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Nutrition Policy

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**Abbreviations, Terms, Definitions**

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| **Abbreviation** | **Definition** |
| ACBS | Advisory Committee on Borderline Substances |
| AHP | Allied Health Professionals |
| BAPEN | British Association of Parenteral and Enteral Nutrition |
| BMI | Body Mass Index |
| CAMHS | Children and Adolescent Mental Health Services |
| CEDS | Community Eating Disorder Service |
| CNS | Clinical Nurse Specialist |
| CYP | Children and Young People |
| ELFT | East London NHS Foundation Trust |
| FREED | First Episode Rapid Early Intervention for Eating Disorders |
| GP | General Practitioner |
| MDT | Multi-Disciplinary Team |
| MEED | Medical Emergencies in Eating Disorders |
| MUST | Malnutrition Universal Screening Tool |
| NICE | National Institute of Clinical Excellence |
| NSG | Nutrition Steering Group |
| SANSI | St Andrew’s Nutrition Screening Instrument |
| SEDU | Specialist Eating Disorder Unit |
| SLT | Speech and Language Therapist |
| STAMP | Screening Tool for the Assessment of Malnutrition in Paediatrics |

**Executive Summary**

East London NHS Foundation Trust (ELFT) serves a large population of service users enduring mental and physical ill health. As part of its strategy, ELFT aims to address population health inequalities and deliver high standards of care. Nutrition care planning is an integral part of effective healthcare and improving population diet-related health outcomes. The nutrition steering group (NSG) and dietetic workforce will support the trust to ensure quality of nutrition and hydration services. This policy outlines key standards which are fundamental to safe nutrition care.

Those enduring physical or mental ill health are at high nutritional risk compared with the general populationi, both malnutrition and obesityii. Malnutrition prevention is demonstrated to improve health outcomes including reduced length of hospital stay, improved overall health and wellbeingiii, and addressing obesity mitigates risks of cancer, covid-19, diabetes cardiovascular disease, and reduces costsiv. The preventable 20 year premature death compared to the general population is related to diet-related disease for people in forensics settingsv and clinical nutrition complications for those with learning disabilityvi. Those with eating disorder experience the highest standardised mortality ratio of any mental illnessvii. As such, clinical nutrition intervention is pivotal for service users in healthcare settings to prevent illness and promote recovery. Prevention of malnutrition and obesity are trust priorities to promote health outcomes for service users accessing trusts.

Pertinent to nutrition care planning, ELFT provides a wide range of specialist community, and inpatient mental health services to children, young people, adults and older adults to the City of London, Hackney, Newham, Tower Hamlets and Bedfordshire including:

* mental health inpatient services across ELFT
* inpatient units for Children and Young People Mental Health Service (CAMHS) in Bedfordshire and Newham
* community health (physical health) services in Tower Hamlets and Newham
* primary care services to homeless people from three practices, one each in Tower Hamlets, Hackney and Newham
* specialist learning disability services across ELFT
* forensic services in City and Hackney, Newham, Tower Hamlets, Barking and Dagenham, Havering, Redbridge and Waltham Forest.
* specialist community Adult Eating Disorders services in Bedfordshire
* specialist disordered eating pathway in Hackney, Tower Hamlets and Newham

It is essential that leading mental health trusts such as ELFT screen for nutritional risk using validated tools. Historically the Malnutrition Universal Screening Tool (MUST) is implemented in physical health settings to screen for complications of malnutrition. This policy recommends the eventual trust-wide use of the St Andrews Nutrition Screening Instrument (SANSI)iii which screens both malnutrition and overweight/obesity and is validated in mental health settings. This is the primary and preferred tool currently used in similar leading mental health trusts to promote timely nutrition care planning that will improve clinical outcomes and quality of life.

Dietitians are trained to advise on evidence-based nutrition care plans, and are under-represented as an available workforce in ELFT. Where they do exist in the Trust, the focus of dietetic intervention has been largely on responding to and supporting complex individual service user cases where malnutrition prevention is a priority. This policy document advocates for a safe dietetic workforce, professional leadership, and presence in the nutrition steering group, and stipulates the need for a range of specialist practice areas that enable comprehensive nutrition and hydration as a standard offer across ELFT services ensuring prevention and safe effective care.

In keeping with the Trust Wide Working Together Group target to offer service users more options and opportunities to improve quality of life, the NSG pledges to work closely with service users, carers, and People Participation Leads to execute person-centred, high-impact and user-led nutrition service across the trust.

**1** **Introduction**

This policy, along with the development of nutrition guidelines and dietetics workforce, are in line with both the Trust’s strategyviii and the NHS Long Term Planix. The Trust’s strategy envisages improving experience of care, population health and improving value. The Long Term Plan is a nationwide drive to improve children’s and adult’s access to mental health services, specifically malnutrition prevention, weight management, diabetes prevention, and early intervention for eating disorder services. Work of the nutrition steering group will promote effective partnerships, support safe admissions and discharges to integrated care settings, and promote positive service user experience of medical and psychiatric settings.

