patient PERSPECTIVE

SERVICE IMPROVEMENT CASE STUDY: SUPPORT AT MEALTIMES 2026

The case study highlights the mealtime support schemes, examining in detail the following:-

- the scope and provision of mealtime support schemes
- training and guidance for staff and/or volunteers
- nutrition and hydration initiatives
- dignity, privacy and patient experienced and
- measuring effectiveness

Contents

Executive Summary

This analysis examines responses to Question 14 of the National Inpatient Survey 2024: "Did you get enough help from staff to eat your meals?" The question provides an important indicator of whether patients who need assistance at mealtimes receive timely, appropriate and dignified support during their hospital stay.

To better understand what may be supporting stronger performance, Patient Perspective submitted an FOI request to 27 trusts that scored above the national average for this question. The request explored the schemes, roles, training, governance arrangements and improvement initiatives in place to support patients who need help to eat and drink while in hospital.

Approach

The Care Quality Commission National Inpatient Survey included 131 NHS trusts in England, covering patients aged 16 and over who had an overnight stay, excluding maternity and psychiatric admissions. This analysis focuses on Question 14: *"Did you get enough help from staff to eat your meals?"* Trusts were selected where their score for Question 14 was above the national average score of 8.0. A purposive sample of 27 trusts was selected for Freedom of Information requests to explore a range of approaches to mealtime support in greater detail.

This approach was intended to identify trusts with comparatively stronger patient-reported performance on mealtime support and explore the schemes, roles, training and governance arrangements that may support stronger patient-reported experiences. Patient Perspective submitted an FOI request to 27 trusts that met this criterion, of which 24 responded (89% response rate).

Responses were analysed thematically across six areas:

1. Mealtime support schemes and roles.
2. Scope and coverage.
3. Training and guidance.
4. Nutrition and hydration initiatives.
5. Dignity, privacy and companionship.
6. Monitoring and evaluation.

Findings were interpreted alongside published National Inpatient Survey results to identify common features among comparatively higher-scoring trusts.

Headline findings

- All responding trusts described arrangements to support patients at mealtimes, although the consistency, reliability and formalisation of support varied considerably.
- Support is often focused on specific wards or patient groups, meaning some patients — particularly those with less obvious or "hidden" needs — may not receive the help they need.
- Volunteers and non-clinical roles, such as dining buddies, dining companions, housekeepers and hostesses, are widely used to increase capacity and provide companionship. However, role boundaries vary between trusts.
- Training is widespread but not consistently structured. Stronger models use competency-based training, including dysphagia and IDDSI awareness, safe feeding and escalation.
- Nutrition and hydration initiatives, such as MUST screening, hydration schemes and improvement weeks, are generally well embedded. The gap is often in the practical, person-centred mealtime support around them.
- Dignity and experience are prominent themes, including protected or supportive mealtimes, environmental preparation and family involvement, but implementation maturity varies.
- Measurement and governance arrangements exist, including audits, PLACE, FFT and PALS feedback, but outcome measurement and clear KPIs for "mealtime help" are underdeveloped in many trusts.

What good looks like

Common features of stronger models include:

- Clear identification of patients who need help, such as red tray or red lid systems and bedside prompts, linked to clear action.
- Defined roles and workflows for staff and volunteers, including boundaries, supervision and escalation.
- Structured, competency-based training for staff and volunteers, including dysphagia awareness and safe feeding principles.
- Dignity-focused delivery, including protected or supportive mealtimes, environmental preparation and social dining where appropriate.
- Governance that triangulates audit, patient feedback and external measures, such as PLACE, with clear ownership for improvement.

Recommended actions

While no single model guarantees stronger patient experience scores, the findings identify several recurring features associated with more developed approaches to mealtime support;

- Standardise a trust-wide mealtime support framework that defines minimum expectations for identification, roles, escalation and documentation.
- Strengthen training and competency sign-off for anyone supporting patients to eat, including staff and volunteers, aligned to dysphagia, IDDSI and safeguarding requirements.
- Improve reliability on wards by building mealtime support into daily routines, including briefings, handovers, protected or supportive mealtimes and environment checks.
- Develop clearer measures of effectiveness, including process KPIs and patient experience indicators, and use them routinely within governance.
- Scale and support volunteer and companionship roles where safe and appropriate, with consistent supervision and feedback mechanisms.

1. Introduction

This report focuses on Question 14 of the National Inpatient Survey 2024: *"Did you get enough help from staff to eat your meals?"* This question provides an important indication of whether patients who require assistance at mealtimes receive the practical, timely and dignified support they need while in hospital.

Ensuring that patients receive safe, timely and appropriate support at mealtimes is a fundamental component of high-quality care within acute NHS hospitals.

Mealtime support schemes — often delivered through roles such as dining companions, mealtime assistants, volunteers and ward-based support staff — aim to ensure that patients who cannot eat or drink independently still receive safe, timely and dignified support.

These schemes typically involve assistance with meal preparation, such as opening packaging and positioning food within reach, as well as direct feeding support where appropriate, encouragement to eat and drink, and the creation of a calm, dignified eating environment.

The importance of structured mealtime support is well established. Poor nutrition and hydration are associated with increased risk of complications, including delayed wound healing, infections, falls and longer hospital stays. Patients who require assistance to eat are particularly vulnerable to malnutrition if support is not consistently available. In busy ward environments, competing clinical priorities can unintentionally lead to missed or

interrupted meals, making formalised mealtime support roles a critical safeguard to ensure that nutritional needs are not overlooked.

Beyond clinical risk, mealtimes are also a key aspect of patient experience. They provide an opportunity to promote dignity, independence and social interaction. Patients consistently report that having the time, help and encouragement to eat improves both their physical wellbeing and overall hospital experience. Initiatives such as protected mealtimes, dining companions and volunteer-led support schemes contribute to a more person-centred approach, helping to ensure that patients are not rushed, interrupted or left unsupported.

For hospitals, the benefits of effective mealtime support schemes are multifaceted:

- Improved clinical outcomes – Adequate nutrition and hydration support recovery, reduce complications and can contribute to shorter lengths of stay (NICE, 2017; BAPEN, 2021).
- Enhanced patient safety – Appropriate support for patients with swallowing difficulties or mobility limitations reduces the risk of aspiration and choking (NICE, 2017).
- Better patient experience and satisfaction – Aligns with findings from the National Inpatient Survey, which highlights the importance of receiving help to eat and drink when needed.
- Operational efficiency – Preventing deterioration associated with malnutrition and dehydration can help reduce avoidable demand on clinical services (BAPEN, 2021).
- Workforce optimisation – Trained volunteers and mealtime assistants support nursing teams, releasing staff time while maintaining quality standards (The King's Fund, 2021).
- Regulatory alignment – Supports compliance with Care Quality Commission (CQC) regulations relating to nutrition, hydration, dignity and person-centred care (CQC, 2022).

In the context of increasing patient acuity and workforce pressures across the NHS, mealtime support schemes represent a practical and scalable intervention that can deliver both quality and efficiency benefits. They are increasingly recognised as an important component of trust-wide strategies to improve nutrition, patient experience and overall standards of care (NHS England, 2023).[1]

- [1]BAPEN (2021). *Introduction to Malnutrition: Identification, Screening and Management.* British Association for Parenteral and Enteral Nutrition.
- Care Quality Commission (CQC) (2022). *Fundamental Standards – Regulation 14: Meeting Nutritional and Hydration Needs.*
- NHS England (2023). *Nutrition and Hydration Programme: Improving Mealtimes and Patient Safety.*
- NICE (2017). *Nutrition Support for Adults: Oral Nutrition Support, Enteral Tube Feeding and Parenteral Nutrition (CG32).*
- The King's Fund (2021). *The Courage of Compassion: Supporting Nurses and Midwives.*

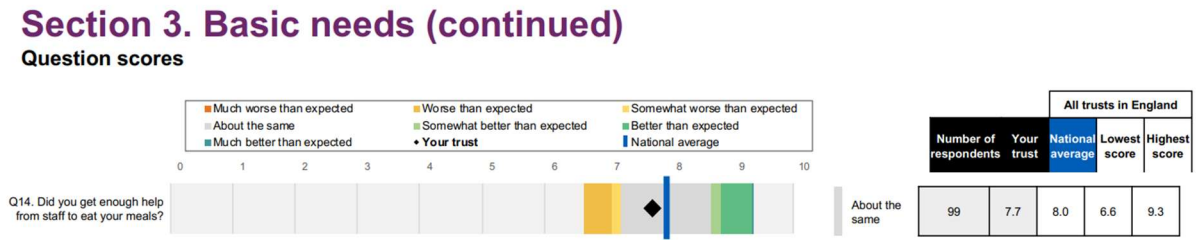
2. Freedom of Information request

Patient Perspective[2] submitted a Freedom of Information (FOI)[3] request to 27 NHS Trusts across England. The purpose of this request was to gather information from NHS trusts about good practice relating to mealtime support for patients.

Patient Perspective are an approved contractor for the National Patient Survey Programme and produce case studies based on the projects, initiatives and service improvements trusts have undertaken to bring about change.

2.1 Objectives of the FOI Request

The FOI sought to identify examples of practice, policies, and service improvements for trusts scoring above the National average for Question 14 in the National Inpatient Survey 2024 - Did you get enough help from staff to eat your meals? [4]



The FOI aimed to gather information for trusts in the following areas:

1. Mealtime support schemes
2. The scope of setting e.g. wards and patient groups
3. Training and guidance provided to staff and or volunteers
4. Nutrition and hydration initiatives
5. Dignity, privacy and companionship actions
6. How effectiveness is measured

[2] Patient Perspective https://patientperspective.org/
[3] https://www.whatdotheyknow.com/select_authority
[4] https://www.cqc.org.uk/survey/19

2.2 Methodology

Of the 27 Trusts contacted, 24 responded to the FOI request (see Appendix 1 and 2). The information received has been analysed and organised into thematic sections based on the focus areas listed above. Examples of practice are provided as Trust-Specific Findings and Main Themes Identified, with overall summaries drawn from all trust respondents.

In addition to general information, several Trusts provided detailed examples of service developments and innovative approaches in their responses. These examples have been selected and included as case studies to illustrate best practice and highlight replicable models of care in Section 4 :

- Royal Berkshire NHS Foundation Trust
- Lancashire & South Cumbria NHS Foundation Trust
- North West Anglia NHS Foundation Trust
- Worcestershire Acute Hospitals NHS Trust

3. Summarised responses and analysis of FOI Questions

3.1 Mealtime support schemes and roles

Mealtime support roles are important because they help ensure patients who cannot eat or drink independently still receive timely, safe and dignified support. Across trusts, these roles range from routine ward-based support by nurses and HCAs to more structured models involving volunteers, housekeepers, nutrition assistants, mealtime companions, dining buddies, carers and specialist facilitators. The strongest responses show that mealtime support is treated as more than a catering task: it is linked to nutrition, hydration, dignity, patient experience and safety. At the same time, there is clear variation in how formalised these roles are, how widely they are available, and whether they are delivered by staff only or by a blended workforce.

3.1.2 Trust Specific Findings

RHW describes a formal volunteer mealtime support model. Trained volunteers are linked to specific wards and help with meal distribution, cutting up food, opening packaging, handwashing, meal choice and, for selected patients, eating and drinking support. The trust also notes that both volunteers and non-clinical staff can be trained under a policy-governed model.

RFF does not describe a specific mealtime support role. Instead, it has introduced a mealtime process to improve safety, formalising the responsibilities of ward staff and hostesses.

RNN reports no formal mealtime support scheme, with support embedded in day-to-day ward care. Patients receive support from ward teams according to need, including help with eating and drinking, positioning, supervision and encouragement.

RWP describes a highly structured mealtime support model. This includes a red tray system, supported mealtimes, visitor/carer involvement and volunteer roles. Volunteers can help with meals and, where trained, may support assisted feeding. The trust also has a specific volunteer guide covering expectations, activities and competencies.

RTG describes a broad blended workforce model. Roles include hostesses, modern housekeepers, ward nutrition assistants, mealtime volunteers, sixth-form students, college placement students and palliative care volunteers. Support ranges from meal service and environment preparation through to encouragement, intake monitoring and feeding support for patients on normal diets and fluids.

RXC relies on clinical staff and carers/families, rather than specific mealtime support roles. Nurses, allied health professionals and clinical support workers provide support, and family/carer input is encouraged. Individualised care plans are used for patients with dementia, learning disability or communication needs.

