British Association for Parenteral and Enteral Nutrition

A multi-professional association and registered charity estalished in 1992. Its membership is drawn from doctors, dietitians, nutritionists, nurses, patients, pharmacists, and from the health policy, industry, public health and research sectors.

Principal Functions

Enhance understanding and management of malnutrition.

Establish a clinical governance framework to underpin the nutritional management of all patients.

Enhance knowledge and skills in clinical nutrition through education and training.

Communicate the benefits of clinical and cost-effective optimal nutritional care to all healthcare professionals, policy makers and the public.

Fund a multi-professional research programme to enhance understanding of malnutrition and its treatment.

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in Touch

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Two winners of the John Lennard-Jones medal

At the 2005 annual BAPEN conference the prestigious John-Lennard Jones Medal was awarded to two individuals for outstanding contributions to Clinical Nutrition. This is the first time that that there was a tie in votes between two individuals. Here is a brief summary of some of their contributions and achievements.

Christine Russell

Christine was Dietetic Manager for Northampton Health Authority, where she was instrumental in developing a Nutrition Support Team and a nutrition screening tool. She was a founder member and previous chair of the Parenteral and Enteral Nutrition (PEN) Group of the British Dietetic Association, and a member of the Kings Fund Working Group, which published the report A Positive Approach to Nutrition as Treatment in 1992, leading to the formation of BAPEN in the same year. Apart from her valuable experience gained through working within the NHS, she has also had extensive experience in industry, as Head of Clinical Nutrition for Nutricia Ltd. The combination of these experiences has been valuable not only to her but also to BAPEN.

Christine not only served on the 1st BAPEN Council, but she has remained actively involved with many of its activities, serving on various committees, including Education and Training, the British Artificial Nutrition Survey (BANS), and the Malnutrition Advisory Group (MAG). She has been actively involved in the publication and launch of 'MUST', and has promoted it since its launch in 2003. She has also helped man the 'MUST' helpline, answering questions from health care professionals across the UK and abroad, and providing training on 'MUST' on behalf of BAPEN. She continues to serve on the MAG committee, and is working towards the improved implementation of nutritional screening and adoption of 'MUST'. Whilst serving on the BANS Committee she acted as treasurer, preparing her well for her current post as Honorary Treasurer of BAPEN, which she took up after AGM in Telford last year.

She co-authored several BAPEN publications, including Standards and Guidelines for Nutritional Support in Hospitals, a number of BANS Reports, the 'MUST' report – Nutritional screening of adults: a multidisciplinary responsibility, the 'MUST' Explanatory booklet and the Health Economic Report on Malnutrition in the UK.

Her long-standing and outstanding contributions to the field of Dietetics/ Clinical Nutrition have undoubtedly made her a worthy winner of the 2005 John Lennard-Jones medal. Her contributions have also been recognised by the British Dietetic Association, which awarded her the Ibex Award in 2003. In addition, members of BAPEN have found it a real pleasure to work with her.

Lynne Colagiovanni

Lynne Colagiovanni is a highly respected and trusted member of her profession with a national profile. A nurse for 32 years, Lynne made the switch to the specialism of nutrition nursing in 1989 whilst working on an Intensive Treatment Unit. Nutrition support captured her heart and mind and she has never looked back, having worked full-time in the specialty ever since.

Lynne has recently been appointmented as a Consultant Nurse in her Trust and this is an acknowledgement by them, of her skills, experience, leadership and achievements.

Colleagues describe her as a born leader, level-headed but proactive, creative and dependable, top-class in clinical matters and an excellent communicator. She's challenging too 'making us think' says one colleague 'about everything we do and say'.

Chair of the National Nutritional Nurses Group (NNNG) first in the late 90s and the current Chair (she steps down late 2006), Lynne has spear-headed a united drive to increase membership and raise the profile of the specialty group.

"What I am most proud of," says Lynne, "is how the profile of NNNG and nursing as a whole has been raised within BAPEN during my Chairmanship."

Lynne's additional Chairmanship during this time of the BAPEN Programmes Committee for 2005 and 2006 has certainly contributed to this

development, as well as providing sterling work for BAPEN itself. The nurses' viewpoint has also been put across effectively during many BAPEN meetings in recent years under Lynne's stewardship, particularly the debates on patient journeys. Lynne has also published widely in nursing journals and is a regular speaker at national and international conferences.

Lynne is an excellent role model for all in nursing, but in addition she is well-liked and loved not only for her professionalism and commitment but also for her sense of humour!

All are agreed that she is an extremely worthy recipient of the John Lennard Jones Medal and the first nurse to receive it.

BAPEN Health Economic Report

Marinos Elia - 'Despite the large literature on the clinical or health consequences of malnutrition, little attention has been paid to its economic consequences.'

One of the reasons for this is that it is difficult to value the physical and psychological manifestations of malnutrition in monetary terms, especially since the manifestations depend on age, and the type and severity of underlying disease and malnutrition. Another reason is that malnutrition and disease can be a cause and a consequence of each other, making it difficult to separate them. However, an economic evaluation of malnutrition is important, especially when new policies or reforms are being proposed and implemented. With this in mind, BAPEN formed an ad hoc Health Economic Working Group, with the aim of establishing, for the first time, the cost of disease-related malnutrition in the UK. It also aimed to undertake a cost analysis of the economic effects of oral nutritional supplements in hospital and the community.

One way to assess the cost of malnutrition is to examine the extent to which patients with malnutrition (and any associated disease) utilise services, such as GP consultations and admissions to hospitals and long term residential facilities. To do this, it is first necessary to establish the prevalence of malnutrition in hospitals and the community and the rate of utilisation of these services, all of which have specific costs assigned to them (2003 prices used in the report). National databases provided by the Department of Health were used and supplemented with information from other reference sources. Malnourished patients were found to have more GP visits, more hospital admissions, longer length of hospital stay, and more admissions to care homes than non-malnourished individuals. The overall cost of treating malnutrition in the UK was estimated to be in excess of £7.3 billion per year, with disproportionately large expenditure on older individuals (> 65 years), who account for only about 15% of the total population. However, older people represent about half of the population in hospitals, and more than 90% of the population in long-term care facilities. This largely explains why older individuals accounted for about two thirds of the total expenditure on disease related malnutrition.

