



BAPEN

Advancing Clinical Nutrition

British Association for Parenteral and Enteral Nutrition

A multi-professional association and registered charity established 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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Guidelines and more guidelines



During 2006 much time has been spent in developing and applying guidelines and recommendations to improve nutritional care in the UK. NICE launched its nutritional guidelines in February 2006 (77 recommendations). The Council of Europe Alliance UK has had a series of meetings to discuss how best to implement the guidelines produced by the Council of Europe (almost 120 recommendations) and a launch is expected in the near future. NHS Quality Improvement Scotland has been assessing the extent to which its 'essential' nutritional standards (launched in 2003) have been implemented in Scottish hospitals. Several other nutritional guidelines have also been actively discussed, including those produced by professional organisations, such as ESPEN and BAPEN (e.g. 'MUST' guidelines, which have served as a basis for producing several of the NICE guidelines) and the National Association of Care Catering, as well as the Department of Health (e.g. the Essence of Care Guidelines on nutrition). Although this proliferation of guidelines/standards might be expected to produce benefits, they might also produce problems.

First, with the development of so many clinical guidelines in different clinical fields, there is a risk that health care workers may develop 'guideline fatigue'. NICE alone currently publishes about 20 guideline appraisals per year. Full implementation of these at a similar rate as they are being produced (one every 2-3 weeks) can be problematic for Trusts.

Second, potential confusion may develop when guidelines conflict e.g. the guidelines on the frequency of undertaking nutritional screening and follow up in care homes in the 'MUST' report (published by BAPEN in 2003), are consistent with recommendations provided in the Department of Health's report 'National Minimum Standards for Care Homes' (and with guidelines produced in some other countries), but not with those produced by NICE. Some senior health care workers have therefore been questioning which of the national guidelines (if any) they should implement.

Third, nutritional guidelines or standards may be under-implemented as well as over-implemented, which may cause further problems. Abacus International assessed whether 28 NICE guideline appraisals were implemented to the desired level. 12 of these were considered to be under-implemented and 4 over-implemented, which means that more than half did not hit the target. The reasons for these results are not entirely clear, and it is difficult to predict the extent to which individual guidelines will be implemented.

However, I strongly suspect that the NICE guidelines on nutrition will be under-implemented for several reasons. One of these is that the NICE guidelines do not have the status of core or mandatory standards, and the motivation to implement them may not be so great. Another reason is that unlike implementation of 'technology appraisals', which often recommend either prescription or no prescription of specific drugs, and guidelines for specific conditions or specialities, implementation of the nutrition guidelines will generally involve a wide range of specialities operating in the absence of an appropriate organisational infrastructure. To be effective, many Trusts will need to first establish or have access to a Nutrition Steering Committee and Nutrition Support Team, and appoint specialist nutrition nurses.

Yet another reason becomes evident from examining the report by NHS Quality Improvement Scotland (QIS), which was published in August 2006. This report highlights the difficulties of implementing essential nutritional standards (equivalent to the core standards in England and Wales), which were launched 3 years earlier. Although some progress has been made in increasing awareness of nutritional problems, it is clear that there is still a long way to go. Despite the 'mandatory' nature of these standards, awareness, education and a training programme had not been under development in 12 out of the 17 Scottish Boards. In 16 Boards implementation of nutritional assessment, screening and care planning had not yet commenced, or had commenced in only some parts of the organisation. Overall, it seems that several of the NHS QIS standards were not implemented in the available time frame, and there is no guarantee that they will be over an extended time frame.

A potentially important motivator to implementing guidelines and standards is inspection. To be effective, the inspection process must have 'teeth' i.e. some actual or perceived benefit resulting from a satisfactory inspection and/or a detriment resulting from an unsatisfactory inspection. In England and Wales, the Healthcare Commission is responsible for inspecting hospitals and the Commission for Social Care Inspection for inspecting care homes. These agencies have a major task ahead of them if they are to objectively and effectively inspect not only the ever increasing number of guidelines that are being developed, but also take appropriate and meaningful action if they are not being implemented. Some believe that the teeth of these agencies are not sharp enough, and specific questions have been raised about the robustness, reliability and accuracy of the questions used in the inspection, as well as the process by which they are

continued over page

generated. They have also asked whether these agencies routinely inspect the guidelines produced or promoted by various divisions of the Department of Health.