**2** **Purpose**

2.1 ELFT is committed to providing high quality, effective nutrition and related services. This will ensure that each service user will have access to appropriate food, drink and artificial nutrition in a safe, dignified and timely manner to meet nutritional and cultural needs.

2.2 Standards pertaining to nutritional care will be evidence-based and comply with the recommendations of expert groups and professional bodies.

2.3 This policy will apply to the general population of service users accessing the trust, however there may be individual cases where the general terms do not apply such as for eating disorder services where local policies will be followed. Nutritional care strategies and catering services will be tailored to the multiple needs of service users, and it is well recognised that the nutritional needs of different populations within the trust may vary between services.

**3** **Duties and Responsibilities**

3.1 The Chief Medical Officer and Executive Therapies Lead along with the Trust board are ultimately accountable for the nutritional care of service users accessing ELFT services.

3.2 The nutrition steering group will be responsible for ensuring that its recommendations for services are relayed to service directorate management teams for their action. Service actions required will be co-led locally with support from dietitians as available and multi-professional clinical and managerial input.

3.3 In inpatient settings, the Estates and Facilities team will be accountable for food services, and the clinical multidisciplinary team (MDT) will be responsible for the provision of nutrition care plans

**4** **Nutrition Care**

**4.1** **Nutrition Screening across ELFT services**

4.1.1 In adult inpatient units, all service users over the age of 18 will be screened within 48hrs of admission, and monthly thereafter by a trained member of the MDT using the MUST or SANSI. Screen results will be recorded electronically where possible. SANSI is the Trust’s preferred nutrition screening tool as it is validated for mental health populations, however at the time of writing, some services utilise MUST. When SANSI becomes available on electronic medical records in a roll out programme over the next two years it will be adopted trust wide. Changes will be reflected at the time of the review of this policy. See Trust intranet pages on nutrition for Nutrition Screening Tools and Flowchart.

4.1.2 In CAMHS, all children and young people under the age of 18 years will be screened for nutrition risk within 48hours of admission to inpatient settings using the Screening Tool for the Assessment of Malnutrition (STAMP) which is validated for children aged 2-16 years. Screening results will be linked to percentage median Body Mass Index (BMI) centile charts and recorded electronically.

4.1.3 For adults in the community, screening for nutrition risk will be routinely reviewed by community services as agreed by the MDT. Staff will refer service users with clinical nutrition concerns including but not limited to unintended weight loss, selective and restrictive eating, disordered eating behaviours, enteral feeding or obesity to the dietitian to assess the service user in Children and Adolescents Mental Health Services (CAMHS) and Paediatrics settings. With the exception of this clause pertaining to Nutrition Screening for children and young people, the standards within this document, unless specified otherwise, relate to nutritional care of adults and children.

4.1.4 Following completion of the Nutrition Screening Tool, any service users at risk of malnutrition or obesity will have a nutrition care plan put in place, incorporating their nutritional needs and dietary preferences, detailing staff involvement and review periods. Every attempt will be made to involve service users in discussions and decisions about their nutritional care, and where appropriate, relatives, advocates and carers will be consulted in the process. The chart below demonstrates the identification of nutrition risk and route for nutrition care planning:

4.1.5 Observation by nursing/care staff at mealtimes is essential to identify any service users with poor nutritional intake and/or difficulties eating or swallowing. Referrals should be made to Dietetics, Physiotherapy, Speech and Language Therapy (SLT), dysphagia trained nurses or Occupational Therapy as appropriate. A care plan will be formulated if any feeding or dietary difficulties are identified detailing actions and referrals.

4.1.6 In inpatient settings, completion of the Nutrition Screening Tool will be completed on admission and throughout admission to identify nutrition risk. Staff will complete monthly screens for those at low risk of malnutrition and/or obese, and weekly for those at medium or high risk. When completing nutritional screening, staff will give special consideration to those with suspected or diagnosed eating disorder for whom the process may be distressing. Staff will complete appropriate nutrition care plans as detailed on the screening tool. It is the responsibility of the ward manager for assurance that this process takes place.

4.1.7 In community settings, frequency of completion of the Nutrition Screening Tool will be agreed with service users, relatives and local care providers. It is the responsibility of local community teams to use clinical judgement to ensure that this process takes place and is realistic and achievable. Monthly screening is advised as routine, and more frequently for those service users whose clinical presentation has significantly changed, who present with high nutrition risk, or are under the care of the dietitian.

4.1.8 The final step of the nutrition screen indicates the appropriate nutrition care plan. The online screening tool will link to other nutrition care pathways including refeeding syndrome, borderline substances, enteral feeding, weight management (see section 4), catering, diabetes and antipsychotic prescription as appropriate, for which full details can be sited in the relevant policy documents.

4.1.9 Service users in paediatrics settings in Newham with complex physical health needs and are at high risk of malnutrition will be referred to the physical health paediatrics team dietitians following local policies and protocols.

**4.2**  **Malnutrition**

4.2.1 In adult services, malnutrition is identified by significant weight loss >5% within 1 month or 5-10% in 3 months, very low BMI <18.5kg/m2 or low BMI 18.5-20kg/m2, and other factors limiting adequate nutritional intake (including eating disorders, psychosis, and obsessive compulsive disorder). In children’s services, malnutrition is identified using percentage median BMI and growth charts. If a service user is at risk of or diagnosed with malnutrition, staff should follow the action plan stipulated on the appropriate screening tool and this will be recorded in service users’ nutrition care plans.