The data are of interest for at least three reasons. First, they demonstrate that the cost of disease-related malnutrition in the UK is large (>£7.3 billion per year), accounting for up to about 10% of the total public expenditure on health. This implies that a small fractional reduction on the overall cost through interventions can result in large net cost-savings (an overall impact of 1% corresponds to £70 million per year). Second, this expenditure is almost two-fold greater than that for obesity and its co-morbidities (as reported by the House of Commons Health Committee on obesity). Although obesity is an important public health problem, malnutrition should not be neglected and overshadowed by obesity. Both problems are important and both need attention. Third, malnutrition was assessed in both hospital and community settings using the 'Malnutrition Universal Screening Tool' ('MUST'), which was developed by the Malnutrition Advisory Group (MAG) of BAPEN. The tool is being increasingly used, not only for clinical purposes, but also for public health purposes. For example, a secondary analysis of the National Diet and Nutrition Survey in older people (65 years and over) using 'MUST' identified a major north-south divide in the prevalence of malnutrition (worse in the north). This was associated with a poorer status of vitamin C, carotenoids, vitamin D, and other nutrients in northern than southern England. Another study, which applied 'MUST' to 1000 patients admitted to one hospital, identified health inequalities in the same geographic area: those from more deprived areas were more likely to be malnourished, and have a poorer clinical outcome in hospital (e.g. greater mortality).

The second part of the report is concerned with a cost-analysis of randomised controlled trials, in which intervention groups, given oral nutritional supplements (ONS), were compared with a control group, in hospital, community, or in both of these, when the patient journey involved both of these care settings. Meta-analysis indicated that ONS given post-operatively can result in significant net cost savings in patients undergoing abdominal surgery, abdominal and orthopaedic surgery, and in older patients at high risk of developing pressure ulcers. Data on patients in the community are scanty and less amenable to economic evaluation. Nevertheless, it seems that the largest potential economic benefit associated with community interventions is a reduction in hospital admissions. Potential financial conflict could arise if there are independent funding streams for the community and hospital. For example, financial benefits associated with expenditure on interventions in the community could favour hospitals rather than the community, a situation that could be avoided if funding followed the patient. A cost-utility analysis (e.g. cost per quality adjusted life years (QALY; an index of both the quantity and quality of life) of ONS was not undertaken because of scanty data that were not generally amenable to economic evaluation and meta-analyses. Such analyses would require a series of assumptions, including assumptions about mortality that are hard to justify with the currently available information.

The report summarises individual studies and synthesises the evidence for surgical, medical, and geriatric (care for the elderly) patients in different care settings. It has large appendices, and over 100 tables. It indicates the limitations of the current economic literature on malnutrition, and makes suggestions for future research. The Executive summary of the report can be found on the BAPEN website (www.bapen.org.uk).

Copies of the report are available from the BAPEN Office. (Price £25 including postage and packaging, £30 outside the UK).

Disease-related malnutrition in the UK and economic considerations for the use of oral nutritional supplements (ONS) in adults. M.Elia (Chairman and Editor) R.Stratton, C.Russell, C.Green, F.Pang. 2005, pp152.

Professor Marinos Elia
Chairman BAPEN

Practice Based Commissioning – the potential impact on Nutrition

I suppose to start you could look at the recent publications and the trends laid out by the government for the NHS of the future. There is a clear aim to increase the amount of care delivered in the community as opposed to in hospitals, this has been confirmed by the new white paper.

Local communities will have care and services developed which meet the needs of their community and the focus for this will be Practice Based Commissioning (I still feel this should be called 'purchasing' not 'commissioning'). The Practice Based Commissioners will also be responsible for the budget and its delivery. Practice Based Commissioners will be able to deliver services themselves as well as purchase services from organisations that meet NHS standards. The recent white paper has also determined that there will be much closer working with both Social Services in the community and locally provided outreach services from secondary care providers.

The larger PCTs will commission all services to be provided by all the different organisations in their area (this includes NHS, Private and 'not-for-profit' organisations). The PCTs will also audit delivery and payment, and be the front line organisation for the public.

Nationally there will be mechanisms to control quality and standards of performance and financial control; these will still be delivered by the Health Care Commission. It is intended to continue standardisation of treatment based on effectiveness and cost and this is the ongoing work by NICE. In the near future monitoring and care pathway development will expand to cover areas and organisations previously untouched.

This is just a very simplified model and does not include changes that will be announced later on around the functions of the Strategic Health Authorities and the re-organisation of the Department of Health due to be announced later this year.

What does this mean for people who deliver services to patients? In the long term the practice based commissioning units will be more 'joined-up' with other organisations who will all be working from community-based centres. There will be representation from primary, secondary and social care providers of all different types such as NHS based, private companies and 'not-for-profit' organisations in these centres. Staff will be working together and therefore communication about patients should improve and there should be shared learning and training.

These centres should be functionally close to the organisation that purchases the services i.e. the Practice Based Commissioning unit. The services will be provided to a community-focused, needs-based delivery that achieves a set standard. These will be monitored and 'assured' around governance and quality controls irrespective of which organisation supplies them.

People working in any service will work to a standard that covers a larger geographical area. Therefore it will not matter which surgery they work in, who employs them, or whose patient it is. This should mean that fewer people will fall through the gaps in services that cause so many of the problems in current patient care. It also means that it is appropriate for services to be different; for instance you would not expect the same type of service in Cornwall as in London city centre. Problems associated with fundholding, such as differing standards of care and levels of service will not re-occur because there will be a more community based focus. There will also be the benefits of larger organisations ensuring that services are of a high quality. This will apply even if they are nationally or regionally commissioned or delivered for a specific type of condition that is in a minority.

The question that still stands out in my mind is who will employ these, at the moment non primary care staff who will become disseminated across community based services? How will staff act in unison with each other, develop best practice and encourage innovation and progress? There is as yet no model that has been developed that fits this type of service delivery.

There are a lot of positives in this impending model that could increase the role of 'nutrition' in the community. If focused on those at risk, such as the elderly in residential and care homes and those with chronic conditions (who will then only be reviewed in the community) nutritional understanding and intervention will improve. Increased sharing of knowledge and peer education with other front line staff should improve services. This list of positives is not exhaustive.

As far as nutrition is concerned then, there will be a closer involvement with a larger number of patients who have a larger number of problems. The result will immediately be an increased demand for advice and guidance for people who are difficult to deal with such as the overweight diabetic or the underweight COPD patient. There could be then an opportunity to implement guidelines and treatment pathways to a larger number of patients and to generally improve the nutrition of a larger percentage of the population than at present.

Could the professionals also get involved with areas they have so far been less engaged, such as pre-conceptual counselling or nutrition in the community. This could be in association with social services and under Local Area Agreements perhaps? This could therefore lead to a higher profile in the arena of public health and health promotion.