It seems that the road ahead will be a long one. A practical difficulty is how to go about establishing an operational infrastructure within Trusts, that would allow more rapid and effective implementation of guidelines. This could be facilitated by establishing a national education and training programme targeted at managers at one end of the spectrum, and ward based staff at the other end. The two ends need to meet, not only to initiate change, but to self perpetuate

it. The same principles apply in the community.

BAPEN has been making strategic plans along these lines, but to achieve its aims it would not only need to integrate some of its own activities, but also to join up with and gain the support of other organisations and agencies. Since nutritional problems are multidisciplinary, it makes sense that we should attempt to work together in an integrated and strategic manner to solve the problems that face all of us.

Professor Marinos Elia, Honorary Chariman

The Scottish Food, Fluid and Nutritional Care Standards: Progress, but a long way to go

NHS Quality Improvement Scotland (NHS QIS) is responsible for maintaining and improving the quality of care in the Scottish Health Service. In 2001, NHS QIS started working on standards for food, fluid and nutritional care (FFNC) in Scottish Hospitals, and these were published in 2003, after extensive consultation with the public, the voluntary sector and groups representing the professions. Scottish health boards have to comply with NHS QIS standards and review visits are carried out to monitor progress and promote good practice. Review visits for the FFNC standards commenced in 2005 and the national and local reports were published in August of this year.

The FFNC standards require Health Boards to set up Nutritional Care Groups to develop policy and strategic plans to improve the nutritional care of their patients. Patients requiring complex nutritional techniques should have access to a clinical nutrition team and screening for undernutrition is mandatory for all patients admitted to hospital. Health Boards are expected to develop care pathways and discharge plans for high risk patients, and should have comprehensive training schemes for all staff that are part of the "food chain". Although the six standards appear relatively simple, they represent a formidable challenge to implement and for this reason the first review visits concentrated on the standards that apply to policy, planning, nutritional screening and education, since these represent the bedrock on which the other standards rest.

The Scottish standards apply only to hospitals and not to the community, but they are very similar to the guidance produced by NICE. The Scottish experience can, therefore, provide useful information about the practicalities of implementing national guidelines across a large population. What has the national overview found, and what lessons can it provide for the NHS at large?

All Scottish Health Boards now have nutritional care groups in place, but few have finalised strategic plans and none have a budget to implement the standards. Some Health Boards appear to have failed to appreciate that the responsibility for implementing the standards rested with them although, in fairness, the Scottish Health Service had been through a period of major management reform which may have attracted attention away from this fact. When considering budgets, it is important to distinguish between the cost of providing nutritional care through catering, dietetics and other services already in place, and the very modest sums that are required to support the activities of nutritional care groups.

Only a small number of Scottish hospitals have clinical nutrition teams and the review visits also found that there was a shortage of specialist nutrition nurses. This is an area where BAPEN has a long experience of campaigning and we must continue to call for more clinical nutrition teams. The standards do not require nutrition teams to be present in every hospital, as this would be quite impractical for smaller community units. Instead the standards require that all patients should have access to a nutrition team allowing a smaller health board to network with a larger board that may already have a team in place.

Most areas have started to bring in routine screening for undernutrition, using a variety of screening tools. Many hospitals have adopted 'MUST', but some have continued to use other tools, some of which have been developed "in house". There are major advantages to using a single screening tool across a region, because it reduces the complexity of training and allows patients and staff to move between units, without the need for re-education or having to become familiar with a different screening tool. Many areas have made progress developing care plans, but few have developed discharge plans that consider undernutrition.

The standard relating to education and training has proved to be a major challenge for most boards. The key principle is that all staff involved with nutrition should receive training "commensurate with their duties". There is, however no agreed definition as to what this means, and we need to decide what competencies various staff should reasonably be expected to have. At a practical level it is important to carry out an audit of the training materials already available locally and then complete a training needs assessment for the various groups of staff.

NHS QIS have committed to revisiting the full set of standards in the next three years. Audit Scotland will also complete a follow-up review later this year and will concentrate on aspects of catering and the quality of food delivered to patients, that were not covered by the FFNC visits. This will include information on how much help patients receive on wards. It should make interesting reading.