RJC describes support as being provided mostly by the nursing team, with a local "Tea for 2" approach on frailty and care of elderly wards. Volunteers also provide some support.

ROB reports a formal mealtime support model delivered by registered nurses, HCAs and volunteers. The description is brief, but it indicates a blended workforce approach.

RWE identifies a more specialist role through Meaningful Activity Facilitators, who support patients with dementia and delirium, including nutrition and hydration where needed. The trust also has mealtime assistance volunteers. This is notable because the mealtime support role is linked to cognitive support and therapeutic activity.

RET describes support through HCAs and registered nurses, with patients encouraged to lunch together in a communal day space for social interaction and easier supervision. The trust also references red tray/red jug systems and mealtime coordinators. This combines supervision, safety and social dining.

RVR presents a catering-clinical interface model. Catering staff support menu choice, including use of pictorial menus and meal planners for families/carers, while nursing staff assist patients who are confused, have learning disabilities, dysphagia or physical limitations. The trust is also exploring ward-level mealtime volunteers, with dietetic and SALT-led training planned.

RTD describes a staff-and-volunteer support model. Nursing staff assess nutritional needs, while volunteers assist with opening packages, delivering trays, conversation and encouragement. Volunteers are explicitly not used for feeding or clinical tasks, with all activity overseen by nursing staff.

RGN reports a strategic shift from Protected Mealtimes to Supportive Mealtimes. The role emphasis is less on named posts and more on a patient-centred model that involves carers and relatives in mealtime support where appropriate.

RXL relies on housekeepers alongside the nursing team, with support from family/carers and alignment with John's Campaign. There are no further formal or informal mealtime support schemes described.

RWY describes Nutritional Support Volunteers who help with eating, drinking, prompting and food/fluid intake, alongside healthcare, nutrition support and nursing staff. A competency framework is being developed.

RRF has Mealtime Companions developed by the volunteer team. Volunteers are trained by the nutrition team and work to set competencies. Staff across wards also follow mealtime standards, and coloured cutlery/plates are used to identify patients needing support.

RH5 reports Mealtime Companion volunteers across the organisation. They do not feed patients but bring meals out, cut food up and collect trays. HCAs and volunteers both undertake the role, while housekeeping staff dish up food.

RW5 describes a Dining Buddy Volunteer role in addition to care-planned 1:1 staff support where required. Volunteers receive basic NHS training and additional ward-specific preparation.

RM3 gives a brief response indicating Dining Companion roles, but with no further detail on duties, staffing or structure.

RYR says there is no formal mealtime support scheme, but patients needing support are assisted by HCAs or nursing staff. A red tray system is used, protected mealtimes are maintained where possible, and visitors/carers are welcomed to assist patients.

RR7 describes informal support that varies between wards, delivered by ward staff, HCAs and volunteers.

RJN has Ward Helper volunteers on adult wards who help with meals, such as giving out meals and opening packaging. Volunteers are not yet trained to feed patients, though feeding training is planned. Family and friends are encouraged to attend mealtimes where helpful, and ward staff support patients identified through the red lid scheme.

RFS reports 6 ward volunteers and 3 ward companion roles. These roles help ensure meals are in reach, offer drinks and provide companionship.

RK9 Patient feeding assistance is delivered by healthcare assistants or registered carers. The trust has no formal mealtime-support volunteering scheme, although *Rehab Legend* volunteers may help by cutting up food and encouraging patients to eat and drink.

3.1.3 Main Theme identified

1. Wide variation in the formality of mealtime support roles

Some trusts have formal, named roles such as Mealtime Companions, Dining Buddies, Ward Helpers or Nutrition Assistants, while others rely on routine ward care without a specific scheme. This shows that mealtime support is recognised across trusts, but not always formalised.

2. Blended workforce models are common in stronger responses

The more developed responses tend to use a combination of staff and volunteers, and sometimes include housekeepers, hostesses, students or specialist support staff. Trusts such as RTG, RWP, ROB, RH5, RWY and RRF illustrate this blended model clearly.

3. Volunteers are a major feature of mealtime support

Volunteers appear repeatedly across the dataset. Their roles commonly include:

- opening packaging
- cutting up food
- helping with drinks
- encouraging intake
- companionship
- tray setup and meal access

In some trusts, volunteers also support assisted feeding where trained and authorised.

4. Practical support is the dominant function

Across most trusts, the most common role functions are practical and enabling rather than clinical. These include helping patients access food, setting up trays, monitoring that meals are within reach, and providing encouragement. This suggests that many trusts see mealtime roles to improve reliability and timeliness of basic support.

5. Role boundaries matter

Several trusts make clear distinctions about what volunteers can and cannot do. For example, some allow trained volunteers to assist feeding, while others restrict them to non-feeding tasks. This highlights an important theme of scope of practice, supervision and safety.

6. Carer and family involvement is part of the mealtime support model

Several trusts explicitly include carers and relatives in mealtime support, either as part of social dining or to help patients who benefit from familiar support. This is visible in trusts such as RWP, RXC, RGN, RXL, RYR and RJN.

7. Support is often targeted to vulnerable groups

Some of the strongest examples are aimed at patients with dementia, delirium, frailty, learning disability, physical limitations, or nutritional risk.

RWE is particularly notable for linking mealtime support to dementia/delirium roles, while RJC and RW5 also indicate targeted support for older or frail groups.

8. Process-led models exist alongside role-led models

Not every trust improves mealtime support by creating new roles. Some, such as RFF, RNN and RYR, rely more on formalised ward processes, handovers and staff responsibilities. This suggests two broad approaches: creating dedicated roles or improving reliability within existing teams.

9. Higher-maturity models combine role clarity, training and coordination

The strongest responses tend to include:

- named roles
- training or competency requirements
- clear supervision/escalation
- links to broader mealtime systems such as red trays, supported mealtimes or social dining

RWP, RTG, RRF and RWY stand out particularly strongly on this basis.

10. Consistency is still a likely issue

Some trusts explicitly state that support varies by ward or is embedded in routine care, which suggests that patients' access to mealtime support may depend on local staffing, volunteer availability or ward practice.

The data show movement in 2024/25 toward broader, coordinated frameworks that combine patient-centred flexibility with visible safety systems such as Red Tray or Red Lid indicators.

3.1.4 Overall Findings

Across the dataset, all trusts recognise the importance of mealtime support, but the way this is operationalised varies significantly.

- A spectrum of delivery models is evident:
    - Formal, role-based models (e.g. RWP, RTG, RWY, RRF, RH5)
    - Blended workforce approaches combining staff, volunteers and support roles
    - Process-led models embedded within routine ward care (e.g. RFF, RNN, RYR)

    - Informal or variable models dependent on ward practice (e.g. RR7)
- Volunteers are a major feature of many schemes, particularly in higher-performing or more developed models. Their contribution is primarily focused on enabling access to meals, improving timeliness and providing companionship, rather than clinical feeding.
- Targeted support for vulnerable groups (e.g. dementia, frailty, learning disability) is present in stronger responses, often linked to more specialist or integrated roles.
- There is increasing evidence of integration with wider mealtime systems, including:
    - Red tray/red lid schemes
    - Supported or protected mealtimes
    - Social dining approaches
    - Individualised care planning
- However, consistency remains a challenge, with several trusts indicating that support varies by ward, staffing levels or volunteer availability.

Overall, the findings suggest that while baseline support is in place across all trusts, the maturity of delivery ranges from basic provision to structured, coordinated and patient-centred models.

Strengths

- Strong recognition of mealtime support as a core element of safe, person-centred care
- Widespread use of blended workforce models (staff, volunteers, support roles)
- Established volunteer roles enhancing capacity and patient experience
- Increasing clarity of role boundaries and supervision in more developed models

Gaps

- Variation in how roles are formalised and defined
- Inconsistent integration of roles into routine ward processes
- Dependence on local ward practice or volunteer availability

Risks

- Variation in role definition and delivery may affect consistency of support
- Less formalised models may reduce reliability
- Differences in supervision and boundaries may affect type and level of support

3.1.5 Key Insight

Effective models are defined by how well roles are integrated, trained and coordinated, rather than the presence of roles alone.

3.2 The scope of setting e.g. wards and patient groups

The scope of mealtime support provision is a critical factor in determining how equitably and consistently patients receive help with eating and drinking. While most trusts recognise the importance of mealtime support, there is significant variation in whether provision is delivered across all inpatient wards, limited to selected areas, or targeted towards specific patient groups such as those with frailty, dementia or complex needs. The extent of coverage influences both patient safety and experience, particularly for those at risk of malnutrition or dehydration.

3.2.1 Trust Specific Findings

RHW Not explicitly stated, but volunteers are linked to specific wards, indicating a localised rather than trust-wide model.

RFF Not clearly defined. Implied that provision is embedded within ward processes, but no explicit scope described.

RNN Mealtime and nutrition/hydration support is provided across all inpatient areas as part of routine care planning. This represents a trust-wide embedded model.

RWP The mealtime guideline applies to all adult inpatient wards, indicating a standardised, trust-wide approach.

RTG Not explicitly stated in scope response eg selected wards, but role descriptions (hostesses, nutrition assistants, volunteers) suggest multi-ward or selected ward deployment, particularly where specialist roles exist.

RXC Provision is limited to selected wards only, indicating a targeted approach.

ROB Support is provided across all adult inpatient wards, with additional specialist input from the delirium and dementia outreach team. This reflects a trust-wide model with targeted specialist support.

RWE Provision is across all adult inpatient wards, indicating a comprehensive model.

RET Support is available across all adult inpatient wards, supported by structured systems such as red trays and mealtime coordinators.

RVR Provision covers all adult and paediatric inpatient wards, representing one of the most comprehensive scopes described.

RTD Support is available across all adult and paediatric inpatient areas, indicating a fully inclusive model.

RGN Structured volunteer support is provided across selected wards, with named ward coverage. Additional support is available via ED volunteers and roaming roles, suggesting a hybrid model.

RXL Scope is not explicitly defined. Evidence suggests a general ward-based approach, supported by housekeepers and carers.

RWY Volunteer support has been introduced on selected pilot wards, with potential for expansion. This is a developing model.

RRF Support is provided across all adult inpatient wards, with additional pilot activity on specific wards. This reflects a trust-wide model with targeted enhancements.

RH5 Mealtime support is available across all adult inpatient wards, with specific wards listed. This is a fully implemented trust-wide model.

RW5 Support is provided across all adult, specialist and older adult wards, with additional targeted volunteer roles on older adult wards. This is a combined universal and targeted model.

RYR Not explicitly stated, but implies a general ward-based approach supported by staff, with systems such as red trays.

RR7 Support is provided on selected wards and for specific patient groups (e.g. frailty, dementia), indicating a targeted model.

RJN Support is available across all adult inpatient wards, indicating a trust-wide approach.

RFS Evidence indicates ward-based volunteer roles, suggesting a localised or selected ward model, rather than universal coverage.

RK9 Mealtime support is provided on all wards where assistance is required. In 2024/25 the trust piloted a volunteer role on Health Care of the Elderly wards (notably, Ward), signalling early expansion toward a formalised scheme.

3.2.2 Main Theme identified

1. Variation in scope is a key feature across trusts

There is significant variation in how widely mealtime support is delivered. Some trusts provide support across all inpatient wards, while others limit provision to selected wards or pilot areas, or target specific patient groups.

2. Trust-wide provision is common but not universal

Several trusts report comprehensive, trust-wide coverage, particularly where mealtime support is embedded in routine care processes rather than reliant on specific roles.

Examples include:

- RNN, RWP, ROB, RWE, RET, RVR, RTD, RH5, RJN

These models suggest that mealtime support is treated as a core element of inpatient care.

3. Targeted models focus on high-risk patient groups

Some trusts prioritise support for:

- older people
- frailty pathways
- dementia
- patients requiring feeding assistance

Examples include: RXC, RR7, RW5, RGN This reflects a risk-based approach, focusing resources where need is greatest.

4. Hybrid models combine universal and targeted support

A number of trusts combine:

- baseline support across all wards, with
- enhanced support in high-need areas

Examples include:

- ROB (trust-wide + dementia team)
- RRF (trust-wide + pilot ward activity)
- RW5 (all wards + dining buddy roles for older adults)
- RGN (selected wards + wider volunteer presence)

5. Volunteer-led models

Volunteer participation is widening but often ward-specific and competency-based, reflecting both safety assurance and resource limits.

