra £10m per year to food, and with the advent of the Better Hospital Food Programme, the NHS rose to the challenge of improving the quality, timing and service of food. Patient Environment Action Team (PEAT) scores for food have risen from 17% 'good' in 2002 to 84% 'good' or 'excellent' in 2005, whilst the National Patients Survey shows 54% of patients rated food as 'good' or 'very good' in 2003/4. In the same period, we have seen over 80% of hospitals achieve the Better Hospital Food targets outlined in figure 2.

Better Hospital Food Programme Targets

- Ward kitchen services – food available 24/7
- Leading chef dishes on the menu
- Extra snacks during the day
- Snack boxes for patients who miss a meal
- Hot meal choice in the evening

Figure 2

"… we must … avoid… the charge of 'good food spoiled', where the efforts … of people early in the food delivery chain are wasted by inadequate services at the end."

DH Department of Health

But we must not be complacent. The NHS has achieved a great deal, but we cannot afford to rest on our laurels. We need a new focus on hospital food to match the new devolved NHS structure and to build on the good work to date.

Moving Forward

Until recently, hospital food was the responsibility of NHS Estates, who developed policy and then led on implementation and monitoring. In today's devolved system, these responsibilities are split, with the Department of Health developing policy, and the National Patient Safety Agency (a part of the NHS) leading on implementation. NHS Estates has been abolished as part of the Arms' Length Body Review.

The same devolved approach applies to funding. The NHS Plan allocated an extra £10m per year to hospital food. Today, those extra funds are no longer held centrally, but are part of the general allocation, reflecting the wider move to a more devolved system, with funding and decision-making placed as close to the patient as possible.

To build on the successes of the Better Hospital Food Programme, the Department is setting up a new advisory group. Many of the existing BHF panel members will be joining us, but the group will also represent a wider constituency, with increased clinical input to reflect a new emphasis on food as an integral part of the business of healthcare.

"… the (new advisory) group will … (have) increased clinical input to reflect a new emphasis on food as an integral part of the business of healthcare."

This mean recognising that good food has real clinical benefits. Good nutrition demands good food, but the best food does no good if it isn't eaten. Making sure that the food that arrives is eaten and enjoyed is one of the most important things we can do for our patients. At the very least, it can improve the quality of their stay and make them feel better about the NHS. At the best, it can transform their recovery and directly improve their health.

The new group will be supported by a strong programme management structure. Separate project groups will be set up to take specific activities forward, and these will report back into the advisory group. Some work will be led by the Department, some by the National Patient Safety Agency (NPSA), and some by other partner organisations such as the Hospital Caterer's Association (HCA) or the British Dietetic Association (BDA). Together, we will make sure that the whole of the food service chain is kept under review.

The new programme will develop over time. However, some projects are already agreed – and indeed in some instances work is under way. For in-

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stance, the HCA and BDA are already working together to review the recommendations of the Council of Europe's resolution on hospital food, and the NPSA have plans in hand for work on pre-operative fasting and protected mealtimes.

A major piece of work will be an analysis of existing data to help us understand what works and what doesn't in food services. We have a great deal of information, but we have not always exploited it to the full. We hope to use this to help point trusts to activities that they can take to maximise their food quality, learning from each other whilst supporting the learning of all.

Conclusion

Hospital food has enjoyed great improvements in recent years, and this is testament to the hard work of the NHS. We now need to build on that to make sure that all patients have a food service that we can be proud of, and that the days of patients' needs being subservient to those of the hospital are consigned forever to history.

"We now need … to make sure that … the days of patients' needs being subservient to those of the hospital are consigned forever to history."

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Questions and Comments from the Floor with Dr Liz Jones

Chris Bryant MP: Right, we've got about five minutes for questions or comments. Lady here in the second row? There are no other hands –

Modi Mwatsama: Modi Mwatsama, Heart of Mersey. I've got a comment rather than a question. At one of the trusts in Merseyside they have a hospital based at their headquarters and there's 250 patients and 1,500 employees on that particular site, so basically the Better Hospital Food programme which is very much patient focused would affect only the 250 and it wouldn't take into consideration providing healthcare options for the 1,500 employees on that site. I think that is a really big oversight on the part of the Department of Health or whoever has developed that programme and they really need to start looking at the whole approach to food provision within hospitals.

Dr Liz Jones: I would agree with you. Hugh, do you want to comment on the work that has been done on food standards?