Change in the NHS is inevitable due to the political changes of direction at the top of the shop. What is needed here is the desire to ensure

that this change, which I feel has great potential, achieves a better delivery for patients. However a word of caution; there has been an intention to move services from the secondary care sector into a community setting by policy change since 1976 with the 'Priorities for Health and Social Services Document' promoted by Harold Wilson! Does the present government have a stronger hand that will drive these changes through?

Dr Bill Barker Chair West Wakefield PCT

References:

- Practice Based Commissioning: Engaging practices in commissioning, DOH 2004.
- Our health, our care, our say: A new direction for community services, DOH 2006 .

ESPEN update report

There was an ESPEN Council meeting on January 14 2006 and a summary of the key points / activities currently being undertaken follows for your information:

Conference Diary Dates

2006	October	19 – 22	Istanbul
2007	September	08 – 11	Prague
2008	September	13 – 16	Florence
2009	September	12 – 15	Vienna
2010	August	22 – 25	Paris

Applications of interest to host future conferences are now being sought.

Istanbul Conference - dates to note

*Closing date for abstracts: April 11 2006

* Early registration deadline: May 25 2006

* Deadline for breaking abstracts (posters only): July 7 2006

*Life Long Learning modules: October 18 -19 2006.

There will be 4 new modules in addition to those which were held in Brussels

European Nutrition Day

As a result of the European Nutrition Day on 19th January this year, there has been a tremendous response to the call for participants and, at one point, the UK was well ahead in the recruitment stakes. Preliminary feedback (just relating to the local units) should be available in the summer. The multi-variate analysis will take longer (this is what will inform the benchmarking process) and we are hoping that this will be ready for presentation at the Istanbul Conference. In the meantime, very many thanks to all of you who joined in this exciting initiative.

ESPEN Guidelines

1. **Enteral Guidelines** – these are going to be published in Clinical Nutrition- possibly the April edition
2. **PN Guidelines** – the Working Group is being set up and all existing guidelines are being considered – including the work that has been done by Janet Baxter's group on behalf of BAPEN.

Lifelong Learning Programme – this is developing on schedule and there is a comprehensive guidebook for learners. It is anticipated that, eventually, nutritional certification could be achieved by participants after 3 years. There are 35 topics and this will yield 105 modules with the full programme being available in 3-4 years. 26 modules are already available on the ESPEN website (www.espen.org) in a preliminary from.

A Teacher- training module is being developed so that delegates can take the "packages" back to their own countries. The only pre-requisite is that they must have attended a live module first to ensure familiarity with the teaching approach.

ESPEN Membership

There is some concern about falling numbers throughout Europe and options for improving the situation were discussed. The prevailing ideas being considered are;

1. That each PEN society member should be asked to pay a token fee and they would then, automatically become ESPEN members.
2. That the fees are reduced but that the price of attendance at the Congress is increased
3. That the fee stays as it is now and membership is increased by other means.
4. That each society should be allowed to determine the level of membership that it wishes to support .

There was also discussion about several other suggestions. If you have any ideas or have views about any of the suggestions above, please get in touch with Pat Howard (pat.howard@ubht.nhs.uk).

In respect of the membership process, a great deal of work has been undertaken to try to resolve the difficulties that so many of you have experienced. The current UK membership list has already been validated and, once this exercise has been completed throughout Europe, there will be a direct link to the Elsevier site to make sure that your Clinical Nutrition subscription is activated.

Finally, it has been agreed that, in future, the membership year will run from January 1 - December 31. We already do this in the UK – but there has been some leeway for late subscriptions. The current deadline is January 31 but, in future this will not be the case and you will have to pay up by December 31!

The membership fees at present are as follows:

Block Membership - €70

Junior membership
(you must be less than 30 to qualify!) - €20

Ordinary membership - €100

Please get in touch with the BAPEN Office if you have forgotten to join this year. In future we will be sending out renewal reminders earlier to give you plenty of warning!

ESPEN Journal

Clinical Nutrition has had a facelift and now has a smart new blue cover. An Associate Editorial Board has been set up to streamline the process of reviewing. Negotiations are currently in hand about the introduction of an on-line journal (which will contain mainly educational and clinical practice items). It is hoped that the outcome of these changes will be an improvement in the current impact factor.

ESPEN Committees

Prof. Alastair Forbes has recently been nominated to take over the chairmanship of the Education and Clinical Practice Committee (ECPC) and is to be congratulated on this prestigious appointment. Professor Claude Pichard reaches the end of his 3 year Chairmanship of ESPEN at the Istanbul meeting and nominations have been requested in the search for a successor. If you are an ESPEN member you will have received your voting papers – please use your vote! It is vitally important that everyone who is eligible to vote actually does so - to ensure that the best candidate is selected and that they know they have the active support of all the membership

Pat Howard ESPEN Liaison Officer

What is the status of nutrition support in Hungary? What have we done in the field of hospital undernutrition?

Emese Antal - President, Hungarian Association of Dieticians, Budapest, Hungary.

During the last few years, there have been many initiatives in Hungary which have focused on better hospital diet, hospital undernutrition and improved clinical nutrition provision.

In November 1996, the Council of Europe Resolution on the Hungarian Society of Clinical Nutrition published a guideline about the status of clinical nutrition in Hungary. This material was based on a consensus conference which had been held in co-operation with 20 Hungarian societies involved in nutrition. This guideline focused on malnutrition, the benefit of the nutritional support team, and on enteral and parenteral nutrition.

We are now celebrating the 10th anniversary of this material and the situation is changing slowly but in a good way. In this article, I will emphasise the role of the Hungarian dieticians and the situation relating to hospital undernutrition.

In 2002, the Hungarian Society of Gastroenterology undertook a survey. The analysis involved 217 gastroenterologists and enquired how they determined the nutritional status of the patients. 59% of the physicians determined it only by observation and 41% answered that they made a more formal evaluation.

The Hungarian Association of Dieticians undertook different surveys about the situation and the role of the dieticians. Furthermore 4 years ago they made some additional observations regarding hospital diets and clinical nutrition.