Examples include:

- RHW, RWY, RGN, RFS

This introduces potential variability in coverage with some trusts planning to extend after evaluation.

6. Emerging and developing models are evident

Some trusts describe:

- pilot schemes
- phased roll-out
- competency frameworks under development

This suggests that scope is expanding over time, but not yet fully embedded.

7. Lack of clarity in some responses

Several trusts do not explicitly define scope, making it difficult to determine:

- whether support is consistent across all wards
- or dependent on local practice

3.2.3 Overall Findings

Most trusts provide some level of mealtime support. Over 80 % of participating trusts reference organised support either across all inpatient areas or defined high-need wards.

Scope is influenced by patient acuity and workforce availability. Trusts with large volunteer cohorts (RH5) or dedicated mealtime coordinators (RGN) achieve broader reach; smaller sites adopt selective or pilot approaches.

Targeting vulnerable groups (frailty, dementia, stroke) is common. This shows responsiveness to nutritional risk but may inadvertently exclude patients with hidden needs on other wards.

Mealtime support is present across all trusts; however, its scope and consistency vary significantly.

Strengths

- Mealtime support present across all trusts
- Many organisations provide trust-wide coverage
- Increasing use of hybrid models (universal + targeted support)
- Growing focus on high-risk patient groups

Gaps

- Variation in whether support is trust-wide or targeted
- Limited clarity in scope in some responses
- Pilot or developing models not yet fully scaled

Risks

- Variation in scope may affect access to support
- Patients with less visible needs may not be consistently identified
- Availability may vary across wards and services

3.2.4 Key Insight

Trusts with the most effective models demonstrate that mealtime support is available wherever it is needed, supported by consistent processes and workforce alignment

3.3 Training and guidance provide to staff and volunteers

Training and guidance on mealtime support are central to ensuring that patients receive effective, safe, and dignified assistance at mealtimes. Approaches vary across trusts—from structured competency-based frameworks to local induction and awareness sessions—but most include teaching on the importance of nutrition, hydration, communication, safe feeding and recognition of swallowing difficulties.

Many organisations have now embedded dysphagia awareness and safe-feeding elements into mandatory training, reflecting rising awareness of aspiration risks and the clinical significance of oral intake. Stronger programmes also extend to volunteer preparation, combining theoretical modules, supervised practice and signed competency assessment before volunteers' support patients independently.

3.3.1Trust-Specific Findings

RHW Comprehensive volunteer training is delivered by the Lead Practice Development Nurse and Voluntary Services Manager before any practical involvement. It covers nutrition and hydration principles, communication skills, choking recognition, patient eligibility criteria, and supervised assessment. Volunteers must successfully complete induction and competency sign-off prior to independent mealtime support.

RFF Mandatory face-to-face *Dysphagia Screen Training* for nurses includes swallowing assessment, IDDSI levels and risk identification. An e-learning package aligned to the *RCSLT Eating and Drinking Competency Framework* (levels 1–2) is being implemented trust-wide. Additional modules address communication between ward staff and hostesses to clarify patient dietary needs.

RNN All healthcare support workers complete training through the *Care Certificate* and local *Care Induction Programme*, which cover fluids, nutrition, hydration, food safety and identification of swallowing problems. Practical sessions include use of thickening agents, positioning, distraction reduction and escalation of dysphagia concerns.

RWP Extensive multi-disciplinary training offer. A *Safe Feeding* module forms part of HCA induction and is accessible to volunteers. Broader programmes include

Nutrition Champions Days, MUST training, tube-care and refeeding-syndrome training, and mandatory Dysphagia Awareness for all patient-facing staff. Catering staff complete Food Safety Level 2, allergen and Natasha's Law training on a three-year cycle.

RTG Comprehensive technical programme encompassing ward-based MUST training, dysphagia tasting sessions for hostess teams, parenteral and enteral feeding training, IDDSI competencies for stroke nurses, and Food Safety Level 2 for catering and ward staff. Non-catering personnel receive a *Food Hygiene Awareness Leaflet*; volunteers access similar materials.

RXC Provides Dysphagia Training Levels 1–2, combining theoretical and practical components on assisting people with swallowing difficulties.

RJC Nursing staff undertake swallow-assessment training and refer to speech and Language Therapy (SALT) where indicated.

ROB Comprehensive essentials covering basic food hygiene, allergy awareness, and detailed swallow-safety instruction. Ongoing *monthly dysphagia training* forms part of the *New-to-Care programme* and includes IDDSI modifications. Enhanced training for stroke specialists and AHPs supports nurse-led screens. Trust also delivers structured *Mouth Care* training linked to nutrition and hydration, set to become mandatory for ward staff by 2026/27.

RWE Applies formalised curricula for housekeepers and clinical teams, including *UHL Nutrition Training for Housekeepers* and materials from the Nutrition and Hydration Action Group (N&HAG). Training integrates dignity, safe feeding and communication components.

RET SALT-delivered dysphagia face-to-face training is mandatory for all clinical staff, supported by e-learning on dysphagia, nutrition and hydration. Focuses on texture-modified diets, safe consistency, and recognition of aspiration risk.

RVR Comprehensive competency framework encompassing theoretical and practical induction for catering and clinical staff. Includes Food Safety Level 2, Dietetics and Nutrition modules, equality and safeguarding training, and dementia and autism awareness (Oliver McGowan training). Protected Mealtimes policy reinforces clinical responsibility for assistance with swallowing or feeding.

RTD Jointly developed training from Nursing, Dietetic and SLT teams for all staff and volunteers. Modules cover assessment, hydration awareness and documentation. Volunteers receive additional local induction and supervised practice.

RGN Tiered volunteer training model: *Basic Mealtime Support* (table preparation, tray access) and *SALT-Enhanced Support* (safe feeding under competency supervision). All receive mandatory induction on infection control, dignity and safeguarding, plus nutrition

guidance and a signed competence assessment. Volunteers complete Dementia Friends or Advanced Dementia Awareness accreditation.

RXL Awareness training for housekeepers covers menu items, food presentation and use of thickening agents. Staff induction includes dignity and feeding support and malnutrition recognition. Delivered flexibly by local experts.

RWY Clinical educators deliver nutrition/hydration education in specialist areas, supported by live dashboards (NG tube training and audits). A structured *nutritional assistance competency* for volunteers and staff is under development.

RRF Highly developed dual training pathway. Volunteers complete assisted-feeding training using competency booklets and three ward-based assessments signed off by a registered nurse. Staff access Nutrition and Hydration courses (covering mouth care, dysphagia, fluid balance). All registered nurses receive swallow-safety training; housekeepers complete Food Safety Level 1 e-learning.

RH5 All volunteers complete mandatory training. Discussions are underway to extend scope to assisted feeding competencies.

RW5 Mandatory dysphagia e-learning added in 2025 for all inpatient staff. Complemented by a ward-level dysphagia resource file, food-hygiene (Level 1–2) and MUST training, plus dietetic and SLT guidance via *FLAGS resources*.

RM3 Volunteer dining companions receive training in nutrition, hydration, communication and safe feeding assistance.

RYR Comprehensive, induction-embedded education. HCSWs complete *Care Certificate* units on nutrition, hydration and safe feeding; registered nurses receive nutrition training during degree programmes. Induction covers mealtime positioning, hand hygiene, dignity, volunteer roles, dehydration recognition and related care-planning skills.

RR7 Structured curriculum for staff and volunteers comprising dignity and person-centred care, safe feeding techniques, dysphagia recognition and SALT guidance on texture-modified diets. Local ward induction and competency assessments ensure safety and consistency.

RJN Training emphasises safe practical support, dementia sensitivity and escalation. The *Be Aware to Care* programme for Bands 2–3 covers thickened fluids, fluid balance recording, communication and mouth care. For registered staff, the multiprofessional education programme builds knowledge of MUST, diabetes and mental-capacity principles.

RFS All staff complete a mandatory one-hour *Food Allergies and Food Hygiene Awareness* e-learning package (based on *Natasha's Law*). Additional training includes care-certificate and apprenticeship competencies on healthy eating, special diets, dignity and privacy at mealtimes. Dysphagia and NG-tube elements appear in supplementary SALT teaching.

RK9 Housekeepers receive Dementia Awareness training. Volunteers in the pilot mealtime-support role completed *Food Hygiene* and *Dementia Awareness* courses alongside standard mandatory training. Ward staff receive dysphagia and IDDSI guidance via Speech and Language Therapists for patients requiring swallow assessment or texture-modified diets.

3.3.2 Main Themes Identified

1. Training is widely recognised but varies in depth

Almost all trusts provide some form of training; however, this ranges from:

- basic induction to comprehensive competency frameworks

2. Strong emphasis on dysphagia and patient safety

Many trusts include:

- dysphagia awareness
- swallowing assessment
- IDDSI compliance
- escalation processes

This reflects the high-risk nature of feeding support.

3. Multidisciplinary training is a key feature of stronger models

Higher maturity trusts involve:

- Speech and Language Therapy (SALT)
- Dietitians
- Nursing teams

This ensures holistic and safe care delivery.

4. Volunteer training is increasingly formalised

Where volunteers are used, stronger models include:

- competency assessments
- structured induction
- supervised practice

However, variation remains in:

- whether volunteers can assist feeding
- how competency is assessed

5. Mandatory training is not universal

Some trusts mandate:

- dysphagia training
- nutrition and hydration training

Others rely on:

- optional or ad hoc training

6. Training is often embedded in wider programmes

Many trusts integrate mealtime training into:

- Care Certificate
- induction programmes
- professional development pathways

7. Emerging competency frameworks

Several trusts describe:

- new competency frameworks
- standardisation efforts

This indicates a shift towards more structured approaches.

3.3.4 Overall Findings

Training and guidance for mealtime support are widely present but inconsistently structured across trusts.

Strengths

- Strong recognition of training as essential
- Widespread inclusion of nutrition, hydration and dysphagia awareness
- Increasing multidisciplinary input (SALT, dietetics, nursing)
- Development of structured and competency-based approaches in stronger models

Gaps

- Variation in depth and structure of training

- Inconsistent use of formal competency frameworks
- Differences in training between staff and volunteers
- Not all key training is consistently mandated

Risks

- Variation in training may affect staff confidence and competence
- Inconsistent competency frameworks may reduce assurance
- Differences in training may affect consistency of support

3.3.5 Key Insight

High-performing trusts demonstrate structured, competency-based training aligned to patient safety requirements.

3.4 Nutrition and hydration initiatives

Nutrition and hydration initiatives form a core component of safe, high-quality inpatient care. Ensuring patients receive adequate food and fluid intake supports recovery, reduces complications and improves overall patient experience. Appendix 4

Nutrition and hydration initiatives are widely implemented across trusts, but the level of coordination, visibility and strategic intent varies. While all trusts describe some form of activity, the strongest approaches demonstrate a structured, multi-layered model combining awareness campaigns, routine monitoring, targeted interventions and staff engagement.

A consistent finding is the widespread use of Nutrition and Hydration Week as a focal point for improvement activity. Many trusts use this as an annual opportunity to promote hydration, improve patient engagement and raise staff awareness through themed events, enhanced menus and ward-based activities. However, in some organisations this appears to function primarily as a standalone awareness campaign, whereas in higher-performing models it is embedded within a broader, year-round strategy.