The launch of the national and local reports was covered by the Scottish press but not by radio or television. Unfortunately the event coincided with the discovery of a terrorist plot to blow up airliners and this understandably was seen as being more "newsworthy". Ironically, far more people die each year from malnutrition than will ever be killed by terrorists. The Scottish Health Minister, Andy Kerr, issued a press release supportive of the standards and urging Health Boards to renew their efforts to implement the remaining standards for nutritional care. The public at the meeting were critical of progress to date. They saw better nutritional care as part of the basic care that patients receive in hospital, and cannot understand a system that tolerates poor quality meals or provides insufficient staff to allow patients to receive help at meal times. Their conclusions are difficult to argue against.

For hospitals elsewhere in the United Kingdom the messages are simple. Don't underestimate the time required to change attitudes towards nutritional care. Form strategic groups as soon as possible. Implement screening for undernutrition early, as this represents one of the best ways of getting onto the wards and is a good starting point for other educational activity. Don't lose sight of the ultimate goal: malnutrition is unpleasant, expensive, and ultimately kills people. It's worth bothering about.

Dr Alastair McKinley



BAPEN 2007

27th-28th November 2007 - Harrogate. For further information see

www.bapen.org.uk

What's in the media?

BAPEN plays catch up on 'Hungry to be Heard' campaign



Media highlights survey among nurses by Age Concern England that concludes they are too busy to help older patients eat.

The publication of Age Concern England's 'Hungry to be Heard' campaign, right at the end of August, came as a surprise to BAPEN as the national charity only provided us with 12 hours' notice of its formal release to the media!

Focused on raising awareness of the number of complaints received by Age Concern from families about older patients not getting the nutrition they required when in hospital, the Campaign document provides seven steps to address these concerns – including the introduction of screening for malnutrition on admission and regular monitoring thereafter.

But with true British spirit, BAPEN Officers co-operated to issue an agreed release within a few hours of receiving information about the campaign (view the release on the BAPEN website). This prompt action resulted in BAPEN being included in a number of key articles in the national media, with comments from our Chair, Professor Marinos Elia, focusing on the importance of identifying more older patients with malnutrition on admission to hospital. Only then, Professor Elia said, will appropriate care and treatment be provided, whether that is enteral or parenteral nutrition, special diet or monitoring of food intake.

BAPEN's quotes were included in articles in the Daily Mail, Evening Standard, Guardian, The Times and Independent. A follow up media release was sent to the health and care professional press.

Caroline Flint, Minister with responsibility for Public Health, declared that a Summit on malnutrition was being organised by the Government in the autumn. BAPEN is still awaiting news of this Summit!

'A Big Step Forward', said the media release from NHS: Quality Improvement Scotland; 'Hospitals miss targets over food nutrition' said the media in Scotland.

NHS Scotland released the results of the first inspection of Health Boards following the introduction of the Standard for Food, Fluid and Nutritional care in 2003, including mandatory screening for malnutrition on admission to hospital. Commenting on the Report, Mrs Jan Warner, NHS QIS Director of Performance Assessment and Practice Development said:

"Until quite recently it would have been unusual to see the nutritional needs of vulnerable patients such as older patients and children systematically assessed. Now in hospitals up and down the country, patients' needs, covering everything from under nutrition to cultural preferences, are being assessed as part of their clinical care. Instead of food, fluid and nutrition being seen as a responsibility only of the catering manager, it is becoming an integral part of the clinical care each patient receives. That is a radical shift that will take time to complete, but today's report reveals that good progress is being made. Having assessed the NHS boards' performance, it is essential to keep up the momentum for improvement by continuing to provide professional development and support to those delivering these essential services."

Douglas Fraser, Scottish Political Editor of The Herald, saw it differently, stating that Health Boards were failing to meet targets, many lacked even a plan and none had yet earmarked specific funding to achieve the nutrition targets set.

Andy Kerr, the Health Minister, said that the Report should be a 'spur for improvement' and that there had been a culture change since the national standards were published in 2003, but it was clear that nutritional care had not been on the strategic radar until fairly recently.

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 am here to help and look forward to hearing from you!