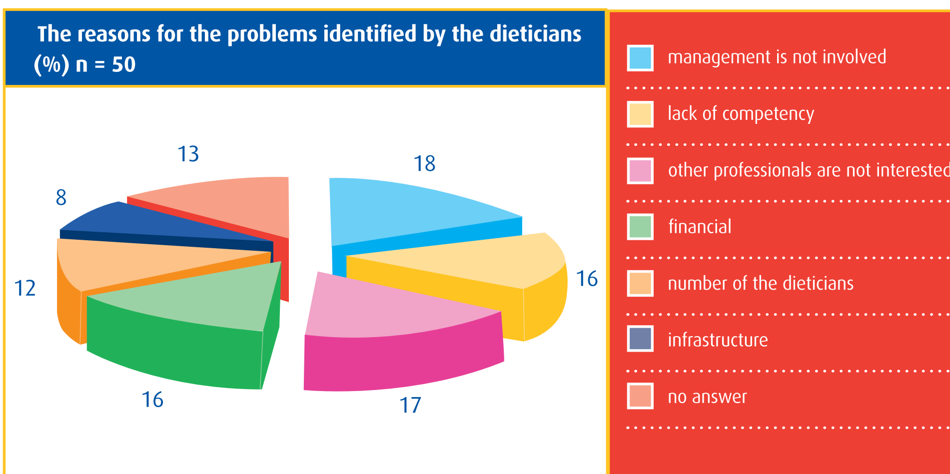
In 2002, our society evaluated the barriers to the work of the dieticians. In fifty hospitals (there are altogether 156 hospitals in Hungary) the chief dieticians filled out a questionnaire. The figure below shows the main general problems.

The Council for Europe Resolution on Food and Nutritional Care in Hospitals – ResAP (2003) has influenced the nutrition society too and the summary of this material has been translated into Hungarian. Based on the guidelines of the Council of Europe, our society has undertaken a survey asking 1226 patients about their situation and the reasons for their hospital undernutrition in 2004. Only 6% of the patients were screened at admission for undernutrition and weight was measured in hospital in only 51% of the patients.

This survey served as the basis for initiating a consensus conference entitled "Screening, examination and therapy of disease-related malnutrition in the field of everyday practice" in 2004. The twenty-two decision-makers who signed the consensus represented the government, the Hungarian Association of Hospital Managers, and other professional societies dealing with nutrition.

The conclusions of the consensus-conference are as follows:

- A dietetic service should be provided at all levels of treatment;
- A dietetic service should become a part of the infrastructure supporting hospital in-patients, ambulant treatments and the family doctor service;
- Nutritional screening should be carried out even in the basic service with the help of dieticians;
- Clinical malnutrition should be be treated in all situations including at home;
- Modern nutritional therapy should be used in order to reduce the surplus costs of treatment due to malnutrition, even if there are no complications;
- Current perceptions of nutritional therapy must be changed in order to solve the problems of professional policy and financing.



At the end of 2004, our association evaluated the use of "in-house" blenderized diets, because many did not use enteral formulas at this time. We evaluated 10 hospitals; in each hospital 3 examples were taken and analyzed for both the nutritional content and microbiological profiles.

The results were as bad as we expected.

The research concluded that no ideal blenderized diet could be made. If enteral nutrition is needed then enteral formulas must be used.

In the summer of 2005, the Hungarian Association of Dieticians gave the results to the media. There was a huge "bomb" with big publicity, open discussions on television, and on the radio. By the end of 2005, i.e. within a short six-month period of time 17 hospitals (10 % of the Hungarian hospitals) replaced the blenderized diets with the recommended enteral formula.

Our Association knows that this action was not a "standard" way to reach our goals. This publicity has also ensured that the dietician is involved in decisions about nutritional therapy in a much more positive way resulting in an improved perception of dieticians among the general population.

However, there are still so many things to be improved in the future that we will be continuing our hard work.

Emese Antal

Sociologist, Dietician.

Literature: http://www.diet.hu/portal/downloads/tbanya_konsz_ENG_2004.doc

Beck AM, Nilson Balknas U, Fürst P, Hasunen K, Jones L, Keller U, Melchior J-C, Mikkelsen BE, Schauder P, Sivonen L, Zinck O, Øien H, Ovesen L: Food and nutritional care in hospitals: how to prevent undernutrition – report and guidelines from the Council of Europe. Clin Nutr 2001; 20: 455-460.

Report and recommendations of the Committee of Experts on Nutrition, Food Safety and Consumer Protection: Food and nutritional care in hospitals: How to prevent undernutrition. Council of Europe Publishing, 2002.

FIRST ANNOUNCEMENT AND REGISTRATION FORM REQUEST

BAPEN

Advancing Clinical Nutrition

2006 Annual Conference

of

The British Association for Parenteral and Enteral Nutrition

to be held at

Hilton Brighton Metropole

on

1st - 2nd November 2006

This meeting is approved for credits under the Continuing Medical Education (CME) Scheme by all Medical Royal Colleges

PROVISIONAL PROGRAMME

Wednesday 1st November 2006

08:30 Registration

10:00 - 10:30 **"BAPEN - Hot Topics"**
Including highlights of this years conference.

10:30 - 12:30 *Symposium 1*
"Pre & Pro-biotics"
The interplay of the intestinal mucosa and the flora of the intestine is fundamental to the understanding of intestinal disease. The flora of the intestine contains more cells than the human body itself, and it is altered by what we eat, by artificial feeding and by disease and its management. This symposium seeks to explore how we might alter the colonic flora to our patients' potential benefit.

12:30 - 13:30 Lunch and Poster Sessions

13:30 - 15:30 *Symposium 2*
"The Management of Water in Injured Patients: will they suffer from drowning or drought?"
One of the hardest parts of management of an injured patient is the amount of fluid they are given. This symposium will address the question of fluid resuscitation in acute injury and the potentially harmful effects of excess fluid administration in the post-operative period. This subject should appeal to a wide range of specialists including those who work in intensive care, surgery and clinical nutrition.

15:30 - 16:00 **The Pennington Lecture**

16:00 - 16:30 Tea

16:30 - 17:30 **Original Communications**

17:30 - 18:30 **Awards followed by BAPEN AGM**

PROVISIONAL PROGRAMME

Thursday 2nd November 2006

08:30 Registration

09:00 - 11:00 *Symposium 3*
"Managing Complications in Long-Term Parenteral Nutrition"
Parenteral Nutrition is acknowledged as a life saving treatment in patients with intestinal failure, but metabolic complications may develop during long-term use and need expert management. This symposium will focus on the recognition and management of metabolic bone disease, liver dysfunction, micronutrient deficiency and toxicity. The symposium closes with an update on intestinal transplantation.