3.4.1 Trust Specifics

RFF Implements practical ward-level initiatives including:

- Variety of menus to support intake
- Hydration initiatives (traffic light jugs, hydration stations)

- Mealtime Matters process
- Red tray / red jug pathway

RNN Highly developed programme including:

- Mealtime Experience Audits
- "Snack & Snooze" initiative (evening nutrition to support sleep and reduce falls)
- Nutrition Champions network
- Structured improvement framework (Six-Step Mealtime Check)
- Continuous audit and feedback loops

RWP Very similar to RNN (shared model), including:

- Mealtime Experience Audits
- Snack & Snooze
- Nutrition Champions
- Structured improvement framework

RTG Wide range of initiatives including:

- Nutrition & Hydration Week campaigns
- Visual menus for patients with cognitive impairment
- Hydration prompts (e.g. coloured jug lids, screensavers)
- Adaptive equipment (cutlery, trays)
- Protected mealtimes
- Safety initiatives (e.g. eating and drinking with acknowledged risk process)
- PSIRF-linked improvement programme

RXC Limited detail provided, but includes:

- Nutrition and Hydration Week activities
- Work on adaptive cutlery and equipment

RJC Initiatives include:

- Participation in Nutrition & Hydration Week
- Hydration improvement via coloured jug systems
- Adaptation for visually impaired patients (coloured beakers)

ROB Extensive programme including:

- Annual Nutrition & Hydration Clinical Improvement Plan
- Dysphagia menu development
- Milkshake rounds
- Nutrition screening and referral processes
- Mouth Care Matters initiative

- SALT-led improvements and FEES provision
- Nutrition and hydration awareness campaigns

RWE Initiatives include:

- MUST (Malnutrition Universal Screening Tool) project
- "7 drinks a day" hydration monitoring
- Fundamentals of Care strategy
- Red tray processes

RET Includes:

- Nutrition & Hydration Week
- Food and Drink Scheme
- Nutrition bulletins
- Switch to decaffeinated tea (hydration-focused)
- Training-linked initiatives

RVR Implements:

- Malnutrition Awareness Week
- Nutrition & Hydration Week
- Milkshake and snack rounds
- Patient education ("food first" principles)
- Afternoon tea initiatives

RTD Highly structured approach including:

- Dietitian-led menu development
- Specialised snack menus (including dysphagia)
- Visual identification systems (red lids, bedside prompts)
- Hydration monitoring systems
- Dementia-friendly food boxes
- Finger food menus

RGN System-focused initiatives including:

- Standardised pantry boards
- Red tray/red lid systems
- Standardised bedside boards
- Clear communication of dietary needs and risks

RXL Focus on:

- MUST compliance and malnutrition identification
- Dysphagia pathway improvements

- Referral to dietetics

RWY Developing structured model including:

- Nutritional support volunteers
- Food diaries
- MUST compliance monitoring (>80%)
- Hydration assessment compliance
- Dashboard monitoring
- Targeted improvement via audit

RH5 Initiatives include:

- Volunteer companionship at mealtimes
- Additional support to improve patient experience

RW5 Comprehensive programme including:

- Nutrition & Hydration Strategy
- Recruitment of specialist staff (dietitians, SALT)
- Hydration stations
- Electronic menu systems
- Menu improvements (portion size, themed meals)

RM3 Includes:

- Nutrition & hydration hub
- Staff resources and guidance
- Fluid balance training
- Audit and feedback mechanisms

RYR Includes:

- Protected mealtimes
- Red tray system
- Carer Passport (family involvement)

RR7 Comprehensive practical approach including:

- Protected mealtimes
- Red tray/red jug system
- Hydration rounds
- MUST screening
- Dysphagia compliance
- Volunteer support
- Fortified diets and supplements

- Monitoring charts

RJN Extensive programme including:

- Nutrition & Hydration Strategy
- Hydration risk scoring
- Menu improvements aligned to national standards
- Protected mealtimes
- Red lid system
- Ward-level QI projects

RFS Limited detail provided, but evidence of:

- Structured mealtime support roles
- Likely linkage to broader nutrition initiatives

RK9 Piloted Mealtime support role#

- MUST monthly nutritional screening audits with results reported on dietetics dashboard.

3.4.2 Main Themes Identified

1. Wide range of initiatives across trusts

Trusts implement a diverse mix of:

- campaigns
- screening tools
- menu adaptations
- monitoring systems
- staff education

2. Screening and identification systems are central

Common systems include:

- MUST assessments
- red tray/red lid systems
- hydration monitoring

3. Increasing use of structured improvement programmes

Stronger trusts demonstrate:

- audit-driven improvement

- formal frameworks (e.g. Six-Step Check)
- continuous feedback mechanisms

4. Patient-centred adaptations are common

Examples include:

- finger foods
- dementia-friendly meals
- visual menus
- adapted equipment

5. Hydration is a key focus area

Initiatives include:

- hydration stations
- jug systems
- monitoring compliance
- hydration rounds

6. Awareness campaigns support engagement

Many trusts participate in:

- Nutrition & Hydration Week
- Malnutrition Awareness Week

7. Governance and strategy vary significantly

Some trusts have:

- formal strategies
- steering groups
- improvement plans

Others rely on:

- local initiatives or ward-level activity

3.4.3 Overall Findings

Nutrition and hydration initiatives are well established across trusts, but vary in structure, scale and integration.

Strengths

- Well-established systems (e.g. MUST, hydration monitoring)
- Strong alignment with national guidance
- Increasing use of patient-centred approaches
- Evidence of structured improvement programmes and innovation

Gaps

- Variation in how initiatives are implemented across wards
- Limited linkage between systems and practical mealtime support
- Inconsistent visibility of outcomes

Risks

- Variation in implementation may affect consistency of impact
- Opportunities to optimise nutrition may not be fully realised
- Limited outcome visibility may reduce improvement focus

3.4.4 Key Insight

There is also evidence of practical, patient-facing interventions aimed at improving intake. These include:

- enhanced or varied menus to support choice and nutritional needs
- structured hydration support (for example, drink rounds or hydration prompts)
- targeted support for patients at risk of poor intake

The most developed approaches move beyond one-off initiatives and demonstrate continuous, system-wide focus on nutrition and hydration, supported by audit, staff training and patient-centred interventions.

3.5 Dignity, privacy and companionship actions

Mealtimes represent a key opportunity to promote dignity, independence and patient experience. Beyond nutrition, the way care is delivered—through environment, interaction, privacy and support—has a direct impact on how patients perceive their care. Trusts have implemented a range of approaches to improve mealtime dignity, including protected mealtimes, environmental improvements, companionship models and patient-centred practices. However, the level of structure and consistency varies significantly. These approaches are particularly important for patients who are frail, cognitively impaired, or physically unable to eat independently.

Appendix 3 - How Mealtime Support Links Directly to Dignity.

3.5.1 Trust Specifics

RHW Builds on its volunteer model to support dignified mealtimes, with assistance focused on respectful interaction, maintaining privacy and enhancing the overall patient experience.

RFF Introduces care partners and promotes the use of communal dining spaces to enhance social interaction, independence and dignity at mealtimes.

RNN Implements a Trust-wide Protected Mealtime Policy to minimise interruptions and prioritise patient dignity, safety and focused support during meals.

RWP Uses Mealtime Experience Audits to identify improvements, resulting in targeted actions to strengthen privacy, reduce interruptions and improve patient-centred mealtime care.

RTG Provides designated dining areas on specific wards to support social dining, independence and a more dignified mealtime environment.

RXC Is updating its Protected Mealtime Policy to strengthen consistency, improve patient experience and reinforce dignity-focused practices.

RJC Applies protected mealtimes across all wards to ensure patients can eat without unnecessary disruption, supporting dignity and focused care.

ROB Has reviewed visiting arrangements to better support mealtime dignity, enabling appropriate family involvement while maintaining patient privacy.

RWE Uses volunteers to provide companionship and practical support at mealtimes, helping to improve patient experience and reduce isolation.

RET Maintains existing arrangements that ensure patients are positioned comfortably and supported appropriately, with a focus on maintaining dignity during meals.

RVR Provides culturally appropriate meal services alongside mealtime support, recognising dignity through personalised and inclusive care.

RTD Reinforces Protected Mealtime Policy implementation to reduce interruptions and ensure staff prioritise patient support and dignity.

RXL Promotes national campaigns such as John's Campaign and Sophie's Legacy to support family involvement and advocate for dignified, person-centred mealtime care.

RWY Uses volunteers to provide respectful, person-centred support, enhancing dignity and companionship during meals.

RRF Displays Protected Mealtime information across wards to reinforce expectations around minimising disruption and prioritising patient dignity.

RH5 Introduces volunteers to sit with patients during meals, providing companionship and reducing social isolation.

RW5 Operates Protected Mealtimes across all wards to support uninterrupted eating and promote dignity.

RM3 Extends open visiting hours to enable greater family presence, supporting companionship and patient choice at mealtimes.

RYR Implements ward-level processes to reduce interruptions during meals, ensuring patients can eat in a calm and dignified environment.

3.5.2 Main Themes Identified

1. Protected mealtimes remain the foundation. Most trusts rely on:

- Protected Mealtime policies
- Reduction of non-essential interruptions

Reinforcement of protected mealtimes as a core approach to maintaining dignity, including reducing non-essential interruptions and ensuring staff availability to support patients during meals. However, implementation varies in consistency and strength.

2. Increasing shift towards "Assisted" or "Supportive" mealtimes. Some trusts are evolving beyond protection to:

- active support models
- patient-centred approaches

3. Environmental preparation is critical. Key elements include:

- clean, uncluttered spaces
- appropriate table positioning
- preparation of the patient (hygiene, comfort)

Stronger models formalise this (e.g. Six-Step Check).

4. Companionship is an important but variable component. Ranges from informal (sitting with patients) to structured roles.

Provided through:

- volunteers
- staff
- family/carers

5. Family and carer involvement is increasingly recognised. Examples include:

- Carer passports
- Open visiting
- Encouraging support at mealtimes

Supports both nutrition and emotional wellbeing.

6. Structured protocols improve consistency. Some trusts use:

- checklists
- visual prompts
- standardised processes

These reduce variation and improve reliability of care.

7. Person-centred care is a recurring theme. Includes:

- respecting preferences
- cultural sensitivity
- supporting independence

8. Variation in maturity remains significant. Models range from:

- basic policy-led approaches
- to highly structured, audit-driven systems

3.5.3 Overall Findings

Dignity and patient experience are widely recognised as essential components of mealtime care, but delivery varies significantly across trusts.

Strengths

- Strong emphasis on dignity and patient-centred care
- Widespread use of protected/supportive mealtimes
- Increasing involvement of volunteers, families and carers
- Emerging structured approaches to environmental preparation

Gaps

- Variation in consistency of implementation across wards
- Reliance on policy without supporting processes in some areas
- Limited formalisation of companionship approaches

Risks

- Variation in delivery may affect patient experience
- Busy ward environments may impact consistency
- Differences in companionship support may affect experience

3.5.4 Key Insight

Trusts with the most effective models move beyond protected mealtimes alone, embedding dignity through structured processes, environmental preparation, companionship and patient-centred care.

3.6 How effectiveness is monitored

Most organisations use a combination of formal audits (e.g. MUST, hydration, mealtime audits), patient experience data (FFT, complaints, PALS) and PLACE assessments to assess quality. More mature systems demonstrate structured oversight through steering groups, integrated dashboards and regular reporting cycles, whereas others rely on individual audit tools or feedback mechanisms without a clearly defined framework for continuous improvement.

3.6.1 Trust Specifics

RHW Monitoring includes PLACE assessments, ward-level mealtime supervision and reporting through a Nutrition Steering Committee. A dashboard tracking complaints and incidents has been developed to support oversight and improvement.

RFF A multi-source approach including FFT, Tendable audits, PLACE assessments, incident reviews (Datix/PSII) and training compliance monitoring. Learning is shared through governance processes.

RNN Highly structured governance framework. Nutrition and hydration are reviewed through a monthly Nutrition and Hydration Steering Group and Fundamentals of Care Committee. Monitoring includes patient feedback (PALS, complaints), PLACE assessments and mealtime audits supported by Patient Public Forum representatives.

RWP Formal governance through Nutrition and Hydration Steering Group and Fundamentals of Care Committee. Monitoring includes audits, patient feedback, and evaluation of initiatives through structured reporting and improvement cycles.

RTG Measurement linked to audit and patient safety processes, including review of incidents, fluid balance documentation and nutrition-related audits aligned to governance and improvement programmes.

RXC Primarily feedback-driven approach, with monitoring through PALS comments and complaints, which are reviewed and acted upon where necessary.

RJC Combination of PLACE audits, mealtime audits led by hotel services, patient feedback tools (e.g. "I Want Great Care") and nursing documentation audits related to nutrition.

ROB Comprehensive audit and feedback model including bespoke surveys, matron mealtime audits, FFT, PLACE, Healthwatch surveys and SALT-led audits. Additional monitoring includes mouth care audits and patient/carer experience surveys.

RWE Monitoring includes nutrition audits, PLACE assessments and nursing metrics dashboards (MEG system), providing structured oversight of nutrition and hydration performance.

RET Measurement through PLACE assessments, Tendable audits, catering surveys, QR-code patient feedback and wider patient experience data.

RVR Uses patient feedback (digital and paper), point-of-service audits and external benchmarking (PLACE and CQC assessments) to evaluate mealtime support.