Hugh Baber: Hugh Baber from the Department of Health. The project that we're working on is to develop nutritional standards for all food provided in the NHS, not just to patients, so actually when it gets rolled out it will cover patient food, staff food and all the other retail outlets on NHS sites. So in fact it is all encompassing, and that's what is envisaged in the White Paper. It sounds easier to say, and it might take a little while, but that is the aim and it is recognised, as has been said today, that the average stay – and I've heard many estimates 4.4, 6.6 – obviously some people stay a lot longer in hospital but the staff there are there for 52 weeks a year so in fact it is recognised that it is a very important element that will be addressed.

Dr Liz Jones: And obviously in a place where you've got such a high number of staff then you're going to see even more acutely how important it is. I do

think we're pushing at an open door in terms of the healthy eating menus for staff. I think that people are interested in how they can change their eating. I think for patients – I recognise what has been said about what matters is that people eat something and what's healthy in one context may not be healthy in another. I do think it is possible for healthy food to be delicious, to be tasty, for it to be acceptable to patients, for it to be exactly what they want. And what we need to do is help people to be able to make healthy choices from a wide range of food, not limiting them but enabling them to make good choices when those are appropriate, and also enabling them to understand when they need to actually, you know, when somebody needs full fat milk and so on.

Rosemarie Hoyle: Rosemarie Hoyle, Apetito. We're actually a frozen supplier of food to the NHS and I don't think anybody had mentioned frozen food this morning so I just thought I would mention us. We supply cook-freeze as opposed to cook-chill and I think one major benefit you have with a frozen product is that actually you don't have the degrees of wastage that you can potentially have with either a fresh-cook or a cook-chill system. Where you've actually got patients who aren't getting the food that they order that is very often because the caterers are frightened of producing too much food, or the cook-chill hospital is actually concerned about ordering too much food and it has been wasted because it has a short shelf life. The benefit with frozen, of course, is that you don't actually have to get the food out of the freezer until you know exactly what you need so you don't have the issues around wastage. Also, I would just like to make the point that an awful lot has been made about fresh food, but in fact frozen vegetables can contain just as much nutrition in terms of nutrients as fresh vegetables because they're frozen so soon after they leave the fields. We do a wide range of soups made from fresh ingredients and I would say they are equally as good as a lot of the homemade soups produced in the hospitals. I think there is a big issue around the fact that hospitals just simply can't afford to buy them, because they are 25p a portion as opposed to 5p for a dried product out of a packet.

Dr Liz Jones: I don't think it is easy, and I don't suggest for a minute that it is, and I don't think that funding is unimportant. But funding is not the only thing. One of the things that I don't think anyone has mentioned so far – so I will – is the Audit Commission work done in 2001 which showed no relationship between the amount spent on food and the quality of the food delivered. Nor was there any difference between the

amount spent on food and the type of catering, nor whether it was in-house or out-sourced. I'm not pretending that money isn't important because clearly it is, but it is not as simple as saying, 'if there were only money suddenly everything would be magically better', because there isn't that direct relationship between spend on food and the quality that you get out of it. I think in terms of frozen versus other systems, each system has its advantages and disadvantages, and what needs to happen is that the right system is chosen for the right circumstances, and in some places that will be cook-freeze, undoubtedly. In other places it won't be, and I think to suggest that one size fits all is not going to get us anywhere. What we need to do is make sure that people have the information that enables them to make the right decision for their area, which is why I'm really encouraged by the work that we're doing with HCA and the BDA and so on, in saying what is it that needs to happen out there? What can we do to understand what decisions need to be made? That is why I think we need to use all the information – a lot of this information is already there, we've just not necessarily exploited it fully and to say 'right, you in your place, in your trust, in your situation, what is it that you need and what would best deliver the needs of your patients?' And sometimes that will be cook-freeze.

Chris Bryant MP: Right, I think that is the end of our session then. Thank you very much.

Chris Bryant MP

Chairman's Closing Remarks

Just a final couple of comments then from me. I suppose as an initiate I'm always intrigued by the fact that the first thing anybody says when you visit somebody in hospital is, 'how is the food?' And, as a constituency Member of Parliament, it is one of the first things that people comment on when they've been in hospital. And yet I suppose in many ways in the past it has been something of a Cinderella element of the hospital budget and of the whole gearing of the hospital around healthy living and returning people of full health.

It just reminds me of the story of the Queen Mother when she was getting married – obviously she's no longer around, should you still call her the Queen Mother? You know who I mean anyway.