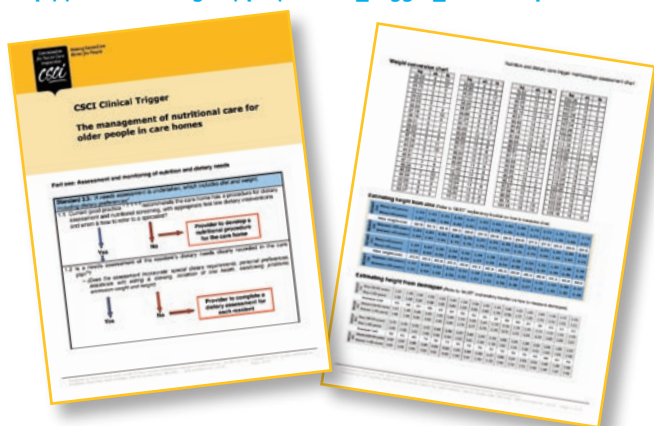
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Raising standards in the Care Sector

Clinical Triggers - Management of nutritional Care

The Commission for Social Care Inspection in conjunction with BAPEN has developed some nutritional triggers for use in Care Homes. These are intended to be used as a guide to help inspectors of Care Homes understand if Homes are meeting the required nutritional standards.

The triggers can be found at
http://www.csci.org.uk/pdf/clinical_trigger_nutrition.pdf



Menu Planning and Special Diets in Care Homes

This manual has been produced by the National Association of Care Catering to assist care home staff meet the nutritional needs of adults in their care. This new manual provides guidance that meets and exceeds the Department of Health National Minimum Standards. It provides solutions to common menu planning problems and special dietary issues. £35 for members, £75 non members.



For further information see www.thenacc.co.uk
or email info@thenacc.co.uk

Highlights from the PEN Group summer meeting

The second day of the PEN group summer meeting was entitled 'NICELY does it' and incorporated a wide variety of nutrition support related topics and recently published guidelines in this area. The focus was on how these impact on dietetic practice.

The morning sessions addressed the now familiar NICE guidance for Nutrition Support, starting with an overview of the 'NICE experience' from Christine Baldwin. She explained how the guideline came about, the professionals involved in the development group and the ever present problems with availability of evidence for nutrition support. How we as Dietitians need to use these guidelines as an opportunity for improving the profile of nutrition was also discussed. Still on the 'NICE' theme, our second presentation from Susan Murray followed on from how the guidelines came about, to how these can be implemented and the tools that are available to help us with this. Susan highlighted some of the common reasons why guidelines are not implemented, such as 'forgetting' or 'not agreeing' with the guidelines and how promotion and team working are two potential solutions to these. There was discussion around the disparities between recent guidelines that have been published, and it was emphasised that we need to look at the process behind the development of them.

Jo Prickett presented the NICE Refeeding Guidelines, focusing on the management of patients that are at high risk of Refeeding and looking at how we can minimise this in clinical practice. These guidelines do differ from the current ones in the PEN Group 'Pocket Guide to Clinical Nutrition' and suggest commencing at a lower rate of feeding with appropriate monitoring of biochemistry, and supplementation of vitamins & minerals. The full guidelines are included in the NICE document and it is planned for the Pocket Guides then to be updated.

Professor Marinos Elia looked at the cost of disease related malnutrition, and covered the basis of health economics, reminding us that resources within the

health service are limited and demands large, therefore choices have to be made.

The afternoon sessions focused on some practical aspects of nutritional support. Dr Simon Gabe touched on the very emotive issue of ethics of feeding patients and reminded us of some of the more infamous ethical cases that have been in the media in recent years. Two important points that came out of the presentation were that there is no legal difference between withholding and withdrawing treatment, and also if in doubt, a trial of treatment could be recommended such as for patients suffering from Dementia, when there is debate around artificially feeding these patients.

Ann Ashworth gave us a comprehensive overview of the NPSA guidelines, 'Preventing wrong route errors with oral/enteral medicines, feeds and flushes', which are due out in final format in autumn of this year. Feeding companies will need to look at the design of their giving sets as they must not contain any in-line female luer ports. Ann encouraged us to be setting up multidisciplinary groups within our Trusts to address the issues in this document.

Ailsa Brotherton presented a summary of a paper she has produced on the impact of PEG feeding upon quality of life. She found that there was a wide range of experiences and perspectives.