RTD Monitoring aligned to nutrition and hydration audits and governance processes, including review of patient feedback and documentation.

RGN Monitoring supported by structured volunteer activity data, audit processes and reporting through governance frameworks, alongside patient experience feedback.

RXL Combination of PLACE inspections, trust accreditation reviews, MUST audits and nutrition/hydration audits, alongside FFT, complaints and national survey feedback.

RWY Daily audits and live dashboards monitor hydration assessments, MUST compliance and NG tube training. Patient experience data (FFT, CQC surveys, PALS) informs improvement work.

RRF Protected mealtime audits (six-monthly), volunteer feedback through PEEG committee, PLACE assessments and nutrition/hydration group oversight.

RH5 Monitoring through complaints, PALS, FFT and Care Opinions feedback.

RW5 Monthly audit programme with action planning, supported by PLACE assessments, ward accreditation and review by the Nutrition and Hydration Group. Includes patient feedback and targeted audits (e.g. dysphagia awareness).

RM3 Monitoring includes patient feedback, nutrition audits, incident reporting (Datix), hydration monitoring and inpatient accreditation assessments.

RYR Performance monitored through fundamental care audits, dashboards, peer review, PLACE assessments and regular nutrition/hydration audits, including weekly patient sampling.

RR7 Comprehensive approach including patient feedback, nutrition audits (MUST, food/fluid charts), hydration monitoring, complaints analysis, PLACE assessments and ward-level observational checks.

RJN Monitoring includes patient food surveys, MUST and hydration audits, ward accreditation processes and oversight via the Nutrition and Hydration Steering Group.

RFS Measurement through training compliance, audit processes and feedback mechanisms aligned to nutrition and hydration standards.

RK9 Monitoring includes PLACE and PLACE Light assessments, ward food service audits, FFT, Experience of Care Week and PALS complaints. MUST audits are completed monthly with results reported via a dietetics dashboard.

3.6.2 Main Themes Identified

1. Monitoring is widely present but varies in maturity. All trusts demonstrate some level of monitoring, but approaches range from:

- basic feedback mechanisms
- to comprehensive, multi-layered governance frameworks

2. Audit and governance structures are key in stronger models. Higher maturity trusts utilise:

- steering groups
- formal committees

- regular audit cycles

These provide systematic oversight and accountability.

3. Patient feedback is a central component. Common sources include:

- FFT
- complaints and PALS
- bespoke surveys
- real-time feedback tools

This ensures the patient voice informs improvement.

4. External benchmarking is widely used. Most trusts participate in:

- PLACE assessments

This provides:

- independent validation
- comparative benchmarking

5. Increasing use of data and dashboards. Some trusts demonstrate:

- real-time monitoring
- performance dashboards
- compliance tracking

Indicating a shift towards data-driven improvement.

6. Link between monitoring and improvement is stronger in mature models

In higher-performing trusts:

- audit findings lead directly to:
    - policy updates
    - new initiatives
    - training improvements

7. Variation in consistency and standardisation. Not all trusts:

- define clear KPIs
- measure outcomes consistently

- demonstrate impact of initiatives

8. Multidisciplinary involvement strengthens monitoring. Effective models include input from:

- nursing
- dietetics
- SALT
- patient experience teams

3.6.3 Overall Findings

Monitoring of mealtime support is widely established but inconsistently developed across trusts.

Strengths

- Strong use of audits, patient feedback and benchmarking (e.g. PLACE)
- Increasing integration into governance frameworks
- Emerging use of dashboards and data-driven approaches
- Multidisciplinary involvement in monitoring

Gaps

- Lack of standardised KPIs across trusts
- Limited use of outcome-based measures
- Variation in how monitoring informs improvement

Risks

- Variation in monitoring may reduce consistency of evaluation
- Limited outcome measurement may affect ability to demonstrate impact
- Differences in governance may affect learning and improvement

3.6.3 Key Insight

Trusts with the most effective models combine structured audit programmes, real-time patient feedback and strong governance frameworks to continuously monitor and improve mealtime support, while less mature models rely on fragmented or reactive approaches.

4. Case Studies

4.1 Volunteer Training for Mealtime Support - Royal Berkshire NHS Foundation Trust – Overview

Royal Berkshire NHS Foundation Trust has developed a structured training approach to support hospital volunteers as part of the wider healthcare team, with a clear focus on safe, dignified and person-centred mealtime support.

This model demonstrates how volunteers can be effectively integrated into clinical environments while maintaining clear boundaries and safety standards.

Key Components of Training

1. Importance of Nutrition and Hydration

Volunteers are trained to understand:

- The role of nutrition and hydration in recovery and wellbeing
- Risks associated with:
    - malnutrition
    - dehydration
- The importance of encouraging intake and timely support

Why this matters: It ensures volunteers recognise that mealtime support is a clinical priority, not just a practical task.

2. Communication Skills – Hints and Tips

Training includes:

- How to communicate clearly and compassionately with patients
- Supporting patients who may have:
    - cognitive impairment
    - hearing or communication difficulties
- Techniques for:

    - encouragement
    - reassurance
    - maintaining dignity

Why this matters: Effective communication is key to:

- improving intake
- reducing anxiety
- enhancing patient experience

3. Understanding the Role of the Volunteer

Volunteers are supported to:

- Understand their scope of practice
- Work alongside clinical staff
- Provide:
    - meal setup
    - encouragement
    - companionship

Clear boundaries are emphasised, including:

- when to seek support from nursing staff
- what tasks should not be undertaken

Why this matters: Ensures safe integration into the multidisciplinary team without role confusion.

4. Recognising and Responding to Choking

Training includes:

- Awareness of choking risks
- Recognising early warning signs
- Understanding when to:
    - stop
    - escalate immediately

Why this matters: Directly supports patient safety, particularly for:

- frail patients
- those with swallowing difficulties

5. Assessment and Next Steps

Volunteers are taught:

- How to identify when a patient may need:
    - additional help
    - reassessment
- When to escalate concerns to:
    - nursing staff
    - Speech and Language Therapy (via staff)

Why this matters:
Creates a safety net, ensuring patients do not miss support due to unclear responsibility.

Why This is Strong Practice

This training model demonstrates:

- Clear role definition (reduces risk)
- Focus on safety (dysphagia/choking awareness)
- Emphasis on communication and dignity
- Alignment with multidisciplinary working
- Support for volunteers as part of the care team

Link to FOI Findings

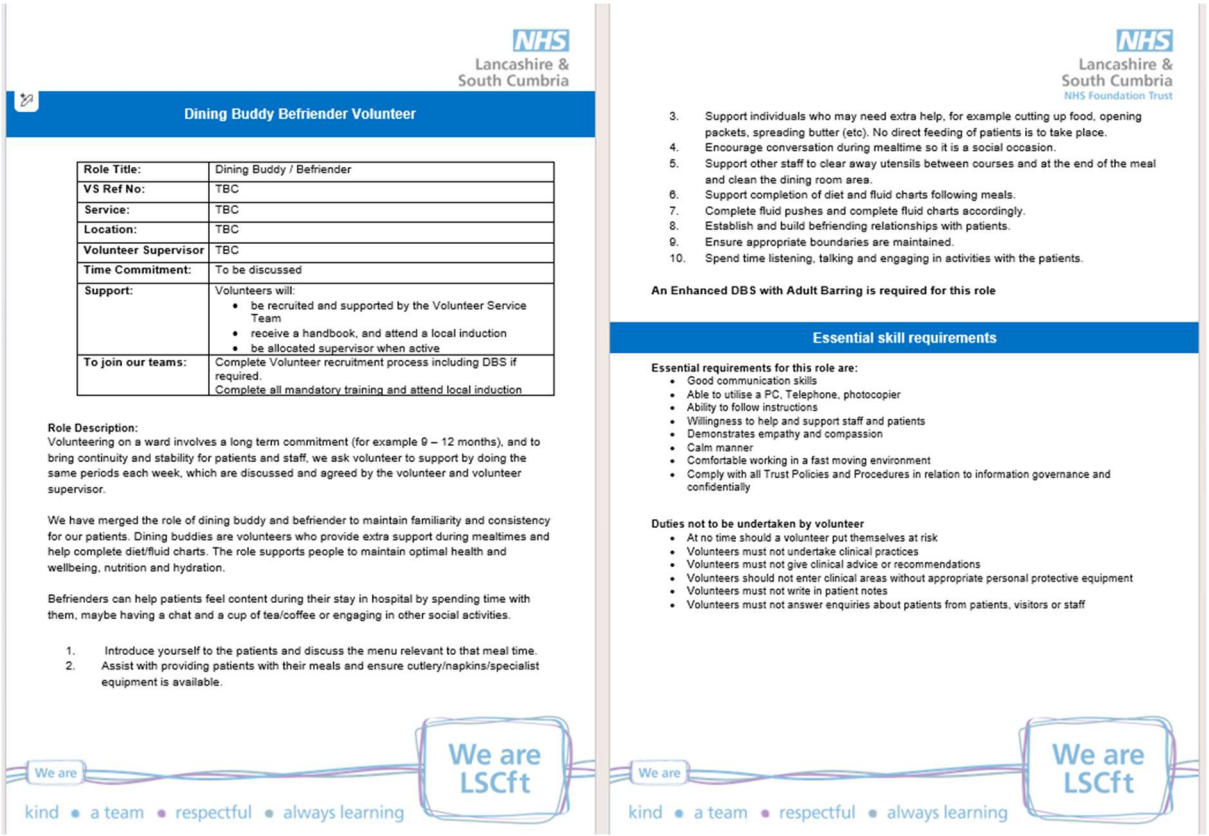
This example directly addresses key gaps identified in FOI responses:

FOI Finding	**How this Case Study Responds**
Variable training for volunteers	Provides structured, role-specific training
Limited clarity on safe feeding roles	Defines clear boundaries and escalation
Inconsistent dysphagia awareness	Includes choking recognition and response
Variation in dignity/communication approaches	Embeds communication skills in training

Royal Berkshire NHS Foundation Trust provides a strong example of structured volunteer training, combining practical support, communication skills and safety awareness. This approach supports safe delegation, improves patient experience and strengthens the role of volunteers within the multidisciplinary team.

4.2 Dining Buddy Befriender Role (Lancashire & South Cumbria NHS Foundation Trust

Lancashire & South Cumbria NHS Foundation Trust has implemented a Dining Buddy Befriender volunteer role to enhance mealtime experience, nutrition and companionship.



NHS
Lancashire & South Cumbria

Dining Buddy Befriender Volunteer

Role Title:	Dining Buddy / Befriender
VS Ref No:	TBC
Service:	TBC
Location:	TBC
Volunteer Supervisor	TBC
Time Commitment:	To be discussed
Support:	Volunteers will: • be recruited and supported by the Volunteer Service Team • receive a handbook, and attend a local induction • be allocated supervisor when active
To join our teams:	Complete Volunteer recruitment process including DBS if required. Complete all mandatory training and attend local induction

Role Description:
Volunteering on a ward involves a long term commitment (for example 9 – 12 months), and to bring continuity and stability for patients and staff, we ask volunteer to support by doing the same periods each week, which are discussed and agreed by the volunteer and volunteer supervisor.

We have merged the role of dining buddy and befriender to maintain familiarity and consistency for our patients. Dining buddies are volunteers who provide extra support during mealtimes and help complete diet/fluid charts. The role supports people to maintain optimal health and wellbeing, nutrition and hydration.

Befrienders can help patients feel content during their stay in hospital by spending time with them, maybe having a chat and a cup of tea/coffee or engaging in other social activities.

1. Introduce yourself to the patients and discuss the menu relevant to that meal time.
2. Assist with providing patients with their meals and ensure cutlery/napkins/specialist equipment is available.

We are kind • a team • respectful • always learning — We are LSCft

NHS
Lancashire & South Cumbria
NHS Foundation Trust

3. Support individuals who may need extra help, for example cutting up food, opening packets, spreading butter (etc). No direct feeding of patients is to take place.
4. Encourage conversation during mealtime so it is a social occasion.
5. Support other staff to clear away utensils between courses and at the end of the meal and clean the dining room area.
6. Support completion of diet and fluid charts following meals.
7. Complete fluid pushes and complete fluid charts accordingly.
8. Establish and build befriending relationships with patients.
9. Ensure appropriate boundaries are maintained.
10. Spend time listening, talking and engaging in activities with the patients.