When she was getting married and she was marrying into the Royal family, and at the time her husband was not going to be King, his older brother was going to be King. So she was marrying into the Royal family and one of the nurses who had cared for her from her childhood wanted to buy her a present, but couldn't afford anything very expensive so up in Aberdeen went round various antique shops and finally found two little figurines in ivory. Very beautiful figurines, they looked quite old, they were a guinea which was rather more than she'd expected to pay, but nonetheless they seemed appropriate because they looked like a King and a Queen and it would be nice because she was marrying into the Royal family. So she sent off her present.

She was very bewildered – because she was just a servant in the household – three weeks later to get an invitation to the showing of the wedding presents, which apparently is a formal part of Royal weddings. And so she was invited in her own right, with her husband, down to Clarence House or wherever it was going to be in London, some very grand place.

"(the food) is one of the first things people comment on when they've been in hospital."

"… people might all too easily think (hospital food) is just an irrelevance in the medical process, but actually it completes the whole picture …"

She turned up with her husband and was very excited because she'd normally be serving the drinks or helping as a servant there. And she was walking around and bumped into one of the other servants that she knew who said, 'have you seen your present?' She said, 'no, no, my present is just a tiny little thing, it won't possibly be here.' And the others said, 'no, go into the main hall, it is there.'

And so she went into the main hall where the couple were receiving everybody before going round to see all the presents, and there was a full chess set laid out on the table. And this had been a Royal chess set which had been missing two figurines for six centuries. And it was a 9th century Chinese chess set and they had found the two figurines and restored them to their place, thereby restoring the value of the complete set enormously.

And I just think that sometimes elements which can seem tiny, little elements can somehow complete the picture, and I guess that hospital food is one of the elements which one or two people might all too easily think is just an irrelevance in the medical process, but actually it completes the whole picture, and without getting that element right you can't have a full chess set.

So I want to thank everybody very much for coming along today. Thanks very much, it has obviously been a fascinating time. Somebody said, we're only preaching to the converted here today, but I think Jesus thought that the converted were quite a good band of evangelists so I hope that the converted will go out as evangelists today and continue to play chess – if I haven't mixed my metaphors too much.

Thank you.

Comment

Rosie Barnes
Chief Executive
Cystic Fibrosis Trust

CYSTIC FIBROSIS TRUST
Registered Charity No. 1079049

Hospital Food and Cystic Fibrosis Patients

Cystic Fibrosis (CF) is the UK's most common life-threatening inherited disease. It is caused by a defective gene, leading to a thick, sticky mucus that obstructs the airways, the digestive system and other organs. People with CF will invariably spend some, or a lot of time in hospital as an inpatient throughout their lives.

For patients with CF a suitable diet is vital to help them keep fit and well. If their weight is good, they will be better able to withstand chest infections. A stay in hospital for CF patients often means weight loss and a decline in nutritional status. This in turn leads to a worse outcome of the disease and a prolonged hospital stay – a vicious circle.

There are various problems with hospital food that affect CF patients. People with CF do not produce sufficient pancreatic enzymes to digest their food and as a result need 20 – 50% more calories than recommended national guidelines. Healthy eating for someone with CF means foods that are high in fat, protein and sugar. The required CF diet is often not catered for in hospital as fatty and sugary foods are often eschewed in favour of 'healthier' options. In addition to this, portion sizes are often not big enough and the menus do not offer enough variety.

It is important to stress that every CF diet is different – some patients have renal failure so need low potassium foods, other patients have diabetes which means they need to regulate their blood sugar. The complications of CF mean that certain foods are off limits, and others are needed in greater quantities.

Food in hospital can often be unappetising, flavourless, and served cold. Despite the fact that CF patients need to eat more than average, they often have little or no appetite. It is important that food is presented in a tempting way to encourage patients to eat.

CF patients are often told not to worry about mealtimes and just eat when they feel like it, which is very hard on a hospital ward. Many inpatients have friends and relatives who are able to help by bringing snacks and takeaways to the hospital. However, this is by no means the case for all patients, particularly those who have to travel long distances to attend hospital, which is quite common for CF patients as many are referred to specialist CF Centres which may be some distance away . Some inpatients are permitted to order takeaways on to the ward, but this is very expensive, and for a two – three week hospital stay can amount to hundreds of pounds.

However, some hospitals are putting things in place to help CF patients. At some hospitals CF patients are permitted to order whatever they want from the staff canteen and have the option of eating in the canteen if they are well enough. Some wards offer special CF menus with high fat, high sugar foods, as well as storage cupboards and fridges for snacks.