4.2.2 Staff must refer those with high risk of malnutrition (identified as above) for nutritional assessment and dietary intervention by a dietitian. This is outlined on the screening tool action plan and should be recorded in the care plan. As part of this care plan, staff involved with menu ordering, including housekeepers must provide at risk service users with the nutrition support menu (see catering section 7)

4.2.3 Staff must commence food and fluid record charts immediately for service users where there is malnutrition risk. These must be completed as directed by the nutrition screening tool or as agreed with the dietitian and the MDT. See Trust intranet pages on nutrition for Standard ELFT food record charts.

4.2.4 Staff must refer any service users who have been prescribed nutritional supplements or enteral feeding (see artificial nutrition section 5) to the dietitian for review and continue their prescription and feeding regimen in the interim. As the Trust adopts a ‘food first’ approach any service users who staff consider may benefit from nutritional supplements must be referred for full dietetic assessment before recommending prescription by the consultant or GP. See Trust intranet pages on nutrition for Quick Reference Guidelines for Oral Nutritional Supplements.

4.2.5 Any service users who are at risk of refeeding syndrome following nutrition screening must be referred to the dietitian. This will ensure appropriate and safe management of introduction of nutrition, details of which can be found in the refeeding syndrome policyx,xi. Staff will follow separate protocols for service users with diagnosed or suspected eating disorder and risk of refeeding syndromevii. See section 4.4 and Trust intranet pages on nutrition for Refeeding Syndrome Screening and Management.

**4.3**  **Overweight and Obesity**

At the time of writing this policy document, ELFT does not deliver formal evidence-based tier 2 intervention (12-week healthy eating programmes) for the growing population of overweight and obese service users within the trust. Therefore, sections below discussing tier 2 programmes are aspirational, based on best practice guidelines and will be implemented as soon as dietetic staff and resource have been commissioned.

4.3.1 Using the SANSI, service users identified as at risk of overweight (BMI >25 kg/m² for general population and BMI >23kg/m² for minority communities including Black, Chinese, Arab and Asianxii) will be offered the healthy eating menu (see catering section 7) by staff, including nurses and housekeeping. This is contraindicated if the service user has history of, suspected or diagnosed eating disorder. Staff will complete training on healthy eating based on a variety of government recommendations tailored for specific population groups, including Eatwell Guidelinesxiii and the Food Pyramid. Staff will promote first-line guidance which will be available on the intranet and learning and development pages. Staff will signpost service users to local services as appropriate, including recovery college healthy eating programmes within the trust.

4.3.2 Service users in long-stay or community settings who do not have eating disorder and are at risk of obesity (BMI >30kg/m² for the general population and BMI >28kg/m² for minority communities including Black, Chinese, Arab and Asianxiv), diet-related complications (including diabetes, heart disease, high cholesterol), or initiating antipsychotic treatment will be referred to the dietitian for initial assessment (including capacity assessment completed with the MDT) and individual intervention. Those who decline will be screened monthly and offered dietetic intervention again in 3 months. Staff involved with menu ordering, including housekeepers, will offer the healthy eating menu (see catering section 7) and promote healthy lifestyle in line with government first-line guidance based on the Eatwell Guidelines.

4.3.3 With adequate staffing (including health support workers and registered nutritionists), dietitians will supervise bespoke ELFT tier 2 healthy eating group programmes which are accessible and appropriate for service users with obesity types I-III (BMI >30, 35 or 40kg/m²) and chronic mental ill health and/or learning disability. Services users will be enabled to participate fully with the consistent support of carers, support workers or trained staff. Service users will be offered MDT input to complete the 12-week programme, comprising weekly nutrition education and practical skills alongside physical activity, and a 26-week follow up. At the time of writing this document, this provision is not available, and staff will refer service users at risk of obesity to local mainstream tier 2 services as available.

4.3.4 Exclusion criteria for tier 2 healthy eating group programmes include service users with risk of malnutrition or refeeding syndrome, clinical complications pertaining to nutrition, wheelchair users requiring MDT intervention, and bariatric service users requiring tier 4 intervention. There is no upper age or BMI limit.

4.3.5 Service users with obesity III, BMI >40kg/m² should be assessed on an individual basis through discussion with the consultant as there is not a dedicated bariatric MDT currently available. Service users will be referred to local bariatric teams in physical health settings as appropriate. Service users will have access to appropriate equipment such as bariatric chairs and weighing scales, and will be addressed using appropriate and sensitive language.

4.3.6 Service users with a new diagnosis of diabetes, poorly controlled diabetes or high risk of diabetes should be escalated to service managers for referral to local diabetes teams for specialist intervention where it is available. Referral routes into specialist diabetes services differ across the trust at present, and the nutrition steering group will support efforts to standardise practice. The covering ELFT diabetes Clinical Nurse Specialist (CNS) will offer support to provide tailored service in ELFT settings using local team resources, and the dietitian will support this work when dietetics cover is commissioned.