An Enhanced DBS with Adult Barring is required for this role

Essential skill requirements

Essential requirements for this role are:
- Good communication skills
- Able to utilise a PC, Telephone, photocopier
- Ability to follow instructions
- Willingness to help and support staff and patients
- Demonstrates empathy and compassion
- Calm manner
- Comfortable working in a fast moving environment
- Comply with all Trust Policies and Procedures in relation to information governance and confidentially

Duties not to be undertaken by volunteer
- At no time should a volunteer put themselves at risk
- Volunteers must not undertake clinical practices
- Volunteers must not give clinical advice or recommendations
- Volunteers should not enter clinical areas without appropriate personal protective equipment
- Volunteers must not write in patient notes
- Volunteers must not answer enquiries about patients from patients, visitors or staff

We are kind • a team • respectful • always learning — We are LSCft

Role Purpose

- Provide additional support at mealtimes
- Help to promote nutrition, hydration and wellbeing
- Offer companionship and social interaction during meals
- Support patients to maintain independence where possible

Key Activities

- Supporting patients with practical tasks (opening packaging, cutting food)
- Assisting with drinks rounds and hydration support
- Encouraging conversation to make mealtimes a social occasion
- Helping clear trays and maintain a safe, clean environment
- Supporting completion of fluid charts and documentation (under supervision)
- Spending time talking and engaging with patients beyond task-based care

Boundaries and Safety

- No direct feeding of patients (unless trained and authorised)
- Volunteers must not undertake clinical tasks
- Clear escalation to ward staff for concerns
- Enhanced DBS and mandatory training required
- Supervision through Volunteer Services

Skills and Behaviours Expected

- Compassion, empathy and strong communication skills
- Ability to follow instructions and maintain confidentiality
- Calm, supportive approach in a busy ward environment

Why this is Strong Practice

- Embeds companionship as a core part of care, not just task completion
- Provides structured, safe volunteer contribution
- Supports continuity and relationship-building on wards
- Enhances nutrition, hydration and patient experience outcomes
- Complements wider systems (e.g. red trays, MUST, protected mealtimes)

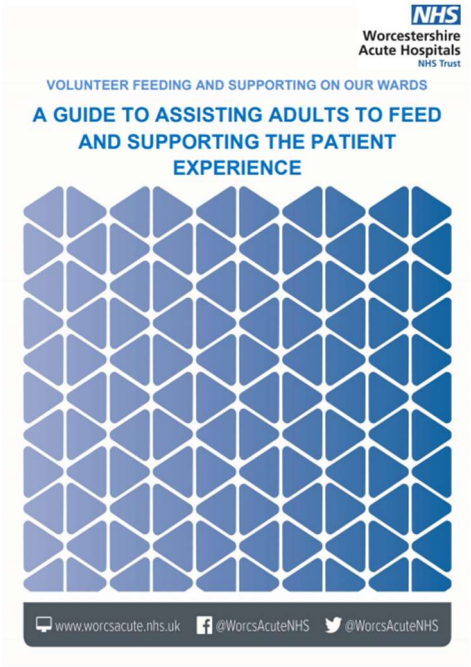
Mealtime Buddy roles are a high-impact, low-cost intervention that improve nutrition, patient experience and safety — particularly when combined with structured training, clear governance and visual identification systems.

Link to FOI findings:

This example addresses key gaps identified across Trusts, particularly variation in volunteer training, lack of clarity on roles and responsibilities, and inconsistent approaches to safety and communication.

4.3 Nutrition Champions - Worcestershire Acute Hospitals NHS Trust

Worcestershire Acute Hospitals NHS Trust has implemented a Nutrition Champions model to strengthen ownership of nutrition and hydration at ward level.



Key features:

- Network of trained Nutrition Champions across wards (HCAs, nurses, ward assistants)
- Champions act as a local point of contact for nutrition and hydration
- Lead ward-based improvement activities and awareness
- Support delivery of initiatives such as Nutrition & Hydration Week
- Provide practical expertise on MUST, mouth care, dysphagia awareness and food choices

Why this is strong practice:

- Embeds accountability at ward level
- Promotes culture change and sustained focus on nutrition
- Bridges gap between policy and day-to-day practice
- Supports multidisciplinary working and peer learning

Supporting Evidence: Volunteer Mealtime Support Guide

The Trust has developed a detailed Volunteer Feeding and Supporting Guide, providing clear, practical instruction on how volunteers support patients at mealtimes.

Key elements of the guide include:

- Assisting with meal distribution and drinks rounds (with clear escalation for thickened fluids)
- Supporting patients to make menu choices and encouraging independence
- Providing companionship (talking, reading, reassurance)
- Preparing the environment (clean tables, accessible refreshments)
- Supporting safe feeding where appropriate

- Promoting dignity (hand hygiene, clutter-free spaces)
- Escalating concerns to staff where required

The guide clearly defines role boundaries, stating that volunteers are not expected to undertake intimate or clinical procedures.

Why this strengthens practice:

- Clearly defines expectations for volunteers from recruitment stage
- Embeds safety (training + positioning) alongside dignity and experience
- Aligns volunteer role with ward processes and clinical oversight
- Supports consistency and reliability of mealtime support delivery

4.4 Competency Assessment Framework - North West Anglia NHS Foundation Trust

The Trust has implemented a formal competency and sign-off framework for Mealtime Support Volunteers, ensuring safe and standardised practice.

Key components of the competency sheet include:

1. Identifying patient needs

- Liaising with nursing staff to confirm suitability
- Checking diet type and fluid consistency (clear escalation to SALT/nursing for modified diets)
- Understanding level of support required (prompting vs full assistance)

2. Preparing the patient and environment

- Hand hygiene and introduction/consent
- Ensuring patient is positioned safely (upright)
- Supporting use of dentures, glasses, hearing aids
- Preparing a clean, appropriate eating environment

3. Safe mealtime delivery

- Checking correct meal and dietary requirements
- Supporting independence while providing appropriate assistance
- Encouraging intake at patient's pace
- Alternating food and drink and monitoring tolerance

4. Safety escalation and observation

- Recognising signs of distress or choking

- Clear instruction to stop and escalate to nursing staff immediately
- Observing and reporting poor intake

5. Post-meal care and documentation

- Reporting intake to nursing staff for recording
- Escalating concerns or difficulties

6. Boundaries and infection prevention

- Clear limits on role (no feeding for isolation or complex diets)
- Strict hand hygiene requirements
- Escalation for tasks outside competence

Why this is exemplar practice:

- Moves beyond informal volunteering to a competency-based workforce model
- Provides assurance around patient safety, governance and accountability
- Aligns with national expectations on safe feeding, dysphagia awareness and escalation
- Enables scalable and auditable volunteer programmes

Link to FOI findings: Addresses a key gap identified across Trusts — variation in training quality and competency assurance — demonstrating how structured competency sign-off improves both safety and patient experience outcomes.

PATIENT EXPERIENCE

NHS
North West Anglia
NHS Foundation Trust

Meal Time Support Volunteer

Performance Criteria, Observation and Competencies Record
Please fill in the relevant dates on the final page and return to Volunteer Office when completed and signed off

No	Performance Criteria	Date achieved
1) Identifying the patient and their needs		
a	Liaise with nursing staff to identify a suitable patient	
b	Check diet and fluid consistencies with nursing staff **and** have a look over the patient's bed for signs that say pureed diet, soft and bite size diet or thickened fluids. Do not assist patients on modified diets/fluids – nurses will look after them (SALT)	
c	Identify the level of support the patient requires (full assistance/hand-over-hand/prompting and encouragement)	
2) Meet the patient		
a	Wash your hands	
b	Introduce yourself to the patient and gain consent for feeding where appropriate	
c	Look at the patient's environment- clear and wipe down their table	
d	Ensure the patient is sitting fully upright (ask nursing staff to reposition if necessary)	
e	Check if the patient has their dentures in and glasses on as well as hearing aids where required	
f	Support the patient to wash their hands prior to eating and drinking (hand wipes will be available on the ward)	
g	Find a chair and position it beside your patient	
3) Getting their meal		
a	Ensure you have the right ticket for your patient (check the bay and bed number/room number)	
b	Check again from the ticket that your patient isn't on a dysphagia diet (pureed diet/soft and bite size diet). Do not assist patients on modified diets/fluids – nurses will look after them (SALT)	
4) Assisting your patient		
a	Check with the patient what level of support they would like (they may not be able to tell you verbally)	
b	Encourage as much independence as possible	
c	Provide active support for patients when they are consuming their food and drink according to their abilities	

d	Support patients to consume their food and drink in manageable quantities, at their own pace, and in a socially acceptable manner	
e	Remember to alternate between food and drinks	
f	Assist patients to clean themselves, if food or drink is spilt or dropped, during and at the end of the meal	
g	Observe and report to nursing staff when the patient's intake is poor	
h	Stop feeding if the patient shows any sign of distress or choking and report to nursing staff	
5) After their meal		
a	Check that the patient has finished their meal and emptied their mouth. Observe, record, and report the patient's intake of food and drink to the Nurse / HCA responsible for completing the patients' food/fluid record chart	
B	Return your chair from where you found it	
c	Report to nursing staff any concerns or difficulties	
6) Other		
a	When you have been in contact with a patient or their environment, each time you leave their room/bay you must wash your hands. You will need to wash them again on your return (e.g. if you need to leave to speak to a nurse/get an extra spoon etc.)	
b	If your patient is in isolation or infectious (there will be a notice outside their door) you must not feed them	
c	Seek support from ward staff when questions or issues are outside your competence to deal with	

Volunteer: (Print)		**Signature:**	
Assessor: (Print)		**Signature:**	
Workshop Date:		**Sign-Off Date:**	

Notes / Comments:

5.Conclusions

Mealtime support is now widely recognised as a core component of safe, dignified inpatient care across NHS trusts. This analysis confirms that all responding organisations have implemented some form of support; however, the consistency, structure and reliability of delivery remain variable.

While nutrition and hydration processes are generally well embedded, the practical delivery of mealtime assistance — particularly for patients who need help to eat — is not yet a universally reliable standard of care. This variation directly affects patient experience and aligns with ongoing differences seen in national survey results, including responses to Question 14 on receiving help with meals.

5.1 Key Findings

1. Mealtime support models are established but inconsistent
Most trusts operate structured or semi-structured models, including volunteer roles, staff-led support or blended approaches. However, level of formalisation, role clarity and integration into ward routines varies significantly, impacting reliability.

2. Access to support is not equitable across all patients
Only 58% of trusts provide support across all wards, with others relying on targeted or unclear provision. This creates a risk that patients with less visible or emerging needs may not receive timely assistance, leading to inequity in care.

3. Training is widespread but lacks standardisation and assurance
Although 71% of trusts report structured training, there is variation in depth, consistency and competency assessment, particularly for higher-risk activities such as feeding support. This introduces potential patient safety risks and variability in care quality.

4. **Nutrition and hydration systems are the most mature area**
Screening tools (e.g. MUST), monitoring processes and improvement initiatives are well established across trusts. However, there remains a disconnect between these systems and the consistent delivery of hands-on mealtime support.

5. Dignity and patient experience are prioritised but inconsistently delivered
83% of trusts demonstrate dignity-focused initiatives such as protected mealtimes, companionship and environmental improvements. However, implementation is variable, meaning patient experience is still dependent on ward-level practice.

6. Measurement frameworks lack outcome focus
Although 96% of trusts report some form of monitoring, this is largely based on audits and feedback rather than clear, standardised outcome measures. As a result, many organisations are unable to demonstrate the direct impact of mealtime support on patient outcomes or experience.

Overall Conclusion

The findings indicate that while intent, policy and supporting systems are well established, mealtime support is not yet delivered as a consistently reliable, person-centred intervention across all inpatient settings.

The most effective models demonstrate that high-quality mealtime care depends not on individual initiatives alone, but on the integration of clear roles, structured training, consistent processes and robust governance.

5.2 What Good Looks Like

High-performing trusts demonstrate that effective mealtime support is delivered through coordinated, system-wide approaches rather than isolated initiatives. These organisations consistently show:

- Clearly defined mealtime support roles (e.g. volunteers, champions, ward-based staff)
- Strong alignment between policy and ward-level delivery
- Consistent training, competency and supervision arrangements
- Integration of mealtime support within wider nutrition and hydration strategies
- A clear focus on dignity, safety and patient experience
- Structured mealtime protocols (e.g. step-based checks, environmental preparation)
- Well-supported volunteer programmes with defined roles and boundaries
- Standardised communication tools (e.g. bedside boards, visual identifiers)
- Strong governance through steering groups and multidisciplinary oversight
- Triangulated measurement using audit, patient feedback and external benchmarking

Key message:
High performance is achieved where mealtime support is treated as a core, reliable system of care, not a supplementary or variable activity.