We would like to see all hospitals adopt these approaches so that CF patients are offered menus to suit their requirements. High fat menus with more choice, larger portions, more flexibility in ordering, more snack options and food available at any time the patient is hungry. The benefits would not just be to the patients. Patients will spend less time in hospital and less food will be wasted, saving the NHS money.

In conclusion, we hope that any reviews in hospital food take account of all patients and all diets, so that everyone can be catered for.

Rosie Barnes is the Chief Executive of the Cystic Fibrosis Trust. She was an MP (SDP) for Greenwich between 1987 and 1992, during which time she developed a keen interest in health matters. She joined the Cystic Fibrosis Trust in 1996, after four years as Director of WellBeing, formerly Birthright.

Tony Bishop-Weston
Food Consultant
Foods For Life

Food as Therapy and the Role of Delicious and Nutritious Vegetarian and Vegan Options as one of the Solutions for a More Efficient, Cost Effective and Improved Hospital Food Service

It sometimes seems that the only thing that everyone can agree on is that there is no one thing that everyone can agree on, no magic bullet that can solve the multiplicity of problems and myriad of stumbling blocks that face NHS catering.

I'm encouraged by the mantras of 'common sense should be commonplace', 'the nutritional value of food not eaten is nil' and lamentations that 'doctors and nurses have a low awareness of nutrition', but where are the practical solutions?

Faced with NHS budget drains of Coronary Heart Disease (CHD) and obesity apparently costing the NHS over £12bn, and armed with statistics from the massive pan European European Prospective Investigation into Cancer and Nutrition (EPIC) study on vegetarian and vegan diets, 'let them eat veg' is a tantalisingly simplistic solution to offer.

However, whilst the rest of us, outside the captivity of hospital catering, grapple with the effects of overeating and drinking, in hospital often the problem is with patients not eating and drinking enough.

It seems the root of the problem is the lack of joined-up thinking in the decision making process. The accountants who hold the purse strings know little about the true costs of malnutrition, the nutritionists often know very little about catering, the caterers know very little about psychology, and the poor nurses don't have time to think about much more than washing their hands and grabbing a cup of coffee and a packet of crisps to keep them going until the end of their shift.

It's sad that there seems to be such little understanding about the hidden costs of malnutrition and the potential of nutritional therapy to save the NHS millions by avoiding unnecessary drugs and procedures with simple inexpensive food solutions that patients could take home with them.

I should imagine the Institute of Optimum Nutrition would shudder to its foundations if it knew how much the NHS spends on laxatives for constipated patients each year.

I find it particularly sad that there are still a number of dieticians who believe that 'delicious' and 'nutritious' are incompatible and who are sceptical of new research and new products that challenge their belief systems. New professional codes and obligations for continual professional development may help to change this.

I believe it's necessary to step outside the surreal confines of the NHS Hospitals and look at the health food retail and restaurant trade to get a reality check on what people really want when they are free to choose.

Whilst hospitals such as Mayday in Croydon are embracing Burger King as the public face of hospital catering, the public have shunned McDonalds to such an extent that they have been forced to completely re-brand. Apart from covering their bets with Prêt a Manger they now have salad and low fat deli choices, organic milk and even a Vegetarian Society approved option!

Prêt a Manger, Starbucks, Café Nero and others now have vegan options and fair trade soyaccinos, and stride where once only the puritanical Cranks Vegetarian restaurants dared to tread.

Overall, the restaurant trade is stagnating with an annual spend that's only being maintained by creatively luring consumers to the luxury end of the market with organic and healthier wild food choices that are difficult to source for home consumption.

The winners seem to be the supermarkets that have intuitively responded to consumer demand for perceived fresher, healthier foods and who are encroaching on the Vegan Pork Pie territory of chains such as Holland & Barrett and The Health Store.

Most supermarkets now have own brand soya milk, vegan and vegetarian 'free-from' ranges and vast sections devoted to meat free, organic and healthy ethnic foods.

As many of the space restricted airline caterers have discovered, vegan food can provide simple solutions for many categories of preferences. People choose the vegetarian and vegan options for a whole variety of reasons; religion, health, allergens, ethical, avoiding cholesterol, special diets, avoiding food poisoning or sometimes just to secure a more interesting choice.

In the shops you can buy clearly labelled vegan foods, from wine and dairy free ice cream to egg free mayonnaise and non-dairy chocolate, as well as a vast array of meat free and fish choices from vegan smoked salmon to vegan bacon and turkey. These products are bought and enjoyed by over 40% of UK consumers ,driving a British market worth over £600m.