Last but not least, Carole-Anne McAtear rounded off the day with a summary of guidelines that have been produced relating to enteral feeding access routes, including the BSG guidelines/NICE/SIGN/ESPEN. Details of how to access these guidelines are available in the presentation, which with all the presentations from both days will be available on the PEN Group website under 'events diary'.

Reported by Alex Leckie

Nutrition Support Specialist Dietitian, Rotherham General Hospital

Nutritional Data – The need for standards

A couple of years ago, NASA and the European Space Agency collaborated to launch a satellite. After the spending of millions of dollars and Euros, the big day came to place the European satellite on top of the American rocket. To the embarrassment of all, it didn't fit. Later it transpired that the rocket was built in feet and inches, whilst (you've guessed it) the satellite was built in metric.

In a field involving international projects like that, the need for standards is obvious and the lack of adherence to them costly. But what about nutrition data? Let's say that a manufacturer of, say, sip feeds, sends you a data sheet on a new product. You look at the nutrition data, see that it looks OK, and file the data sheet away. If there were any obvious errors, such as an amount in grams rather than micrograms, or the values for sodium and vitamin B12 mixed up, you would probably notice.

What just happened? Well... you as a trained professional had sight of the data and your finely-tuned brain applied a whole range of quick checks, probably without you noticing. If there was an error, there is a good chance that you would see it. But imagine that you received the data as an electronic file, which you could import into some program that used it. Would you still check the data? Would you simply assume that it was correct because it came to you from a reliable source? Would you expect the software program receiving it to perform the check and tell you if the data were wrong?

This is where standards come in. If there were a standard for the presentation of nutritional data to which all sources adhered, this would go some way to ensuring that the data you received was reliable. However, a standard is no use unless it is adhered to. Back in the 1800s, there was a standard for the distance between railway lines, but it was not rigidly adhered to, causing some spectacular crashes. Ultimately there was a railway inspectorate to make sure things were done properly. We don't have such a monitoring body in nutrition. Yes, you can rely on the professionalism of nutritionists and dietitians, but they are not always the ones sourcing the data.

In the work that we do, we receive nutrition data from many organisations, which are then incorporated into databases for use in nutritional analysis software. These data range in quality from the excellent to the abysmal. Some organisations provide many nutrients, include the appropriate measure, tell you how they have calculated carbohydrate, etc. Others send you two or three nutrients – sometimes they haven't even calculated the energy from macronutrients correctly, or leave you guessing as to whether some nutrients are in grams or milligrams. The one thing that these data sources have in common is – nothing. They may be in an Excel spreadsheet, in a Word document, on a web page, a scrap of paper, or just read out to you over the phone. Each of these sources has to be handled differently. Even when the data does arrive in an electronic format, they are never the same. We have had some suppliers who, having provided us with a particular format, changed the format completely for a subsequent issue. In that second data set, the order of nutrients had changed, some had been removed, others added, even the measures for the nutrients had altered. As we had written special software for each supplier's data, the work had to be redone. Fortunately, we were diligent in checking the data and format. Wouldn't it be nice to have a consistent format, internationally available, in the public domain, which everyone used?

Now for the good news. It is now possible to design self-checking data formats which will ensure that our nutrition data is properly formatted, consistent with a standard and, most importantly, can be verified at the source and destination. Without going into the details, this approach (which is now being widely used, including NASA) will allow recipients of data to be sure that there are no glaring errors in the data. We are presently working on this standard with the UK e-government project. If you are interested in learning more about this, see www.tinuvielsoftware.com/xmlschemas. Can you manage without it? Of course! You have been working without this wonder solution so far, so can it help you? I believe that it can provide all users with extra confidence that the data they receive is formulated to a high standard. This means that, in time, users can be confident in the data quality without the need to check each nutrient. If this does nothing else for you, it will save time. Moreover, you might be able to access a larger amount of data from a wider range of sources, if it were to adhere to a standard.

The first hurdle is to have the standard approved. This, we hope, will happen in the next couple of months. Then we will have to convince suppliers and consumers of these data to use the standard. That, we suspect, will be a bigger struggle. We'll keep you informed of any progress.