5.3 Key Opportunities for Improvement

Across the system, the findings highlight four priority areas where trusts can strengthen the delivery of mealtime support:

1. Standardise Mealtime Support as Core Care

Move from targeted or variable provision towards consistent, trust-wide delivery, ensuring that all patients who require support are identified promptly and receive reliable assistance at mealtimes.

2. Strengthen Training and Competency Frameworks

Ensure that all staff and volunteers involved in mealtime support receive appropriate training and competency assessment in:

- feeding assistance
- dysphagia awareness
- safe escalation and risk management.

3. Improve Consistency of Delivery

Reduce reliance on:

- staffing variability
- informal ward-level processes

by embedding mealtime support within routine ward workflows, handovers and daily standards of care.

4. Develop Robust Measurement Frameworks

Introduce:

- defined KPIs for mealtime support
- outcome-based measures, including nutritional intake and patient experience
- benchmarking against national patient experience measures, including Question 14 of the National Adult Inpatient Survey.

Key message

Without consistent measurement and governance, trusts cannot reliably demonstrate improvement, identify variation or assess the impact of mealtime support initiatives.

Collectively, these actions provide a clear framework for trusts to move from variable provision towards a consistent, safe and patient-centred model of mealtime care. Ultimately, improving mealtime support is not solely a nutrition initiative, but a patient safety, dignity and experience priority.

Limitations

This analysis reflects self-reported information provided through Freedom of Information responses and was not independently validated on site. Inclusion was limited to trusts scoring above the national average for Question 14 and therefore does not represent all NHS trusts in England. The findings should therefore be interpreted as examples of current practice and emerging themes rather than evidence of direct causation between specific interventions and survey performance. The trusts included represent a purposive sample of higher-scoring organisations and were not intended to be statistically representative of all trusts scoring above the national average.

6. References

Reference 1

- [1]BAPEN (2021). *Introduction to Malnutrition: Identification, Screening and Management.* British Association for Parenteral and Enteral Nutrition.
- Care Quality Commission (CQC) (2022). *Fundamental Standards – Regulation 14: Meeting Nutritional and Hydration Needs.*
- NHS England (2023). *Nutrition and Hydration Programme: Improving Mealtimes and Patient Safety.*
- NICE (2017). *Nutrition Support for Adults: Oral Nutrition Support, Enteral Tube Feeding and Parenteral Nutrition (CG32).*
- The King's Fund (2021). *The Courage of Compassion: Supporting Nurses and Midwives.*

Reference 2 – Patient Perspective - NHS patient experience surveys Patient Perspective is an approved contractor for the National Patient Survey Programme and has been working with trusts for nearly 20 years. As part of our service, we have developed case studies of good practice. Case studies are based on the projects, initiatives and service improvements trusts have undertaken to bring about change.

The case studies aim to highlight and share examples of service improvements made due to several factors including poor scores, issues and themes highlighted by patients from the national surveys and often linked to feedback from patients from other methods of patient involvement.

Reference 3 – https://www.whatdotheyknow.com/select_authority

Reference 4 - Adult inpatient survey 2024 - Care Quality Commission

7. Appendices

Appendix 1 - Trust codes for responses

Trust Code	Trust Name
RFF	Barnsley Hospital NHS Foundation Trust
RXL	Blackpool Teaching Hospitals NHS Foundation Trust
RWY	Calderdale and Huddersfield NHS Foundation Trust
RFS	Chesterfield Royal Hospital NHS Foundation Trust
RJN	East Cheshire NHS Trust
RXC	East Sussex Healthcare NHS Trust
RVR	Epsom and St Helier University Hospitals NHS Trust
RR7	Gateshead Health NHS Foundation Trust
RW5	Lancashire & South Cumbria NHS Foundation Trust
RNN	North Cumbria Integrated Care NHS Foundation Trust
RGN	North West Anglia NHS Foundation Trust
RM3	Northern Care Alliance NHS Foundation Trust
RHW	Royal Berkshire NHS Foundation Trust
RH5	Somerset NHS Foundation Trust
R0B	South Tyneside and Sunderland NHS Foundation Trust
RJC	South Warwickshire University NHS Foundation Trust
RTD	The Newcastle upon Tyne Hospitals NHS Foundation Trust
RET	The Walton Centre NHS Foundation Trust
RTG	University Hospitals of Derby and Burton NHS Foundation Trust
RWE	University Hospitals of Leicester NHS Trust
RK9	University Hospitals Plymouth NHS Trust
RYR	University Hospitals Sussex NHS Foundation Trust
RWP	Worcestershire Acute Hospitals NHS Trust
RRF	Wrightington, Wigan and Leigh NHS Foundation Trust

Appendix 2 Trust-specific summary of FOI responses demonstrating processes in place

Trust code	Trust-specific position
RHW	Volunteer mealtime support on selected adult wards, targeted using the red tray system. Volunteers help distribute meals, open packaging, support feeding where appropriate, and are trained before deployment. Measurement includes PLACE, ward-level supervision, and mealtime service oversight.
RFF	No distinct mealtime support role, but a formal mealtime process has been introduced to improve safety. Stronger emphasis is on dysphagia screening, protected mealtimes, communal dining where appropriate, and care partner involvement. Effectiveness is tracked through FFT, Tendable, PLACE, complaints, incident themes and training compliance.
RNN	No formal named scheme, but mealtime support is embedded as routine ward-based care across inpatient areas. Strong training detail through Care Certificate, induction, food/nutrition teaching, dehydration and swallowing difficulty recognition. Also evidence of Protected Mealtime Policy, fluid-balance improvement work, and wider visiting hours to support family input.
RWP	One of the most developed responses. Has a clear Guideline for Good Practice at Mealtimes, red tray system, supported mealtimes, volunteer role guidance, and extensive training including safe feeding, MUST, dysphagia and nutrition support. Strong improvement activity via Mealtime Experience Audits, Six-Step Mealtime Check, and governance through steering groups and patient experience reporting.
RTG	Uses a mix of staff-based mealtime roles including hostesses, modern housekeepers and ward nutrition assistants. Evidence of ward-specific companionship features such as dining rooms and social initiatives. Strong focus on training around MUST and oral nutritional support, with effectiveness tracked through Nutrition and Hydration Steering Group, complaints and divisional reporting.
RXC	Mealtime help is mainly delivered by clinical staff, with encouragement for family/carer support. Not limited to one specialty, so support can be provided wherever needed. Dysphagia training is in place. The Trust is moving from Protected Mealtimes toward an Assisted Mealtimes Policy, suggesting a shift to more practical support-focused language.

Trust code	Trust-specific position
RJC	Support is mainly from the nursing team, with some volunteer contribution and local companionship-style activity such as "Tea for 2" on frailty/elderly wards. Protected mealtimes are in place. Measurement relies mainly on PLACE and mealtime audits.
ROB	Formal support delivered by ward staff and volunteers, with all adult inpatient wards covered and added input in dementia services. Includes food hygiene, allergy and swallowing-related training. Notable action is expanded visitor arrangements so families can help at mealtimes. Uses patient feedback and local experience mechanisms to assess impact.
RWE	Response highlights Meaningful Activity Facilitators supporting patients with dementia/delirium, including support around meals, alongside volunteers. Covers all adult inpatient wards. Nutrition and hydration are monitored through audits, PLACE and nursing metrics, but the mealtime role model is less clearly defined than in some other Trusts.
RET	Encourages patients to eat together in a communal day space where appropriate, with support from HCAs and RNs. Protected mealtimes remain in place. Stronger training detail around dysphagia, nutrition and hydration. Uses PLACE, surveys, Tendable and patient experience data.
RVR	One of the more comprehensive models. Covers adult and paediatric inpatient wards. Strong emphasis on culturally appropriate food, dignity, safe support, and a detailed training and competency framework for catering staff and others. Effectiveness is measured using patient feedback and multiple audit routes.
RTD	Patients are assessed by nursing staff for nutritional support needs, with staff and volunteers trained by nursing, dietetics and speech and language therapy. Protected mealtime principles have been reinforced. Broad ward coverage is described, but the response gives less detail on formal measurement, with Q6 effectively weak/unclear.
RGN	A very strong structured response. In 2024/25 the Trust moved from Protected Mealtimes to Supportive Mealtimes, introduced a Mealtime Champion role, standardised pantry boards/bedside boards, and used red tray/red lid systems across adult inpatient areas. Also has volunteer roles and clear sign-off/training processes. One of the strongest examples of system design and standardisation.

Trust code	Trust-specific position
RXL	Uses housekeepers plus support from ward staff and promotes John's Campaign / Sophie's Legacy to enable loved ones to support at mealtimes. Organisation-wide approach rather than a dedicated feeding-assistant model. Measured via PLACE, local inspections and patient feedback.
RWY	Has Nutritional Support Volunteers and staff support, with initial deployment on selected pilot wards. Volunteers assist with eating, drinking and prompting. Stronger focus on operational learning through daily audits, including hydration documentation issues. This looks like an evolving model with room to scale.
RRF	Has Mealtime Companions developed through the volunteer team, plus wider MDT support across wards. All adult inpatient wards provide support but assisted feeding volunteers are currently more of a pilot on one medical ward. Protected mealtime posters and six-monthly audits are in place.
RH5	Has a substantial volunteer presence with mealtime companion volunteers across sites and community settings, although volunteers do not feed patients directly. Coverage includes many adult wards. Notable addition is volunteers sitting with patients for companionship. Measurement includes complaints, PALS, FFT and Care Opinion.
RW5	Mental health setting response. Mealtime support is generally a core part of personalised ward care, with Dining Buddy volunteers on some older adult wards. Protected mealtimes and ward hosts are in place. Monthly audit and action plans suggest a structured monitoring approach.
RM3	Clear, simple model based on Dining Companion roles across all adult inpatient wards. Volunteer training covers nutrition, hydration, communication and feeding assistance. Open visiting hours help families support meals. Measurement includes patient feedback, nutrition audits and Datix review.
RYR	No formal scheme, but HCAs and nursing staff support patients as required, with a red tray system on selected wards. Training is included within HCSW induction. Dignity action is mainly around protecting meals from interruption. Monitoring uses audits and performance dashboards.

Trust code	Trust-specific position
RR7	Informal support model varying by ward, with staff, HCAs and volunteers involved. Focuses on selected wards and specific groups such as older people, frailty, stroke and dementia. Training includes dignity, person-centred care and patient choice. The response suggests strengthening protected mealtimes and expanding volunteers.
RJN	Uses Ward Helper volunteers on adult wards to support meal access, opening packaging and similar tasks. Supported by policy and dementia-related guidance. Mealtime and hydration policy has been reinforced. Measurement includes food surveys, MUST, hydration audits and ward accreditation audits.
RFS	Structured volunteer and companion model supporting mealtimes, focused on non-feeding tasks such as ensuring access to meals, opening packaging and offering drinks. Provision is targeted across adult inpatient wards, particularly frailty and stroke, with plans to expand companion roles. Training is centred on food hygiene and allergy awareness, with broader clinical training routes but limited specific focus on feeding or dysphagia at mealtimes. No additional initiatives beyond core provision, although Nutrition and Hydration Week is supported. Monitoring is embedded through ward accreditation, audits, patient feedback and PLACE assessments.
RK9	Primarily staff-led model, with feeding support delivered by HCAs or registered carers and no formal volunteer feeding role. Volunteers provide supplementary, non-clinical support such as encouraging intake and assisting with meal preparation, with a pilot mealtime support role introduced in 2024/25. Focus on supporting independence, with clear boundaries around feeding as a clinical task. Training includes food hygiene and dementia awareness, supported by red tray identification and SALT referral processes aligned to IDDSI guidance. Monitoring is well established through MUST audits, PLACE, audits, FFT and PALS feedback, with no additional new initiatives identified beyond the pilot.

Appendix 3: How Mealtime Support Links Directly to Dignity

Ensuring dignity at mealtimes is central to providing person-centred, compassionate care. Guidance from the Department of Health, NICE and the Care Quality Commission emphasises that patients should be supported to eat and drink in a manner that promotes independence, privacy, comfort and respect (Department of Health, 2009; NICE, 2017; CQC, 2022). Appendix 3

Practical examples below illustrate how structured mealtime support roles and ward practices can uphold these dignity principles.