Organic Soymeat in particular offers a low cost opportunity for a solution that needs no refrigeration; low risk, low hazard, low fat, low carb, low sodium, high fibre, high quality protein that's ready in minutes and can be enjoyed by almost everyone from meat lovers and Halal and Kosher devotees to the strictest vegan.

Let's see common sense solutions outside become commonplace inside.

Having grown up in Durbin & Allwrights, an acclaimed West London family delicatessen, Tony seemed destined for a life in food and catering from an early age. During the 1990s he won a string of accolades and awards for his tiny hotel, well off the beaten track on the shore of Lochbroom near Ullapool in Scotland. A cookbook and then a green guide to Scotland followed and he sat on a variety of committees for the Scottish and area tourist boards, Federation of Small Business and local arts council. After a stint in local radio (notoriously drowning out Chris Evans) he joined first The Vegetarian Society and then The Vegan Society as Business Development Officer. It was here he first worked on The Better Hospital Food Project and grappled with the complexities faced by NHS Estates on trying to improve hospital catering. He has optimistically worked with the FSA, FDF, FDA, organisations such as Westminster Diet & Health Forum and manufacturers such as The Food Doctor, Plamil and Soymeat in his quest to find new ways to help nutritional therapy reach its logical place in UK consciousness. He says the recent leadership and commitment shown by 3663 in their attempts to bring some synergy, sustainability and common sense to the catering industry have been hugely inspiring for him. Tony's latest cookbook 'Vegan' by Hamlyn written with his wife, clinical nutritionist Yvonne Bishop-Weston, is selling well around the world, attracting rave reviews for the redesign of vegetarian food and is featured on the www.bbc.co.uk/food website.

Nick Ellins
Policy and Planning Adviser
Water UK

Water – A Vital Nutrient in NHS Hospital Nutrition

It is now well recognised that poor nutrition affects health and wellbeing, prolongs hospital stay and increases the risks of infection and complications.

In a wholesome patient diet, water must be considered as one of the six basic nutrients – along with carbohydrates, fat, vitamins, proteins and minerals. In its Water, Sanitation and Health guidance, the World Health Organisation advises that *"water is a basic nutrient of the human body and is critical to human life".*

It might properly be called the 'first nutrient', since all the body's important chemical reactions – such as the production of energy – take place in it.

But the effects of poor hydration are less widely recognised. Dehydrated individuals are susceptible to pressure sores, constipation, urinary infections and incontinence, kidney stones, headaches, dizziness, falls, tiredness, blood pressure problems, skin conditions, poor oral health and certain cancers.

Dehydration has been acknowledged as a serious problem by the NHS*, and this is especially true for older hospitals that have little ventilation and warm, crowded wards.

Yet basic fresh water access and consumption remains unresolved by the Better Hospital Food project and Essence of Care guidance. It remains absent from NHS Dietary Reference Values and all the fundamental nutritional guidelines.

In the media, the NHS suggested that patients should be drinking 2.5 litres of water a day, or half a litre with each meal. Yet, at ward level, often both patients and staff suffer from poor provision through lack of facilities and no structured hydration policy. Let's remind ourselves – water is 'a basic nutrient of the human body and is critical to human life'.

There is a need to bring water to patients and staff in its most pleasant and palatable condition – fresh, mains supplied water, served cool and offered regularly. Often patients are faced with bedside jugs of warm, unappealing water.

Whilst bottled water has been criticised for working directly against the NHS Sustainable Procurement Strategy (due to the high initial price and the extensive food miles incurred in transporting it from original sources), tap water costs the NHS around one-tenth of a penny for each litre

and is available fresh 24/7. It is sustainable, and brings NHS procurement teams an immediate opportunity to reduce their operational and patient whole-life costs.

A better hydrated patient often uses fewer medicines (like laxatives) and heals faster. Promoting cool, fresh water often reduces the call for expensive and less healthy caffeinated and high sugar drinks. Presented well and offered regularly, it can rapidly become the drink of choice.

The Forum discussion on hospital food showed that it is time to join together and make change happen – to improve access to fresh water, understand its health benefits and visibly promote these in the hospital environment. The Water for Health Alliance (www.waterforhealth.org.uk/) will work alongside the primary hospital stakeholders to build future best practice.

Impending reviews of nutritional standards, and the arrival of the NPSA to the hospital food debate, bring added opportunities to help patients choose healthy options. The Department of Health must set a clear policy framework for good hydration.

Free, fresh water should be available to hospitals' patients, staff and visitors throughout their day. It should be presented with the same energy and enthusiasm as the other key components of nutrition, and be offered regularly.