Since this article was written, the XML schema for nutrient composition data has been formally approved by the UK government and the schema, samples and supporting documentation can be found in the GovTalk Schema Library:

http://www.govtalk.gov.uk/schemasstandards/schemalibrary_schema.asp?schemaid=253

The content links can also be found on the Tinuviel Software website.

Tony Johns, Tinuviel Software

An epidemic of obesity, an epidemic of surgery?

Obesity has become recognised as a growing health problem within the United Kingdom and tackling obesity is a key priority for the Department of Health. Along with the overall rise of obesity in the United Kingdom, there has been a marked increase in the prevalence of morbid obesity¹.



The popular press and recent television programmes have heightened public awareness of bariatric surgery as a means of achieving sustainable weight reduction. This goal has proven so elusive in conventional weight management programmes that some health professionals have reached the conclusion that bariatric surgery is the most if not the only effective treatment for morbid obesity rather than as a treatment of last resort. A search of recent literature suggests that surgery is no longer seen as a last resort for morbid obesity but as a tool for managing obesity, as illustrated by the following quote: "Gastric banding is effective for mild-to-moderate obesity. A minimally invasive procedure is better for weight loss than non-surgical programs"². Between 1998 and 2002 the rate of bariatric surgery in the United States increased approximately fourfold³. A similar situation appears to be developing in the UK with the British Obesity Surgery Patient Association (BOSPA) noting on their website that "the number of surgeons conducting obesity surgery (called bariatric surgeons) in the UK is growing rapidly."

If we, as a society, accept that surgery is 'the way forward' in managing obesity and fail to adequately engage the community in modifying our eating, physical activity behaviours, and our environment, then we will fail to slow the epidemic of obesity and risk the health of the next generation. The growth in provision of surgery, although an essential element of the care pathway for obesity, must be accompanied by a proactive development of effective non-surgical options. We need prevention programmes that support a healthier future for our children.

Maryon Davis⁴ (see Figure 1 below) proposed a three tier provision of services. We have modified this model of service for Peterborough and have placed treatment services in the centre of the community. We view our role in health as one of providing leadership, linking with our partners in local government, and other agencies, seeking engagement of communities and community leaders as the force able to generate the cultural change needed for the prevention of obesity.

The challenge of slowing the epidemic of obesity is a challenge that must be accepted by all, as both a personal and societal health aim, if we are to succeed in reducing the health risks we face from obesity.

The challenge for dietitians and other health professionals is to:

1. Provide choice, that is to develop and provide effective and efficient non-surgical programmes
2. Contribute to the evidence base of effective treatment
3. Provide effective programmes to support optimal outcomes for the increasing numbers of patients, who do choose surgical management of their obesity

NICE⁵ recommends that, prior to being considered for surgery, patients should have received appropriate and comprehensive non-surgical management of their obesity for at least six months. We must provide patients with the opportunity to access intensive non-surgical evidence based programmes at a local level. These need to be provided by specialist health care providers such as dietitians, prior to consideration of surgery. In keeping with 'Our Health, Our Care, Our Say', we need to modernise our services and link with surgical providers to provide local specialist services that support patients in achieving the best outcomes from surgery.

It is essential that we support not only assessment and follow-up care of patients seeking surgery, but that we adequately prepare them for surgery and the lifestyle changes they need to put into place. Bachman et al⁶ recommends that prior to surgery, a pre-surgical preparation programme should be available for patients to support informed patient consent and to ensure that patients are adequately prepared for surgery in order to optimise surgical outcomes.

"Pre-Operative) obesity patients may require a lengthy period of preparation to ensure that they have an adequate understanding of the risks and long-term nutritional and medical impacts of bariatric surgery and acceptance and commitment to the long-term behaviour changes required for optimal surgical outcomes..."

They urge that surgery not be provided to potential patients until they have had the opportunity to demonstrate their willingness and ability to put in place the required lifestyle changes. They suggest that this be achieved through participation in a structured multidisciplinary pre-operative preparation programme. Such programmes should support the development of new sustainable behaviour patterns that will promote long-term maintenance of weight loss. Although weight loss is considered an excellent marker for ongoing efforts at behavioural change, the change is emphasised more than the weight loss. Patients are advised that the rate of their progress through the programme to surgery is directly related to their behavioural change. Patients are also encouraged to attend a local pre and post surgery support group throughout the pre-operative process.