1. Being able to eat independently (or with discreet support)

Dignity issue:
Patients report a loss of dignity when they are left unable to eat, rushed, or publicly assisted without sensitivity. Maintaining independence in eating—supported by timely, discreet help where needed—is a key element of dignified care (NICE, 2017; RCN, 2021).

Examples of dignity-linked practice:

- Mealtime companions who:
    - sit at eye level rather than stand over patients,
    - ask patients how they prefer to be helped, and
    - support independence first (e.g. cutting food, opening packaging).
- Staff or volunteers trained to offer help without assumption, particularly for people with frailty, stroke, Parkinson's disease or arthritis (Age UK, 2018).

How to reflect this in Section B:
Actions to support independence and choice at mealtimes, including discreet assistance with eating.

2. Privacy and environment at mealtimes

Dignity issue:
Eating while exposed, interrupted or in noisy/shared spaces undermines dignity and appetite. The CQC and NHS England advocate calm, comfortable mealtime environments with minimal interruptions (CQC, 2022; NHS England, 2023).

Examples of dignity-linked practice:

- Protected mealtimes with reduced clinical interruptions.
- Curtains drawn and personal care completed before food arrives.
- Patients supported to sit upright, wash hands and prepare comfortably.
- Dining areas used where possible rather than eating in bed.

FOI phrasing cue:
Actions taken to improve privacy and comfort during meals (e.g. protected mealtimes, reduced interruptions).

3. Choice, cultural respect and personal preferences

Dignity issue:
Dignity is compromised when patients cannot access food aligned with cultural, religious or personal preferences. NICE and the CQC stress that nutrition must reflect individual values and clinical requirements (NICE, 2017; CQC, 2022).

Examples of dignity-linked practice:

- Menus adapted for cultural, religious or dietary needs.
- Staff asking patients what and when they prefer to eat, where clinically appropriate.
- Support for patients who eat slowly, rather than removing trays prematurely.

FOI phrasing cue:
How cultural, religious and personal preferences are respected during mealtimes.

4. Companionship and human interaction

Dignity issue:
Eating alone when unwell or confused can feel dehumanising. The Dignity in Care framework and NHS volunteer guidance highlight the value of mealtime companions for reassurance and social connection (Department of Health, 2009; NHS England, 2023).

Examples of dignity-linked practice:

- Dining companions providing conversation and reassurance, not just feeding support.
- Volunteers trained to recognise loneliness, confusion or distress and report concerns to staff.

FOI phrasing cue:
Actions to provide companionship and social interaction during mealtimes.

5. Supporting people who need longer or repeated opportunities to eat

Dignity issue:
Removing trays too quickly or failing to offer alternatives can result in missed meals and embarrassment. NICE and BAPEN guidance recommend flexibility and encouragement for individuals who require longer to eat (NICE, 2017; BAPEN, 2021).

Examples of dignity-linked practice:

- Flexible meal or snack rounds for people who miss meals due to tests or fatigue.
- Red tray systems linked to active support rather than stigma.
- Hydration or snack trolleys offered respectfully and within reach.

FOI phrasing cue:
How the Trust ensures patients who require more time or support are not rushed or overlooked.

6. Respectful support for people with swallowing, cognitive or communication needs

Dignity issue:
Unsafe or insensitive feeding can be both humiliating and clinically risky. NICE and RCN highlight training in dysphagia management, communication aids, and consent as essential (NICE, 2017; RCN, 2021).

Examples of dignity-linked practice:

- Training on swallowing safety, texture-modified diets and consent.
- Staff explaining what they are doing before assisting.
- Use of communication aids or visual menus to promote understanding.

FOI phrasing cue:
Training and guidance to support respectful feeding for patients with additional needs.

References

- Age UK (2018). *The Role of Volunteers in Supporting Older People at Mealtimes in Hospital.*
- BAPEN (2021). *Introduction to Malnutrition: Identification, Screening and Management.* British Association for Parenteral and Enteral Nutrition.
- Care Quality Commission (CQC) (2022). *Fundamental Standards – Regulation 10: Dignity and Respect; Regulation 14: Meeting Nutritional and Hydration Needs.*
- Department of Health (2009). *Dignity in Care: Practice Guide.*
- NHS England (2023). *Nutrition and Hydration Programme: Improving Mealtimes and Patient Safety.*
- NICE (2017). *Nutrition Support for Adults: Oral Nutrition Support, Enteral Tube Feeding and Parenteral Nutrition (CG32).*
- Royal College of Nursing (RCN) (2021). *Nutrition and Hydration: Fundamental to Patient Safety, Dignity and Compassion.*

See Appendix 4 for policy and governance frameworks that embed these dignity principles.

Appendix 4: How Mealtime Support is Evidenced in NHS Trust Policies

Mealtime support schemes within acute NHS trusts are rarely standalone initiatives. Instead, they are embedded across a suite of trust-wide policies, clinical standards and operational frameworks that collectively govern safe, dignified and person-centred nutritional care.
Review of local and national frameworks shows that expectations for identifying, supporting and documenting mealtime assistance are consistently referenced within key policy domains (NICE, 2017; CQC, 2022; RCN, 2021; NHS England, 2023).

1. Nutrition and Hydration Policies

Most trusts maintain an overarching *Nutrition and Hydration Policy* or equivalent document, which serves as the primary source of assurance for mealtime care standards.
Typical policy content includes:

- Identification of patients who require assistance using visual systems such as red trays or red napkins.
- Defined roles and responsibilities for nursing, allied health and, where applicable, volunteer staff.
- Expectations that help with eating and drinking is timely, proactive and documented.
- Requirements for recording intake on food and fluid balance charts.
- Links to the Malnutrition Universal Screening Tool (MUST) and clinical escalation pathways.

Evidence: Policies normally state that *no patient identified as requiring support should be left without assistance at mealtimes*, making this a mandated standard of care (NICE, 2017; BAPEN, 2021).

2. Protected Mealtimes Policies

Many trusts implement *Protected Mealtime* or *Supportive Mealtime* policies that embed mealtime assistance within ward routines.
These frameworks typically require that:

- Non-urgent clinical activity is paused during meals.
- Staff prioritise helping patients to eat and drink.
- Wards provide a calm, interruption-free environment.
- Volunteers or dining companions are included as part of the mealtime workforce.

Evidence: These policies position mealtime support as a collective ward responsibility, rather than a discretionary activity (NHS England, 2023).

3. Nursing and Fundamental Care Standards

Fundamental nursing care frameworks explicitly include nutrition and hydration as core domains of practice.
Standards and local guidance often outline:

- The expectation that dignity, comfort and independence are maintained during eating and drinking.
- Safe positioning and preparation of patients before meals.
- Encouragement of independence while providing assistance where needed.
- Inclusion of mealtime checks in intentional rounding schedules.

Evidence: Mealtime support is defined as a central nursing duty and an indicator of compassionate, person-centred care (RCN, 2021; Department of Health, 2009).

4. Volunteer Services Policies and Role Descriptions

Where volunteer-based mealtime schemes operate, clear governance is provided through *Volunteer Services Policies* and associated role descriptions.
These outline:

- Scope of role and permitted activities (set-up, encouragement, companionship, supervised assisted feeding where competent).
- Mandatory training and competency assessment.
- Supervision, boundaries of practice and escalation routes.
- Compliance with infection prevention, safeguarding and dignity standards.

Evidence: The inclusion of mealtime duties within formal volunteer governance demonstrates that it is a recognised and structured workforce function
(Age UK, 2018; NHS England, 2023).

5. Speech and Language Therapy (SALT) and Dysphagia Policies

For patients with swallowing difficulties, mealtime assistance is directed through dysphagia and SALT policies, which specify:

- Use of texture-modified diets and thickened fluids.
- Requirements for trained staff to support feeding safely.
- Documentation of swallowing assessments and individualized risk-management plans.

Evidence: Dysphagia guidance positions safe feeding support as a core patient-safety requirement, not just a comfort measure (NICE, 2017; RCN, 2021).

6. Patient Safety and Quality Governance Frameworks

Mealtime support is frequently referenced within quality and safety systems, including:

- Annual Quality Accounts describing nutrition and dining companion initiatives.

- Audit programmes such as PLACE
  (Patient-Led Assessments of the Care Environment) and nutrition audits.
- Incident themes highlighting missed meals, dehydration or choking events.

Evidence: Mealtime-related activity and outcomes are routinely monitored through patient-safety governance processes (CQC, 2022; NHS England, 2023).

7. Training and Competency Frameworks

Effective delivery of mealtime support depends on structured training.
Typical trust frameworks cover:

- Nutrition and hydration awareness.
- Feeding-assistance competencies.
- Dysphagia and texture-modified diet training (aligned to SALT standards).
- Dignity, compassion and person-centred care modules.

Evidence: Training requirements formalise mealtime support as an expected element of staff competence, reinforcing its consistency and importance (RCN, 2021; BAPEN, 2021).

Synthesis

Across acute NHS trusts, the consistent inclusion of mealtime support within multiple policy domains confirms that it is:

- A mandated standard of care, not an optional initiative.
- A multidisciplinary responsibility, spanning nursing, allied health professionals and volunteers.
- A patient-safety priority, particularly for individuals at nutritional risk or with swallowing difficulties.
- A measurable, auditable component of quality and governance frameworks.

Although policy wording varies, the central principle remains uniform:
Every patient who requires help to eat or drink must be identified, prioritised and supported in a safe, timely and dignified way.

References

1. Age UK (2018). *The Role of Volunteers in Supporting Older People at Mealtimes in Hospital.*
2. BAPEN (2021). *Introduction to Malnutrition: Identification, Screening and Management.* British Association for Parenteral and Enteral Nutrition.
3. Care Quality Commission (CQC) (2022). *Fundamental Standards – Regulation 10: Dignity and Respect; Regulation 14: Meeting Nutritional and Hydration Needs.*
4. Department of Health (2009). *Dignity in Care: Practice Guide.*
5. NHS England (2023). *Nutrition and Hydration Programme: Improving Mealtimes and Patient Safety.*
6. NICE (2017).

Nutrition Support for Adults: Oral Nutrition Support, Enteral Tube Feeding and Parenteral Nut rition (CG32).
7. Royal College of Nursing (RCN) (2021).
Nutrition and Hydration: Fundamental to Patient Safety, Dignity and Compassion.

Appendix 5 Abbreviations

Core NHS / System Terms

- NHS – National Health Service
- FOI – Freedom of Information
- CQC – Care Quality Commission
- QI – Quality Improvement
- KPI – Key Performance Indicator

Patient Experience & Feedback

- FFT – Friends and Family Test
- PALS – Patient Advice and Liaison Service
- PLACE – Patient-Led Assessments of the Care Environment
- PEEG – Patient Experience and Engagement Group

Clinical Roles & Workforce

- HCA / HCSW – Healthcare Assistant / Healthcare Support Worker
- RN – Registered Nurse
- AHP – Allied Health Professional

Nutrition, Hydration & Screening

- MUST – Malnutrition Universal Screening Tool
- NG tube – Nasogastric tube

Swallowing / Feeding Safety

- SALT / SLT – Speech and Language Therapy / Therapist
- IDDSI – International Dysphagia Diet Standardisation Initiative
- RCSLT – Royal College of Speech and Language Therapists

Governance, Safety & Reporting

- PSIRF – Patient Safety Incident Response Framework
- Datix – Incident reporting system used in NHS organisations

Training & Frameworks

- Care Certificate – National standard for healthcare support workers
- FLAGS – (Local training/resource framework – should be defined locally if used)

Nutrition & Professional Bodies

- BAPEN – British Association for Parenteral and Enteral Nutrition
- NICE – National Institute for Health and Care Excellence
- RCN – Royal College of Nursing

Terms used :

- Protected Mealtimes – Policy to minimise interruptions during meals
- Supportive Mealtimes – Evolved model focusing on active assistance
- Red Tray / Red Lid System – Visual identifier for patients needing support
- Nutrition Champions – Designated staff promoting nutrition at ward level
- Dining Buddy / Mealtime Companion – Volunteer or support role at mealtimes
- John's Campaign – Initiative supporting family/carer involvement
- Sophie's Legacy – Campaign advocating for family presence in care