4.3.7 For those without eating disorders, upon commencement of anti-psychotics known to be associated with weight gain (See Trust intranet pages on nutrition for Antipsychotics associated with appetite regulation), staff will commence routine monitoring according to the trust policy, including weekly nutrition screening for obesity and physical health observations. ELFT staff will be offered evidence-based information on healthy eating where appropriate, and informed staff will provide first-line healthy eating advice, use educational resources maintained by dietitians, and guide service users to use the ‘Healthy Eating’ menu.

4.3.8 Staff will remain vigilant in monitoring those prescribed high dose antipsychotic medication by using the nutrition screening tool, and make prompt, appropriate referrals to the dietitian. Where service users who are prescribed antipsychotics do not have capacity, staff and carers will work in service users’ best interests to promote healthy eating.

**4.4** **Eating Disorder Services**

4.4.1 An MDT approach is important to the successful treatment of eating disorders and psychological therapies will be central to these teams. Dietitians are important members of the team who will offer timely and objective nutritional advice with the aim of helping the service user develop a better relationship with food and to improve nutritional status.

4.4.2 In NEL, local Improving Access to Psychological Therapies (IAPT) services in Newham, Tower Hamlets and City and Hackney will accept referrals (including self-referrals) for any ELFT service user who has mild to moderate eating disorder, namely all of the following:

- disordered eating

- stable eating disorder (purging/binging less than 3 times weekly)

- low physical health risk

- BMI greater than 18

- greater than 18 years of age

4.4.3 In NEL, any service user over 18 years old who presents with mild to moderate eating disorder (criteria in 4.4.2) with compounding mental ill health which might exclude them from IAPT services will be referred to the ELFT Disordered Eating pathway of the Transformation Project. This is a provision embedded in local Primary Care Networks / Neighbourhood Teams designed to prevent escalation of eating disorders. The teams comprise psychologists, Clinical Associates in Psychology, an Advanced Eating Disorder ELFT dietitian, nurses and health support workers. This team will support service users referred from outpatient settings in Newham, Tower Hamlets and City and Hackney CAMHS, neighbourhood teams, GPs, community dietitians and IAPT services, as well as from mental health inpatient settings within ELFT. See Trust intranet pages on nutrition for Referrals for mild-moderate eating disorder in North East London.

4.4.4 In NEL, the St Ann’s Hospital, a specialist tertiary unit led by Barnet, Enfield and Haringey Mental Health Trust will accept referrals for ELFT service users who present with an eating disorder whose behaviours might indicate high physical risk, including:

- BMI less than 17.5 for anorexia nervosa with purging more than 3 times per week

- Bulimia Nervosa with binging more than 3 times per week

St Ann’s staff will assess service users as part of their service agreement. St Ann’s will offer advice across acute and community settings if a diagnosis of eating disorder is confirmed. If the service user experiences disordered eating secondary to a mental health primary diagnosis, requires nasogastric feeding (under restraint or not), or may need a refeeding protocol, St Ann’s will offer ward visits and remote support for the covering ELFT mental health dietitian and staff, and will provide the opportunity for case discussions through monthly consultation. ELFT staff should refer to St Ann’s Eating Disorders Service protocols and guidelines, and NICE guidelinesxv, and keep regular observations of bloods, food and fluid charts, blood pressure as recommended by St Ann’s. See Trust intranet pages on nutrition for Monitoring Guidelines for Eating Disorders.

4.4.5 In Bedfordshire, ELFT provides specialist NHS adult eating disorder services via its adult Community Eating Disorder Service (CEDS), and specialist NHS children’s and young people’s eating disorder services via CAMHS. ‘Caraline’, a local stepped care charity partner, accepts self or professional referrals for mild to moderate eating disorder.

4.4.6 CEDS accepts referrals for severe and complex eating disorder from GPs, IAPT, NHS teams and Caraline stepped care. Adult community Eating Disorder Services offer a First Episode Rapid Early Intervention for Eating Disorder (FREED) pathway, a ‘gatekeeping’ pathway for Specialist Eating Disorder Units (SEDUs) admissions, and close links with Children and Young People’s Units (CYPs) to promote smooth transfer between services.

4.4.7 ELFT eating disorder and CAMHS units are leading in the field offering cutting-edge innovative practice recommended by the New care Models Provider Collaborative for Adult Eating Disorders, writing national guidelines for Feeding Under Restraintxvi, and chairing local to networks to promote implementation of Medical Emergencies in Eating Disorder (MEED)vii pathways and protocol. Local protocols for monitoring have been devised by clinical specialist lead psychiatrists and dietitians adapted from the recently updated guidance. See Trust intranet pages on nutrition for the MEED guidelines.

4.4.8 ELFT dietitians working in eating disorders and related services are advanced practitioners and will offer dietetic intervention locally, and offer supervision, training, advice, and liaise for the wider ELFT community of mental health clinicians, general community dietitians, students, and support workers.

**4.5** **Nutritional Care in Inpatient and Community Settings**

4.5.1 In settings where there is dietetic cover, dietitians will collaborate with managers and staff to formulate population-specific nutrition dietetic resources based on latest evidence and guidance. Dietitians will be responsible for maintaining and reviewing dietetic information and training resources.