The hurdles to providing this important nutrient are miniscule when compared to the potential health and economic benefits for our healthcare system.

Notes
* *Sunday Telegraph* 11 April 2004 / Daily Express 12 April 2004

Nick facilitates the UK-wide Water for Health Alliance. This voluntary stakeholder coalition comprises 26 health based organisations working together to move drinking water up the health policy and research agenda, improve public access to fresh water and promote the health benefits to society. www.waterforhealth.org.uk/

Contributor and Westminster Diet & Health Forum Biographies

Chris Bryant MP

Chris joined the Labour Party in 1986 and was Chair of the Christian Socialist Movement and a Hackney Councillor from 1993-98. He stood as Labour's candidate in the 1997 General Election in Wycombe, a formerly 'safe' Tory seat.

Following his election as Rhondda's MP in June 2001 he has served on the Culture, Media and Sport Committee of the House of Commons, as well as the Joint Committee of the Lords and Commons on Reform of the House of Lords. In November 2002 he was elected Chair of the Labour Movement for Europe.

Chris was re-elected (with an increased majority) in 2005 and in May 2005 was appointed Parliamentary Private Secretary to the Lord Chancellor, Lord Falconer of Thoroton (Secretary of State for Constitutional Affairs).

He is an Associate of the National Youth Theatre of Great Britain and a member of the Co-op Party, Amnesty International, the MSF Union and the Fabians. He speaks fluent Spanish and good French. He lives in Porth in the Rhondda Fach.

Professor Marinos Elia
Professor of Clinical Nutrition and Metabolism
University of Southampton

Marinos Elia is Professor of Clinical Nutrition and Metabolism at the University of Southampton and Honorary Consultant Physician at Southampton General Hospital.

He undertook research for a medical doctorate at the MRC Metabolic Research Laboratories, Oxford, headed by Sir Hans Krebs, before moving to Cambridge, where he headed the Clinical Nutrition Group of the MRC Dunn Nutrition Unit, and the Nutrition Team at Addenbrooke's Hospital, and was Senior Research Fellow at Churchill College, University of Cambridge.

He is currently an editor of five nutrition journals, and has been Editor-in-Chief of *Clinical Nutrition.* He has served on many national and international committees, and chaired a number of them. He has published extensively on various aspects of nutrition and metabolism.

Professor the Baroness Finlay of Llandaff

Ilora Finlay was elevated to the peerage in 2001 as the Baroness Finlay of Llandaff. A Fellow of the Royal College of Physicians and the Royal College of

General Practitioners, Ilora is an internationally renowned expert in palliative medicine and the care of the dying. She holds an Honorary Doctorate of Science from the University of Glamorgan; is an Honorary Fellow of Cardiff University; and was the Johanna Bijtel Professor at Gröningen University, Netherlands 2000-02.

Ilora's medical career has included periods as a General Practitioner, Member of the Expert Advisory Group on Cancers, and Chairman of the Association for Palliative Medicine, and as Vice-Dean of the School of Medicine, University of Wales College of Medicine. She is now President elect of the Royal Society of Medicine.

A co-author of *Care of the Dying - a clinical handbook*, Lady Finlay has been extensively published: she is Co-Editor of *Medical Humanities*, *Effective Management of Cancer Pain*, and has written many chapters in books and papers on palliative medicine, medical education, ethics and service provision.

Ilora is an independent Crossbencher in the House of Lords and has served on a number of its key committees. She has recently served on the Assisted Dying for the Terminally Ill Bill Select Committee.

Lady Finlay is a Patron of the Westminster Diet & Health Forum.

Emma Hockridge
Hospital Food Project Officer
London Food Link

Emma works on the hospital food project, which aims to increase the amount of local and/or organic food being served in four London hospitals. The project links local suppliers with the hospitals, as well as educating patients, staff and visitors on the benefits of sustainable food.

Emma has recently completed a Masters in Sustainable Development Advocacy, which focused on rural land use. This included work placements at Elm Farm Research Centre, Unilever, and Sustain. Prior to this she worked for HSBC and Defra, and carried out conservation in the Peruvian jungle after completing her degree in Geography and Environmental Studies.

Dr Karen Jochelson
Research Fellow in Health Policy - Public Health
The King's Fund

Karen Jochelson is Acting Policy Lead in Public Health at the King's Fund. She is interested in the relationship between health and the physical and social environment, and writes about sustainable development, health and the NHS. She is also developing a new programme of work examining individual responsibility, motivation and health. Her most recent work includes *Sustainable Food and the NHS: A Report for the Better Hospital Food Programme* (2005), which develops a framework for sustainable health and food provision for the acute sector.