11:00 - 11:30 Coffee

11:30 - 13:30 *Symposium 4 - Nutrition Society Symposium*
"Eating, Illness and the Gut - Disorder in the House?"
Gut dysfunction and food aversion have long been associated with critical illness and the astonishing array of devices and methods to get food into patients. This symposium will examine the psycho-neuroimmunological basis of disordered eating in patients, and the way in which illness alters gut metabolism and function. It will close with analysis of ways to manipulate ingestive behaviour in order to optimise nutritional intake.

Symposium 5
"Nutrition in the Community"
High amongst those groups identified as 'at risk' from malnutrition are the free living elderly, those with chronic diseases, and those in care/nursing homes. This symposium will explore issues of importance in some of these patient groups.

13:30 - 14:30 Lunch and Poster Sessions

14:30 - 15:15 **The Nutrition Society Cuthbertson Medal Lecture**

15:15 - 17:15 *Symposium 6*
"Inflammation Technology: Putting Theory into Practice"
The aim of this symposium is to give some good practical advice on feeding the patient with an acute or chronic inflammatory response. Starting with critical care it will look at the safe use of intensive insulin therapy before reviewing the controversial aspects of estimating energy requirements. The PEN Group will present the results of their Summer Meeting debate on the use of stress factors and we will move on to see the practical implications for nutritional support and management of the inflammatory response.

17:15 Close of Conference followed by Tea

A TRADE EXHIBITION WILL BE HELD THROUGHOUT THE MEETING

ABSTRACTS

Abstracts will be considered by BAPEN for Oral, E-poster and Static Poster Sessions. the method of presentation will be decided by the BAPEN Programmes Committee.

Abstracts relating to the symposia themes are particularly encouraged, although papers pertaining to all areas of clinical nutrition will be welcomed.

CLOSING DATE FOR RECEIPT OF ABSTRACTS IS

FRIDAY 23rd JUNE 2006

For full details please refer to Direction to Contributors, Abstract Submission Forms and Copyright Assignment Forms on the BAPEN website.

www.bapen.org.uk

For a registration form please contact;
Sovereign Conference with your details

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Further details are available:
see our website - bapen.org.uk

Council Update

While hopefully unapparent to the wider BAPEN membership, the greatest organisational challenge facing the organisation in 2006 relates to its income and it was no accident that the first item on the agenda at the Council meeting of 7th February was 'Finances'.

It has become increasingly evident that the model of industry sponsorship, which has operated since the inception of BAPEN, is no longer sustainable. In part this is due to the increasing cost pressure on industry, with the consequent need to use resources more effectively in responding to market pressures, and in part on the need for BAPEN to be accepted as an independent association, which is not overwhelmingly dependent on funding from industry.

In discussions between representatives of industry and BAPEN over the past 12 months, an alternative model of sponsorship has been developed, which enables individual commercial organisations to shape their annual commitments according to requirement and spending priorities, while continuing to encourage liaison between industry and BAPEN Council and appropriate committees. This replaced the previous guaranteed sponsorship system from the beginning of 2006. This has necessarily resulted in a somewhat uncertain period fiscally, though we are delighted to be able to announce that our previous industry partners have demonstrated their ongoing commitment to the organisation by availing themselves of such packages. Christine Russell, the new Honorary Treasurer has risen magnificently to the challenge and we are hoping to be back on an even keel within the next couple of years.

Despite the current state of financial uncertainty, the mood around the Council table was incredibly upbeat, with a genuine sense of excitement and enthusiasm for using this as an opportunity to review critically our practices and strategy with a view to establishing a strong base for the future.

A number of ideas were discussed.

- Review of Organisational Structure: this includes a plan to review membership, remit and terms of reference of each committee. The executive officers have increased in number from 3 to 5 this year, with the addition of Carolyn Wheatley and Simon Gabe to the group. It is hoped that this expanded executive will, among other things, improve liaison between the committees, council and officers.
- Communications and technology: exciting developments within the next year or so include a re-vamped website, an upgraded member's database and electronic reporting for BANS.
- BAPEN profile and links: as nutritional issues assume ever greater prominence in the public domain, it is recognised that BAPEN should make all efforts to be represented where appropriate. This will include continued promotion and implementation of the already widely used 'MUST'.

And of course, we shouldn't neglect the most important date on the BAPEN calendar this year – the Annual Conference in Brighton on 1st and 2nd of November. The Programmes Committee, chaired by Lynne Colagiovanni has been working extremely hard; with a new venue and plans for an extremely exciting and varied programme, this already promises to be an event not to be missed!! Please start thinking about potential abstracts for submission and put the date in your diary. We rely on your support this year more than ever.

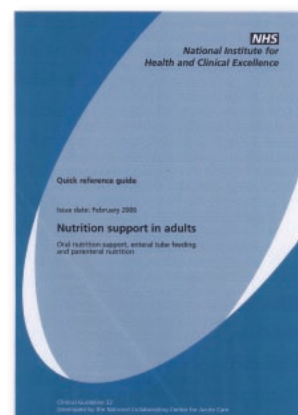
Dr Penny Neild Honarary Secretary

NICE Guidance on Nutrition Support in Adults

The long awaited NICE Guidelines on Nutrition Support in Adults are now available from www.nice.org.uk.

Congratulations to Dr Mike Stroud who was Chairman of the Guideline Development Group and led the development of this complex piece of work. The breadth of the remit was large and the evidence base for nutrition support can be difficult to interpret. As a result, many of the recommendations in the Guideline are derived from a combination of clinical evidence, clinical experience and expertise.

However, the nutritional messages in this substantial guideline are relevant to all who care for patients – whether in hospital, community or care homes. They provide an excellent resource for ensuring that the basic standards for the nutritional care of patients are put in place by all providers of healthcare. Ten recommendations in the final document have been selected as key clinical and organisational recommendations for implementation.



The guideline has several components:

- The full version which includes the complete recommendations, details of how they were developed and summaries
- Quick reference Guide
- NICE Guideline – all of the recommendations
- Information for the public
- A set of implementation slides
- A costing template which includes a spreadsheet allowing individual Trusts to evaluate their own implementation costs

LITRE addresses withdrawal of the Baxter 6060 ambulatory pump

A proportion of patients on home parenteral nutrition (HPN) use an ambulatory (portable) pump and the one with the largest share of the market is the Baxter 6060 multi-therapy. On 15th November 2005 Baxter announced its decision to stop further manufacturing and distribution of the 6060, and to conduct a controlled withdrawal of all 6060 pumps. This decision was taken because Baxter had received reports of failures within the Patient Controlled Analgesia profile as well as reports of incidents that resulted in interruptions of therapy in various other profiles. After consideration of the technological limitations of the product and obsolescence of certain critical components needed for the manufacturing of the pump, Baxter decided to remove the 6060 from the market. Baxter gave an assurance that they would continue full service of the pump along with providing the necessary ancillaries until healthcare professionals had identified a suitable replacement for the pump.