4.5.2 For those identified as having nutritional risk, dedicated staff including nurses, carers, support workers and housekeepers are required to observe and record service users’ intake at mealtimes to ensure that problems are highlighted to the nurse in charge, care manager or dietitian if. If problems continue referral should be made to the appropriate professional and risks should be recorded and escalated locally.

4.5.3 Healthcare assistants, nurses, housekeepers and other staff involved in mealtime provision will provide assistance and supervision in a respectful, sensitive manner. Assistance includes help with positioning, opening packaging, cutting up food, ensuring special dietary needs are met, support with menu choices using pictorial menus if appropriate, providing prompts or feeding a person. Prior to assisting with feeding all staff will be informed of individual needs by the nurse in charge or care manager, and receive training if required on feeding techniques from appropriate professionals such as the Speech and Language Therapist (SLT). Staff and carers will be aware of information contained in individual mealtime guidelines or nutrition care plans. In hospital settings, staff should implement protected mealtimes to allow adequate time for completion of meals without unnecessary interruption.

4.5.4 When additional risks are identified such as poor posture, swallowing problems and feeding difficulties, staff will refer to the SLT. The following policies will support this process;

* Referring to SLT for dysphagia [ELFT IntranetS](https://elftintranet/sites/common/private/search_quick21.aspx?q=dysphagia%20policy&orderby=0&url=ObjectInContext.Show(new%20ObjectInContextUrl(2%2C28624%2C1%2Cnull%2C970%2Cundefined%2Cundefined%2Cundefined%2Cundefined%2Cundefined))%3B)xvii
* Staff dysphagia training (course: 363 Dysphagia and Swallowing Difficulties e-Learning)
* International diet and dysphagia standardisation initiative (IDDSI)xvi

Staff will follow SLT care plans outlining concerns, detailing actions and referrals. When relatives, or care assistants help service users with eating and drinking, registered nurses and trained carers will remain diligent to the needs and safety of the service user.

4.5.5 Privacy, dignity and nutritional needs of women who are breast feeding will be maintained. Breast feeding mothers will be provided with an appropriate room to feed their babies.

**4.6**  **Nutrition Equipment and Resources**

4.6.1 All units and clinics should have access to the recommended hospital standard scales SECA Class 3 for weight measurements, and a stadiometer and height measuring equipment. This includes standing scales for service users who are fully mobile, and chair scales, wheelchair, bariatric or hoist scales where service users are unable to mobilise safely. Equipment may be available via access to GP surgeries, nurse-led or MDT clinics in other services and local pathways for service users will be agreed. Equipment will be kept in good working order and be professionally serviced or calibrated at recommended intervals.

4.6.2 Recommended assistive feeding equipment following therapists’ assessments will be provided for those service users who require it. This equipment will be kept in a designated area where it will be labelled and maintained in a clean condition by staff and made available to the individual service user whenever necessary.

4.6.3 Oral nutritional supplements and thickening agents recommended by the SLT or other qualified professional will be stored in an accessible place, such as the unit kitchen and labelled for specific service users. Recommended individualised instructions detailing how to use the thickener and any modified texture diet will be available and promoted to all nursing/care staff, relatives and carers who may provide food and drinks. Nurses will be responsible for the safe storage and administration of borderline substances to modify the texture of food or fluid, and oral nutritional supplements.

4.6.4 As recommended by the ‘Making Every Contact Count’xvii campaign, dietitians, SLTs, physiotherapists and occupational therapists are well-placed to provide additional support and training to nursing staff and carers with the aim of achieving optimal and safe consumption of food and drink, including but not limited to correct positioning, thickening drinks, fortified diet and/or manipulating food textures. Training will be provided remotely

**4.7** **Discharge and Transfer between Services**

4.7.1 ELFT service users may transfer between various local community and physical health services, including transition from paediatric to adult services, acute settings to local public health initiatives, and between physical health and mental health services. Where indicated, the nutrition steering group will recommend the terms of transfer including referral criteria and pathways in the absence of dietetic resource.

4.7.2 At the point of discharge or transfer to different services, medical and nursing discharge summaries will include nutritional risk, special dietary needs and hospital passports with updated nutrition care plans for GPs and community teams. Details of ongoing monitoring, prescribed supplements and thickeners will be stipulated, and pertinent therapists will be alerted in a timely manner to assist with training and education of carers, and will be available electronically where possible.

4.7.3 Discharge summaries will stipulate the clinical indication for ongoing prescription of oral nutritional supplements including the product, daily dosage, total requirement per month and rationale for recommendation/discontinuation when appropriate. Any service user requiring oral nutritional supplements at the point of discharge will be referred to the local community Dietetic Service.

4.7.4 Service users requiring enteral feeds or nutritional supplements on discharge from hospital will be given a fourteen day supply of products from ward stock (unless safety concerns or clinical need indicate less), including plastics for enteral feeding (see next section).

4.7.5 When planning for discharge for service users requiring assistive feeding devices, information on how to acquire or purchase these will be provided by the relevant clinicians to service users, relatives or carers.