Good Corporate Citizenship and the NHS: a regional mapping (HAD, 2004) surveyed sustainable procurement, capital building, waste and transport projects in the NHS. She was a lead author for the King's Fund publication *Claiming the Health Dividend. Unlocking the Benefits of NHS Spending* (2002) which looked at health and financial benefits of applying sustainable development principles to the NHS.

Dr Liz Jones
Head of Patient Environment
Department of Health

Liz is Head of Patient Environment at the Department of Health, and is responsible for dealing with issues relating to clinical aspects of estates and facilities management. She has a particular responsibility for policy on hospital food, cleanliness, and privacy and dignity.

Liz's background is in elderly care nursing, research and education. She has held posts in the NHS and the university sector as clinician, senior lecturer and in staff development.

Before joining the Department of Health, Liz was Head of Development at the Leeds Teaching Hospitals Trust. She has a degree in nursing and a PhD in nutrition in older inpatients.

Andy Kemp
Group Sales Director
3663 - First for Foodservice

Andy Kemp is Group Sales Director at 3663 – First for Foodservice, the UK's leading foodservice distributor.

Having completed his studies in Hotel & Catering Management, Andy went on to Exeter University where he majored in Food Law. Andy has noteworthy experience in the foodservice industry having previously held a variety of key positions including Managing Director of Universe Foodservice, which traded internationally. He is also regarded as a driving force behind improving quality standards.

Andy has sat on the Executive Food & Drink Federation Foodservice Committee for four and a half years, he is a board member of Springboard UK, Chairman of Arena and was made a Fellow of the HCIMA in November 2004 for service to the Foodservice Industry.

Professor Alison Kitson
Executive Director, Nursing
Royal College of Nursing

Alison Kitson is Executive Director, Nursing at the Royal College of Nursing (RCN). As part of the RCN's top team she is responsible for leading on the organisation's professional nursing agenda and helping it deliver its mission to represent nurses and nursing, promoting excellence in practice and shaping health policies.

Previous to this post she was Director of the RCN Institute, responsible for the delivery of professional development, lifelong learning, research and clinical practice support services to members. As Director she instigated and has supported the development of a number of innovative projects including the RCN's work on knowledge utilisation and transfer and an extensive set of practice-based research programmes.

Alison has a distinguished academic and professional career. She has published over 100 articles and has represented nursing on many local, national and international stages. She sits on numerous policy advisory boards and has a track record of successfully managing innovation and change within nursing policy and practice. In 1991 she was awarded a Fellowship of the Royal College of Nursing for her work on Standards of Care. She is a supernumerary Fellow of Green College, Oxford, holds a number of Visiting and Honorary Chairs and in 2001 was awarded Distinguished Graduate of the Year from her old university, University of Ulster.

Peter Mansell
Director for Patient Experience
National Patient Safety Agency

Peter left school without any qualifications and worked in various manual jobs until becoming paraplegic at the age of 20, in 1978, through a road traffic accident.

His injury lead to an interest in poverty and disability, and the social policy issues surrounding them, and led to his reading for a degree in social policy. In a long career Peter has been Chair of a hospital, Chief Executive of two national charities and worked in the Department of Health.

Peter took up post as the National Patient Safety Agency's Director for Patient Experience on May 1st 2002.

Alison McCree
Chairman
Hospital Caterers Association

Alison has considerable experience of health care catering gained from 21 years within the National Health Service. Her entry into the world of public sector catering began in 1984, as a NHS Trainee Cook at Dryburn Hospital in Durham. She rose rapidly through the ranks and in 2003 was appointed to her current position of Associate Director of Estates & Facilities at County Durham & Darlington Acute Hospital NHS Trust. She is responsible for an extensive range of essential services under the Patient Environment Department.

Alison currently holds the position of National Chairman of the Hospital Caterers Association (HCA). She has been an active Member of the HCA for 15 years.

Alison is also currently a member of the Better Hospital Food Panel. Alison's catering services have gained national recognition, winning the 2003 Excellence in Hospital Catering category of the Building Better Healthcare Awards and in 2004 being the first hospital ever to win the Food and Farming Awards , as well as being the first hospital in the country to achieve the EFSIS standard for catering establishments.

Claire Rayner
President
The Patients Association

Claire has had a long relationship with the Patients Association. She brings her considerable expertise and experience from a professional background in nursing and journalism and her personal experience as a patient and carer.

She was, for many years, a leading 'Agony Aunt' and is also well known as a medical correspondent for many popular magazines. She has published articles in a number of professional journals.