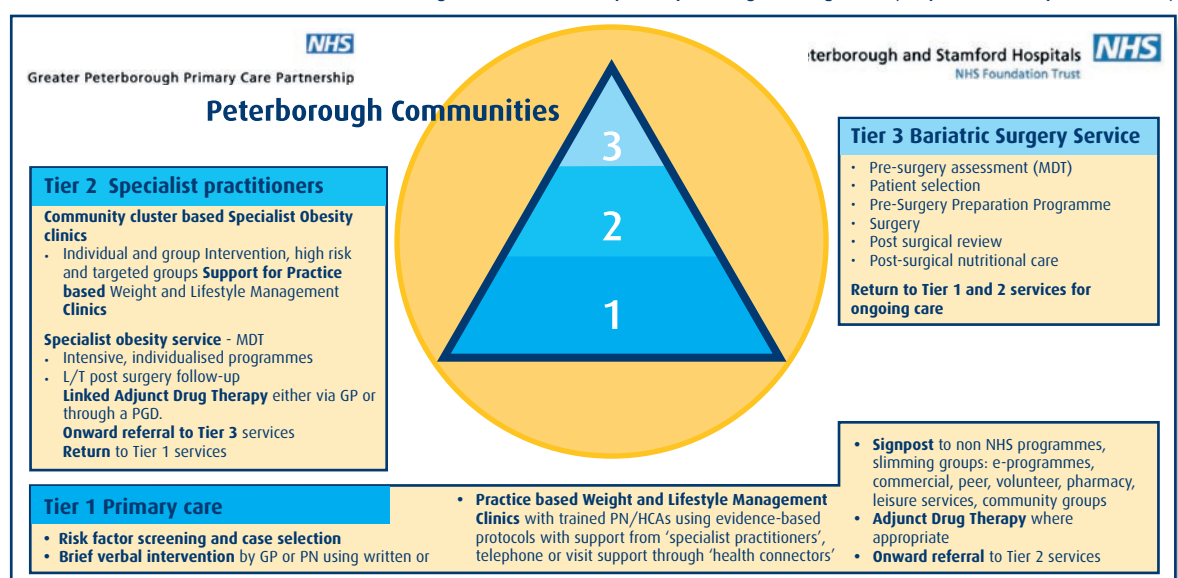
Today, bariatric surgery patients are appearing in general dietetic clinics, having had surgery from an independent provider or in another commissioning area or even abroad. These patients may require post-surgical nutritional advice and guidance, as the surgical provider may not have provided this, or the information may have been poorly understood by the patient or not tailored to their complex needs. Dietitians need to be able to address these needs.

The challenge is to develop specialist services at a more accessible local level and to support community change for a healthier future. In today's economic climate, can we rise to the challenge?

Jean Hughes
Consultant Dietitian in Obesity Management

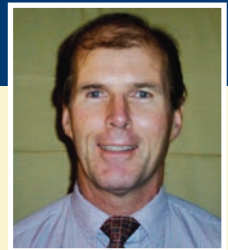
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Figure 1. The three-tier pathway for weight management (adapted from Maryon-Davis 2005)



¹The Health Select Committee Third Report, May 2004. ²A minimally invasive procedure is better for weight loss than non-surgical programs. Health News. 2006 Aug;12(8):11-2. ³Nguyen NT, Root J, Zainabadi K, Sabio A, Chalifoux S, Stevens CM et al. Accelerated growth of bariatric surgery with the introduction of minimally invasive surgery. Arch Surg 2005; 140:1:198-203. ⁴Maryon Davis A (2005) Weight management in primary care: How can it be made more effective? Proceedings of the Nutrition Society; 64: 97-103. ⁵March 2006 NICE issued draft guidelines for consultation. ⁶Bachman, K et al. Bariatric Surgery in the KP Northwest Region: Optimising Outcomes by Using a Multidisciplinary Program. The Permanente Journal/Summer 2005/Volume 9 No 3. Jean Hughes, Consultant Dietitian in Obesity Management, Peterborough Primary Care Partnership.