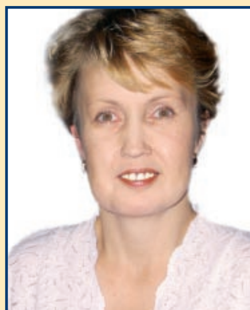
This situation has worried a lot of patients on HPN and PINNT has received many queries from patients; the information they are receiving from hospitals and homecare companies is inconsistent and they are concerned that their quality of life will be adversely affected by the withdrawal of the 6060. LITRE decided that this issue needed to be addressed and to this end invited representatives from companies which had possible replacements - the Ambix IVantage (Fresenius/Calea), the Gemstar (Hospira) and the CADD Prism (Smiths Medical) – to its meeting on 16th January 2006. Fresenius/Calea and Hospira accepted the invitation to attend the meeting.

Each representative did a 30-minutre presentation about their product and its ancillaries, and answered questions.

LITRE felt that this issue needed some interested parties co-opted for this meeting and so invited two HPN patients, two carers and an adult nutrition nurse specialist in addition to those experts already on the committee. It was acknowledged that given the limited time and conditions it would not be possible to fully evaluate the individual pumps on full functionality, but it was hoped a better insight would be gained and feedback given to the representatives. We have since learnt that our concerns are being addressed where possible by the manufacturers and we are very proud of this.

Each pump had its advantages and disadvantages; the full report can be accessed through the BAPEN website via the LITRE page.

It has since come to LITRE's attention that there is another suitable pump for replacement and it is hoped to meet with a representative from the company at our next meeting on 8th May.



Justine Bayes LITRE Chairman

LITRE

Looking Into The Requirements *for* Equipment

The committee is a multi-professional group led by patients. It is a standing committee of the British Association of Parental and Enteral Nutrition (BAPEN).

WHO are we ?

L.I.T.R.E is a multi-disciplinary group which aims to improve the quality of life for patients on nutrition support at home

WHY are we here ?

Previously no group has been available to discuss or advise patients on equipment issues

WHAT can we do ?

- Investigate and respond to the needs and concerns, raised by patients
- Forge a link between patients and the industry
- Act as a forum for users to help in product and service development and in market research

HOW can YOU help US ?

- *Share* your experiences with us
- *Involve us* with your new product development ideas
- *Join* the committee

HOW can WE help YOU ?

- *Provide* access to user groups, industry, regulatory and purchasing bodies
- *Communicate* solutions and advice

WE LOOK FORWARD TO LISTENING TO YOU

PLEASE GET IN TOUCH BY: Visiting our stand *or* e-mailing us *or* visiting our website *or* completing the form below and handing it in at our L.I.T.R.E. stand

Name:

E-mail:

Telephone Number:

Company and Profession:

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What's in the media?
2006 – the year of nutritional care?

As predicted, the New Year has seen continued interest in the issue of malnutrition in the media, in print and across the airways, and in political circles.

January was dominated by continuing follow up and interest in news of the release of BAPEN's new Health Economic Report. This Report provides for the first time an assessment of the additional cost burden to health care systems and individuals due to the failure to screen for malnutrition, and the failure to provide appropriate nutritional care.

Media attention turned smartly afterwards to the issue of abuse of older people in care settings, driven by the introduction of the Human Rights Bill by Paul Burstow MP, an initiative designed to close a legal loophole that fails to protect the human rights of those in private care settings. Abuse takes many forms – physical, mental, environmental – and by definition includes lack of appropriate nutritional care and access to nourishment.

Case studies of older family members dying of malnutrition whilst in care featured in the press, leading to further media enquiries from the BBC in regard to planning for a forthcoming series of issues in care for older people.

It also led to a request from Paul Burstow MP for a meeting and briefing on BAPEN and malnutrition. This briefing took place in anticipation of Burstow's Westminster Hall debate at the House of Commons on food and nutritional care for older people. This key debate, attended by Health Minister Jane Kennedy and by MPs from all sides of the House, drew on and referenced key facts and statistics sourced from BAPEN materials.

The key outcomes of the debate were:

- an all-party agreement on the importance of nutritional care now that the numbers and costs had been identified
- a call for more specific standards for care homes
- effective co-ordination of the initiatives surrounding nutritional care from the FSA's (Food Standards Agency) work on minimum nutrient requirements in care to CSCI's (Commission for Social Care Inspection) work on screening for malnutrition using 'MUST'
- and a meeting with the Minister of Health to discuss the impact of malnutrition and the potential for improving nutritional standards

This meeting with the Minister of Health is in the offing and BAPEN will be party to it. Watch this space – and do also read the Hansard record of the Burstow debate at Westminster (Westminster Hall, 7th February 2006). It sets the standard now for the number of times that BAPEN is referenced. And all those who spoke pronounced BAPEN and its full name correctly.

As if all this wasn't enough, February saw the launch into the public domain of the long-awaited Guidance from NICE on nutritional support in adults. Embedded into formal guidance are key principles for which BAPEN has fought long and hard – screening for malnutrition on entry to hospital and care settings and the establishment of a Nutrition Steering Committee. Additionally, there appears to be the promise of teeth and resources to help Hospitals and Health Trusts and care providers with training of staff to support the implementation of this guidance into daily practice.

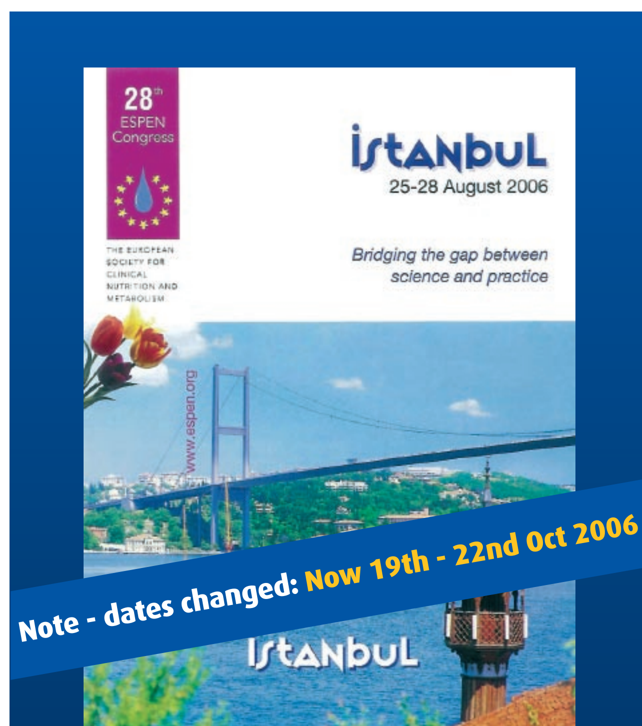
BAPEN looks forward to being a party to these discussions as strategies and action plans are developed. Watch this space – again!