Claire believes passionately in standing up for patients and continues to work tirelessly to this end. She was appointed a Commissioner in December 1997 to the Royal Commission on Long Term Care for the Elderly. She has also been appointed to Chair the Health Advisory Board to improve healthcare standards at Holloway Prison. She has launched a great many campaigns including *Dignity on the Ward*, *Tackling Migraine Together*, the *Medical Passport Scheme* and is involved in the Children and Violence Forum.

Mike Tiddy
Category Manager – Fresh Produce and Nutrition
NHS Purchasing and Supply Agency

Mike has the responsibility for the supply chain arrangements for fresh produce supplied to all NHS Trusts in England. He also manages the logistical arrangements for the school fruit and vegetable scheme, part of the Department of Health (DH) 5 a day campaign. This involves purchasing approximately 200 tonnes of fruit and vegetables daily for supply to 16,000 schools and 600 hospitals.

He has a small team producing contracts for this public procurement activity. Tenders are produced seeking sources of supply that can fulfil customer requirements as well as meeting the wider government targets particularly those of DH and Department for Environment, Food and Rural Affairs (Defra).

Mike is a member of the Defra-led Public Sector Food Procurement Initiative which sets the strategy for farming and food. He also is responsible for the nutrition policy of NHS PASA and works with DH and the National Patient Safety Agency to implement the Food and Health Action Plan throughout the NHS.

Peter van Gelder
Director
Westminster Diet & Health Forum

Peter is a former Managing Director of strategy consultants Informed Sources (sold to Mercer Management Consultants in July 2002) which advised

many leading media organisations and retailers. He held similar positions at British Interactive Broadcasting and Teletext Ltd. He was previously Managing Editor of TV-am and before that an Editor of Children's Programmes, and a producer and news reporter with the company.

Peter began his career as a broadcast journalist with the BBC. He worked at BBC Wales and *Newsnight*, and was political correspondent of BBC Radio Leeds.

He has published a cinema reference book, *Offscreen Onscreen.*

Chris Whitehouse
Director
Westminster Diet & Health Forum

For 16 years, Chris Whitehouse worked in Parliament providing research and campaign support for MPs and Peers from all parties. He has served as Clerk to the All-Party Parliamentary Media Group since its launch in 1992 and as Director of the Westminster Media Forum since 1996.

A former Chief Executive of the Manufacturing and Construction Industries Alliance, he is now Director of a specialist consultancy (www.whitehouseconsulting.co.uk) providing advice on public and parliamentary affairs to a wide range of clients which have included The Health Food Manufacturers Association, Holland and Barrett, Consumers for Health Choice, The Green Machine, The Health and Diet Company, The British Health Care Association, Slimming World, the British Olympic Association, The Obesity Awareness and Solutions Trust, Healthnotes Inc, The American Soybean Association, The Cambridge Diet, and Atkins Nutritionals UK.

Rick Wilson
Director of Nutrition and Dietetics
King's College Hospital

Rick began his professional career in Coventry in 1977. He is now the Director of Nutrition and Dietetics at King's College Hospital NHS Trust - a position he has held since 1985. During this time he has had an abiding interest in food services and their vital role in nutritional care of patients in hospital.

In 1993 he chaired a multi-disciplinary group in South East Thames Region which produced two documents outlining standards for the provision of hospital food – *Menu Planning* and *The Food Chain.* In 1995 Rick was on the Health of the Nation working party which produced *Nutritional Guidelines for Hospital Food.* An audit tool to assess compliance with these guidelines was published in 1996. He contributed to the 1998 publication *Eating Matters* and the 1999 publications *Hospital Food as Treatment* from BAPEN and *Management of Nutrition in Hospitals* from the Nuffield Trust.

Rick has presented on the nutritional importance of hospital food nationally and internationally, and is the author of the chapter on 'Institutional Catering' in all three editions of the *Manual of Dietetic Practice*.

Rick took part in the nationwide audits of food services commissioned by NHS Estates in 2000 and became a representative of the British Dietetic Association on the Better Hospital Food project team in May 2001. Since then he has been actively involved in the implementation of the project and is now the dietetic member of the Better Hospital Food panel and member of the BDA/HCA joint working party of the development of nutrition and hospital food across the UK.

Rick is an active member of the British Association for Parenteral and Enteral Nutrition (BAPEN), sitting on BAPEN council and committees for communication, the Malnutrition Action Group and is regional representative for South London.

Information for biographies has been supplied by speakers.

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