4.7.6 Staff supporting service users with learning disability or who have received treatment in forensic services will update hospital passports xviii. Carers will be invited to bring them to appointments or upon admission when accessing services, and acute staff will be able to review hospital passports during admission and at discharge to support with dietary care planning.

4.7.7 Health support workers, volunteers, housekeepers and catering staff will be updated regarding special diets and nutrition care plans, and will guide service users towards the appropriate menu according to identified need, the nutrition support menu for services users at risk of malnutrition, and the healthy eating menu for service users at risk of obesity.

4.7.8 If service users require specialist dietetic advice and physical team intervention beyond the remit of mental health settings, then the dietitian will liaise with the consultant regarding referral to physical health services.

4.7.9 Community Health Services should continue to screen for nutrition risk locally as part of holistic assessment, including MUST, SANSI and other tools as appropriate. Service users identified as being at high nutrition risk will be referred to local community dietetics services.

**5** **Artificial Nutrition**

Artificial Nutrition is a clinical treatment and supportive diet therapy to maintain nutrition intake through the oral and enteral routes when service users is unable to meet nutritional needs through their usual diet. Artificial nutrition methods include sip-feeds, also known as nutritional supplements, and enteral feeds, which are delivered through feeding tubes to bypass the mouth. Feeds are available on FP10 prescription, recommended by a dietitian, and prescribed by a medical professional or pharmacist.

**5.1**  **Oral Nutrition Supplements**

5.1.1 Following identification of malnutrition risk with routine SANSI screening, staff will follow the recommended first-line advice as part of the nutrition care plan, and refer to a dietitian if appropriate.

5.1.2 Service users who struggle to maintain their weight through oral intake due to a small appetite, raised energy requirements, dysphagia or malabsorption will be actively encouraged to follow food fortification advice as directed by the nutrition screening tool. This advice can be found on the intranet.

5.1.3 Prescribable oral nutrition supplements will only be considered by staff if first-line dietary measures are found to be unsuccessful, with suitable justification by monitoring of food and fluid intake amongst other observations.

5.1.4 Oral nutrition supplements will be prescribed by the GP, doctor or nurse prescribers following referral to a Dietitian where a full nutritional assessment has been completed in accordance with the product’s prescribable indications as listed by the Advisory Committee on Borderline Substances (ACBS).

5.1.5 Any service users who are admitted to ELFT services with oral nutrition supplement prescription should be referred to the dietitian for assessment and ongoing monitoring.

**5.2**  **Enteral Nutrition**

5.2.1 Enteral nutrition products will be recommended following dietetic assessment in accordance with the products prescribable indications as listed by the Advisory Committee on Borderline Substances (ACBS).

5.2.2 ELFT dietitians will participate in the local consortiums led by local physical health services. Ongoing review of enteral nutritional products and providers in London and Bedfordshire to will assess clinical efficacy and outcomes, value for money and quality. At the time of writing this policy, Fresenius Kabi is the third-party provider for London, and Nutricia is for Bedfordshire and Luton.

5.2.3 As per recommended guidelines, enteral tube feeding is indicated in people who are malnourished or at risk of malnutrition with inadequate or unsafe oral intake, and a functional, accessible gastrointestinal tractxix,xx. For inpatients who are admitted with existing enteral nutrition care plans, staff will refer to the dietitian and register service users with the local third-party provider who will offer training, pump and plastics delivery, and routine review (Fresenius Kabi in NEL, and Nutricia in Bedfordshire). Staff will monitor enteral nutrition care plans, and the dietitian will review the clinical indication for enteral tube feeding ongoing and will refer to the local community dietitians at the point of discharge.

5.2.4 Nasogastric feeding is not recommended for adults across ELFT settings and in the community due to the high risks associated with tube displacement and resulting aspiration. In children’s community settings, staff will follow local guidelines and protocols pertaining to nasogastric feeding on a risk-based assessment as part of an MDT approach.

5.2.4 In outpatient settings, the dietitian will work closely with the MDT if a service user is being considered for enteral nutrition. In the community, the MDT will complete a mental capacity assessment (adults only), best-interests decision meeting with an advocate, and make a referral for elective gastrostomy placement to a local physical health service. Community teams will follow local home enteral feeding policies and protocols and will be trained by the local third party provider (as aforementioned).

5.2.5 If an adult service user admitted to ELFT inpatient services is thought to require enteral feeding by the dietitian or MDT, staff will not instigate the establishment of enteral nutrition care plans, and will refer to local physical health services.

5.2.6 Standardised training, equipment, feeding regimes, monitoring charts and other templates will be offered collaboratively with local physical health services and third-party providers across ELFT settings to ensure a safe enteral feeding pathway for service users.

5.2.7 In eating disorder service settings, feeding under restraint is adapted to the least restrictive practice, and local guidelines and protocols are followed in these unitsxvi.

**6** **Public Health Nutrition**

6.1 ELFT will ensure that nutrition education is included in all health promotion and healthy lifestyle development initiatives undertaken for service users and staff as appropriate.