Media coverage of the NICE Guidance was huge. NICE took the lead as spokesman – including our own Dr Mike Stroud - and BAPEN secured good coverage with the appearance of Professor Marinos Elia and Rick Wilson on TV and radio and the use of 'best practice' case studies in care and hospital.

I hope you all noted that the source of the statistics featured in the BBC's news items was flagged as BAPEN. I think we are making progress!

If you have seen coverage mentioning BAPEN or any of our key players and initiatives, please do drop me an email so that we can capture that coverage. Do also let me know if you are approached by any media contacts, or would like to initiate media contact locally. I look forward to hearing from you!

Rhonda Smith Media Co-ordinator, BAPEN
rhonda.smith1@btinternet.com 07887 – 714957



For the Hansard record of the debate (initiated by Burstow), go to the link below. It is easy to locate either via Google or via Parliament website: http://www.parliament.the-stationery-office.com/pa/cm200506/cmhansrd/cm060207/hallindx/60207-x.htm

Journal Watch – from a dietitian's perspective

To screen or not to screen for adult malnutrition?

M. Elia, L. Zellipour and R.J. Stratton.

Clinical Nutrition 2005; 24: 867-884

2 systematic reviews were undertaken to help address the controversy surrounding the role of routine nutritional screening and its clinical benefits. The introduction includes a summary of reports that have been produced on recommendations for nutrition screening in the UK such as the'MUST' report (2003) and PEAT (2004) and looks at certain issues regarding studies that have been undertaken on screening that need to be taken into consideration when interpreting results. One example is the gap that exists between desired and current practice, known as the 'care gap' as the smaller this gap is, the more difficult it is to improve care and demonstrate that an intervention is of benefit.

The authors highlight the high prevalence of malnutrition and the potential consequences if screening is not undertaken. More than half the patients at risk of malnutrition do not appear to be recognised and/or are not referred for treatment.

The 1st systematic review looked at the proposition that malnutrition is under recognised and under treated and that nutritional interventions in malnourished patients, identified through a screening procedure produce clinical benefits. The authors state that under recognition of malnutrition continues to be a major problem, but if routine nutrition screening is to be recommended 'it must be demonstrated that when malnutrition is identified treatment can alter outcome'.

Twelve RCTs assessing the effects of treatment (oral nutrition support/ enteral tube feeding) in patients identified as malnourished by screening were reviewed. These RCTs included patients with specific conditions such as fractured neck of femur, cirrhosis of the liver and those with certain other conditions within specific wards. Whilst patients who had had abdominal. surgery or had head and neck cancer demonstrated clear clinical benefits from nutritional interventions, studies on specific wards, but in patients with a wide range of conditions showed various positive but not necessarily clinically significant outcomes. The authors concluded that 'a number of RCTs specifically involving malnourished patients have shown benefit from nutritional interventions' and went on to state that if these patients are to benefit they first need to be identified.

The 2nd systematic review in the paper addressed nutritional screening interventions in both malnourished and well-nourished patients. 9 studies with clinically relevant outcome measures were included. The economic impact of nutrition screening was also discussed. The majority of studies involved a wide range of differing conditions and study designs, and these along with outcomes are summarised in a table. 'Clinically relevant outcome data suggest that nutrition screening linked to a care plan, has benefits in specific conditions and wards/hospital'.

Some studies reported resource implications such as an increase in referrals and the use of nutritional supplements/feeds as a consequence of nutritional screening, but other studies dispute this. The authors also state that increased costs may be counteracted by positive gains associated with clinical benefits e.g. reduced complications/decreased length of hospital stay.

The authors conclude that there is significant evidence that treatable malnutrition is under recognised and under treated and that there is widespread demand for screening in high-risk populations/environments, especially where the gap between routine care and desired care is large.

Semi-Elemental Formula or Polymeric Formula: Is There a Better Choice for Enteral Nutrition in Acute Pancreatitis?

Laurent-Eric Tiengou, Romain Gloro, Julien Pouzoulet, Karine Bouhier, Marie-Helene Read, Francz Arnaud-Battandier, Jean-Marie Plaze, Xavier Blaizot, Thong Dao, Marie-Astrid Piquet.

Journal of Parenteral and Enteral Nutrition. 2006; 30: 1-5.

This trial was a randomised, single blind prospective pilot study comparing the tolerance of 2 different enteral feed formulas (semi-elemental vs. polymeric) given via NJ tube in patients with acute pancreatitis.

The study was carried out over a 1 year period on 30 adult patients in a teaching hospital (Vera , any idea where ?), using a self-propelled NJ tube placed beyond the duodenojejunal flexure.

Goals of nutrition therapy were 35 Kcal/Kg and 1.5g protein/Kg/d, administered via a feeding pump over 18 hours.

Feed tolerance was assessed by patient questionnaire, assessing gastrointestinal symptoms such as number of stools, gastrointestinal pain and bloating. The investigators also recorded the quantity of analgesics used.

Results showed that there was no clinically significant difference as far as tolerance was concerned between both formulas used. Nutritional goals were met in both groups, although the 'clinical course appeared to be better with the semi-elemental formula, as it was associated with favourable prognostic criteria such as decreased weight loss and reduction of total hospital stay'. There was no difference in CT findings between groups.

The authors stated that the evaluation of global tolerance was excellent, but readers should take into account that this patient population did not show clinical or laboratory findings that necessitated ITU admission, therefore can be categorised into moderately severe necrotic acute pancreatitis. They went on to say that pancreatic exocrine secretion is preserved in moderate pancreatitis.

The authors also stated that no definite conclusions can be made due to the small sample size used and they recommended a larger study looking at more severe forms of acute pancreatitis.

Alex Leckie
Senior Nutrition Support Dietitian
Rotherham General Hospital

Diary Dates 2006

National Dates	Meetings - National	Venue and Contact Details
24th April	Nutrition Society The Diet and Health of the Next Generation	The Royal Society of Medicine, London. Website: http://**www.rsm.ac.uk/academ/A10-diet.htm**
9th May	Careers in Academic Medicine	**Venue:** Royal College of Physicians. **Location:** London. **Book online: www.rcplondon.ac.uk**
11th May	Falls, Fractures, Food, Fitness and Medicine: Treating and Preventing Osteoporosis	**Contact:** David Gentles, Events Assistant, Human Nutrition, Division of Developmental Medicine, Queen Mother's Hospital, Glasgow, G3 8SJ. Tel: **0141 201 9353**
13th June	Key Advances in the Clinical Management of Intestinal Failure.	**Venue:** The Royal Society of Medicine, 1 Wimpole Street, London, W1G 0AE. **Further information: http://rsm.ac.uk/academ/A10-intfai.htm**
14th – 16th June	Nutrition Society Meetings - Irish Section, Nutrition in Young People	University College, Cork, Republic of Ireland.
20th – 22nd June	BDA Conference	International Hotel, London. Website: **www.bda.uk.com**
Friday 23rd and Saturday 24th June	BPNG Annual Summer Symposium	Belfry Hotel, Nottingham.
3rd – 6th July	Nutrition Society Meetings – Scottish Section Interaction between genetics, diet, health and disease	Aberdeen Exhibition and Conference Centre, Aberdeen. For further information contact: Liz Costin Tel: **01442 825568**, e-mail: **e.costin@nutsoc.org.uk** **www.nutritionsociety.org**
1st and 2nd August	PEN Group Summer Meeting	London House, William Goodenough College, London, WC1N 2AB. Further details for registration will be in future of *Dietetics Today* and on the PEN Group website: **www.peng.org.uk**
5th - 8th September	The 24th Leeds Course in Clinical Nutrition	Further information: **www.clinical-nutrition.co.uk**
19th – 22nd October	ESPEN	Istanbul. Further information visit: **www.espen.org**
1st - 2nd November	16th Annual BAPEN Meeting	Hotel Metropole, Brighton. Further information: **www.bapen.org.uk**
Thursday 7th December	Choosing, eating, living – Institute of Food Research Open Day	Institute of Food Research. Contact: Jo Belsten: Tel: **01603 255218** Fax: **01603 2558168** e-mail: **ifr.communications@bbsrc.ac.uk**
11th – 13th December	Nutrition Society Meetings- MCR-NHR Cambridge Nutrition in early life – new horizons in a new century	Churchill College, Cambridge. For further information and registration, contact: Liz Costin Tel: **01442 825568** e-mail: **e.costin@nutsoc.org.uk www.nutritionsociety.org**

	Meetings – International	
30 April – 3 May	The International Conference on Nutrigenomics and Gut Health	Auckland, New Zealand. Website: **www.nutrigenomics.org.nz**
20 – 25th May	AGA – Digestive Disease Week 2006	Los Angeles, USA. Website: **www.ddw.org**
16 – 17 June	Perspectives in Inflammatory Bowel Diseases	Lisbon, Portugal. Chairs: Richard P MacDermott, MD and Simon Travis, MD. **Abstract deadline: May 1, 2006** Website: **www.imedex.com**
28 June – 1 July	8th World Congress on Gastrointestinal Cancer	Barcelona, Spain. Website: **www.worldgicancer.com**
1 – 5 July	12th International Symposium on Viral Hepatitis and Liver Disease	Paris. Further details: e mail: **isyhid2006@mci-group.com**
21 – 25 October	14th United European Gastroenterology Week (UEGW 2006)	Berlin, Germany. Website: **www.uegw2006.de**

Remember!

BAPEN Annual Meeting

1st and 2nd November 2006

Remember!

Abstract deadline: Friday 23rd June 2006. See BAPEN website for details. www.bapen.org.uk

ATTENTION! ATTENTION!

Three regions are up for election for regional reps. These are:

NW Thames Wales SW region (East)

The process for election of new representatives is for advertisement here followed by a vote in the next edition, assuming that more than one person applies for each region. Therein lies the problem: so often nobody applies. However, people do think about applying but don't put pen to paper or finger to keyboard. I would like to ask anyone thinking about being a BAPEN rep to get in touch.

Thinking about being a BAPEN rep?... Get in touch!

I can send information on what is involved or discuss it over the phone. Often people ask why there is no new blood in an organisation. The reason is because there is no competition. We all recognise that competition is a good thing especially in this situation. It stimulates thought, brings in new ideas, brings in new blood, a different opinion ... I could go on. Being a regional representative is not particularly difficult and it does help the organisation.

This may be a suitably inappropriate point to announce that I will be handing in the towel as regional rep and Chair. I have been a rep for 6 years now and Chair for 3 years. New blood is needed especially as my commitments as a BAPEN executive officer will divert my attention. I have enjoyed being a BAPEN rep and have learnt a lot. The role of the rep has developed over time and I am sure that the reps will continue to grow and become more influential. Last year the reps managed to bring money into BAPEN for the very first time - over £1000!

There will be a new Chair shortly who will be elected from the current reps and I wish him or her the very best.

Simon Gabe Chairman BAPEN Regional Representatives **s.gabe@imperial.ac.uk**

BAPEN Nutricia Research Fellowship Award 2006

An Opportunity to Win £5,000

BAPEN and Nutricia Clinical Care are pleased to announce an award of **£5,000 to facilitate a research project.**

In addition there will be **3 runner-up awards** of a funded place at the BAPEN 2006 annual conference (Brighton, 1st-2nd November).

The award is designed to encourage research in the area of clinical nutrition and contribute to the evidence base. The award can be used to **fund research, audit or education in a hospital, community or care setting**. All Healthcare Professionals actively involved in clinical nutrition are entitled to apply.

How to Enter: A typed protocol of no more than 1200 words describing the purpose of the study, methodology and details of how you would use the funding should be submitted electronically to Carol Smallman (csmallman@nutricia.co.uk). Instructions for protocol submissions are available upon request from Carol Smallman by e-mail or Tel: 01225 711590.

If you require any further information, please do not hesitate to contact:
Dr Gary Hubbard, Clinical Research Associate: **ghubbard@nutricia.co.uk** or Tel: **01225 711543**

An external panel of judges will assess your protocol. The award will be presented at the BAPEN meeting (subject to approval).

The closing date for application is May 31st 2006

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Wales
VACANT

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