6.2 Dietitians will maintain a shared folder of effective, practical, evidence-based, expert advice and nutritional guidelines and recommendations on the trust intranet ELFT learning academy, and will regularly review and update it, incorporating resources and practices from local public health partners and providers.

6.3 Dietitians will liaise with local services, catering contractors, local charities and other stakeholders to address the specific needs of ELFT service users when accessing mainstream services. ELFT will partner with local charity initiatives to innovate and deliver healthy weight services within ELFT.

6.3 Staff will encourage and support service users to take an interest in their diet and lifestyle, and to make healthy and appropriate dietary choices. In conjunction, staff will use the shared nutrition guidance available, will make onward referrals to ELFT public health initiatives as well as signposting accessible local services, and will encourage participation in exercise programmes.

6.4 ELFT will promote staff wellbeing through embedding practices to enable healthy workplace environments, such as providing access to healthy foods (in vending machines for example) and healthy eating resources.

6.5 Healthy eating programmes will be developed by the nutrition steering group with the support of dietitians to address population-specific needs in the context of mental and community health. Delivery of programmes will depend on workforce capacity. ELFT will work with local initiatives and support staff to offer consistent and targeted healthy eating messages for populations at risk of premature death, including prevention of orthorexia and escalation to eating disorder, and healthy eating in forensics and learning disability settings.

6.6 ELFT will aim to identify external partners including local council and charity initiatives to deliver specialist / tailored nutrition and cookery programmes beneficial for specific population groups to promote long-term independence with nutrition.

**7**  **Catering**

It is the aspiration of the nutrition steering committee that dietary therapeutic menus will be presented according to nutritional need consistently across the trust, namely, ‘healthy eating’ and ‘nutrition support’ menus. This will permit service users to have access to dietary options which prevent harm and promote health according to clinical condition. At the time of writing this policy, there are different practices for menu ordering across the trust, and varied input from service users. In attempt to standardise practice, the following measures are recommended.

7.1 Catering services will provide ‘healthy eating’ and ‘nutrition support’ menus, food, and drinks, and will clearly demarcate therapeutic options available. This could include the development of traffic light label systems as well as visual symbols to support service users to make therapeutic dietary choices.

7.2 Staff involved in supporting service users to order from the menu will complete nutrition training on nutrition screening and care planning as well as menu ordering, and support service users to make therapeutic menu choices promoting their health according to clinical nutrition need.

7.3 In specific settings, staff will offer service users the ‘healthy diet’ menu options by default unless service users are identified as requiring ‘nutrition support’ following nutrition screening. The ‘nutrition support’ menu will be the default menu on eating disorder and older adult units.

7.4 Staff will be trained to order special and therapeutic diet menu options including religious/cultural diets eg Kosher/Halal, texture modifications, food allergies or restrictive diets eg renal and will liaise with catering and the dietitian as required. Catering services will offer 3 choices daily according to recommended standardsxxi, and ensure that special diets are presented in an appetising manner. In eating disorder settings, special meal plans may already be advised by dietitians.

7.5 Where possible, menus will be available to order online no more than 48hr before service provision, filter as ‘healthy diet’ or ‘nutrition support’, in accessible/pictorial format, and coded to link to the ingredients list and nutrition information. Assistance to read and interpret the menus will be given to service users and relatives as required. Out of hours meal provision will be available in the event of missed meals related to clinical events.

7.6 As part of a subgroup of the NSG, dietitians, catering managers, experts by experience, people participation leads and service leads will meet regularly to ensure nutritional standards are met, and regularly evaluate service provision together, including food plate waste and service user feedback. Orders will be recorded by staff online to support audit and service improvement, and will incorporate nutrition outcomes.

7.7 In community settings, dietitians and dietetic support workers will offer bespoke training on meeting nutritional requirements for care providers who provide catering services as required.

7.8 Service users who lack the capacity to make appropriate meal or food choices, especially when they have special dietary requirements; will be supported to make choices in their best interests, based on their known preferences, nutritional requirements and input from relatives if available. Easy-read capacity assessments pertaining to healthy eating choices will be available on the intranet.

7.9 Service users will have protected mealtimes from clinical intervention to permit them adequate time to complete their meals, and respect their privacy and dignity whilst eating. Units/wards will facilitate an environment which promotes good nutritional intake and social interaction which is locally agreed. Two volunteers per meal are invited to eat with service users to promote sociable mealtimes and improve dietary intake as appropriate and as is available through catering services in some settings. Service users are invited to engage in meal service as suitable to promote service user dietary outcomes eg laying the table in partnership with local charity input.

7.10 Partnerships with charities and non-profit parties, including bodies collecting surplus food or delivering cooking and healthy eating programming, will be project managed by a member of staff allocated by service managers. The project manager will ensure that food surplus will be donated to named local charities or beneficiaries as is feasible and locally agreed, account for costs, ensure staff training on food handling and safety is up to date, and manage partnerships.

7.11 Current menus, ordering guidelines and further information can be found on the intranet and in the Catering Specifications (reference policy)

7.12 Catering and contract managers will liase with service managers to agree local protocols and polices regarding service users and relatives bringing food from external environments into kitchens and clinical spaces. In inpatient settings with contracted catering service, food from external sources will not enter ward kitchens which are classed as controlled areas. In eating disorder settings, relatives and carers may be permitted to bring food into units to promote family mealtimes and may have specific meal plans. Service managers in long-stay settings will develop local protocols pertaining to take-away ordering with the support of the NSG to promote healthy dietary choices and a safe environment for service users, stipulating portion-size, frequency, and quality rating. Service users will be discouraged from ordering take-aways, and this will be discussed on admission and recorded.

**8** **Staff Training**

8.1 Multiple stakeholders, including members of the nutrition steering group, will collaboratively identify who requires nutrition training, develop the training, and support with training delivery as resource allows. Essential online training will be available on the ELFT Learning Academy Platform, and it is the responsibility of the service leads to ensure staff compliance.

8.2 The nutrition steering group will be responsible for the delivery and audit of core nutrition training for staff throughout the trust, namely the ‘Nutrition Screening and Nutrition Care Planning’ module.

8.3 Additional nutrition training modules will be available for staff to complete, including ‘Eating Disorders’ and ‘Healthy Eating’.

8.4 Nutrition and Dietetics resources should be available for staff on the intranet, including screening, referrals and monitoring resources, as well as diet sheets and signposting to other services for service users. Dietitians routinely review and update resources.

8.5 It is the aspiration of the nutrition steering group that care providers in the community will receive consistent nutrition training with adequate resource becomes available.

8.6 Nutrition training will be available online for all staff, and in-person on request and dependent on service needs. Nutrition training will be rolled out according to clinical priority and provision of dietetic cover.

**9** **Identification of Stakeholders**

**9.1** **Nutrition Steering Group (NSG)**

9.1.1 The NSG will meet regularly to discuss, advise on and campaign for matters of nutrition and hydration throughout the trust, and will provide a forum for proactive development and dissemination of pertinent strategies, policies, guidelines and protocols. This group is recommended by the British Association of Parenteral and Enteral Nutrition (2010)xxii.

9.1.2 The NSG will report into the Physical Health working group, and partner with bodies internal and external to the trust. The group will be led by medical and dietetic leads, and other key stakeholders and members will contribute to discussion and service development. These include Service Managers, Catering and Estates leads, Support Staff including Housekeepers, Allied Health Professionals, Specialist Nurses, Pharmacists, champions from each directorate, people participation leads, experts by experience, and the Safety Advisory Group.

9.1.3 The NSG will map and identify service risk gaps and workforce development, lead on nutrition training and professional development, and act as an expert reference group.

9.1.4 The NSG shall meet quarterly, and more frequently as required. Quorum shall be at least five from across three professional groups. Committee members will review the Terms of Reference routinely.

**10**  **Monitoring Compliance**

10.1 Members of the NSG will work together to ensure that all aspects of the Nutrition Policy are implemented, monitored and updated. Quality Improvement approaches will be used to support improvement strategies.

10.2 Annual audits will be undertaken so that the ELFT may be assured that service users are receiving adequate and cost-effective nutrition. Programmes may include:

-User satisfaction surveys

-Audit of nutrition screening practice and dietetics referral practice

-Risk register review of safe workforce

-Nutritional analysis of the menus and comparison with nutrient based targets

-Audit of service user food orders and uptake

-Appropriate administration of enteral feeding

-Evaluation of tier 2 weight management programming

10.3 Service managers will take an active role in monitoring nutritional standards working closely with catering staff, dietitians and nursing staff.

10.4 The Nutrition policy will be reviewed yearly from the date of issue.

**11** **Green Agenda**

Clauses below are extracted from the Net Zero team statement of intent which are pertinent to nutrition and hydration services within ELFT:

11.1 Reducing food related emissions in our services and in our communities means exploring the content of our diet, distance travelled, the impact of the food industry, plastics, packaging, processing, and waste.

11.2 The accessibility of cheap, healthy foods is a major determinant of health yet many in our communities face food poverty and are making painful decisions everyday about how best to use limited resources.

11.3 Globally, the reliance on meat eating has led to increased emissions from industrial farming, deforestation, and soil erosion. It is clear that a diet that includes more plant-based foods and fewer animal source foods has both a lower environmental impact and greater health benefits, reducing the risks of heart and lung disease, obesity, diabetes, dementia, and cancers and preventing millions of premature adult deaths per year.

11.4 In the NHS, the Hospital Food Review will consider sustainability and the impact of the whole supply chain, including sustainable procurement and waste. New national standards due from NHS England and NHS Improvement may include ensuring suppliers have sustainable production and transportation practices, and source locally and seasonally.

11.5 Food growing initiatives such as community orchards, allotments, and urban farms are abundant in our communities from Stepney City Farm to Cody Dock to Growing Communities’ Patchwork Farm. Each creates opportunities for local communities to come together, and a lasting connection to the natural world, as well as better mental and physical health.

11.6 We will approach local community initiatives with humility to help us educate and inform on food, farming, and nutrition. We will work with suppliers to increase our plant based offer to inpatients, to reduce waste from catering, and to eliminate plastic packaging. We will install water fountains at our inpatient sites. We will map the community provision of food growing initiatives and explore links with our health navigators.

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