Executive Summary of BANS data, 2005



Introduction

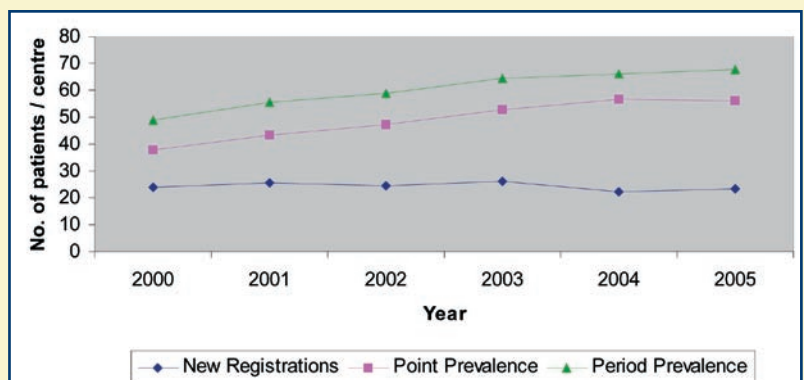
This brief document gives an overview of the data collected in 2005. A full printed report will not be produced this year, but instead the analysis will be placed on the BAPEN website. This is to permit the committee to concentrate on developing and introducing electronic reporting (e-BANS) which we hope to introduce in 2007. It is anticipated that e-BANS will facilitate reporting and quicker and easier access for all to BANS data.

BANS would like to thank the major commercial enteral and parenteral homecare companies for providing independent data in 2006. This has allowed us to provide a better estimation of the total number of HETF and HPN adults and children in the UK by taking into account the shortfall in the accrual of complete data by BANS.

Adult HETF

- New registrations increased by 5.7% between 2004 and 2005 (n 5978) while the numbers of reporting centres remain constant at 257. Point prevalence and period prevalence increased to 18,686 (56 patients per centre; 333 centres) and 23,095 (68 patients per centre; 340 centres) respectively in 2005 (Figure 1). Period prevalence per million population continues to rise (England 384; Scotland 371; N Ireland 465; Wales 386/million).

Figure 1: Adult HETF - Number of new registrations, point prevalence and period prevalence per centre, 2000 to 2005

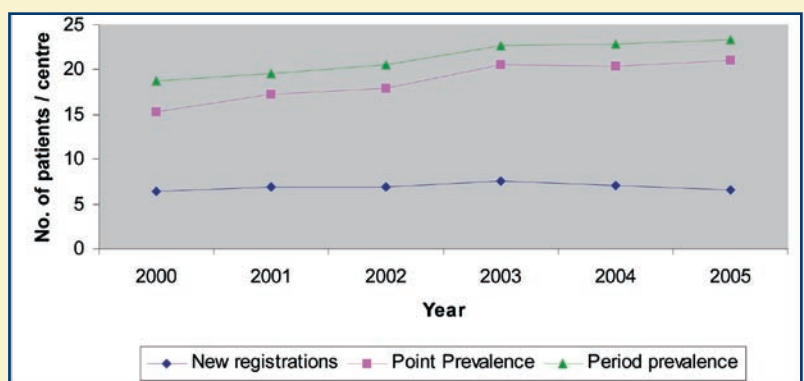


- CNS diagnoses accounted for 52.8% of new registrations with CVA being common diagnosis (26% of patients) followed by neoplasia of all types at 33%. Head and neck cancers accounted for 14% of all new HETF patients. GI disorders represented 24.1% of new registrations.
- The primary reasons for starting HETF were "swallowing disorders" (68%) and "to improve nutritional status" (23.7%). Of new cases, 26.8% were reported to have full activity, 32.8% limited activity, 26.7% were bedbound and 13.2% housebound. A small number of new (n 33; 0.6%) and established (n 138; 0.7%) cases were unconscious which raises ethical questions as to the futility of their treatment.
- Total help was required in 50.6% of new cases while 29.3% were fully independent. 63.4% live in their own home with 34.2% in a nursing or residential home.
- The route of enteral access was gastrostomy in 81.2% and nasogastric tube in 13% of new cases with 84.6% and 12% for established patients.
- There has been no change in new case involvement with a homecare company (new: 81.2%; point prevalence 75.2%).

Paediatric HETF

- New registrations (n 950) have remained stable, but point prevalence (n 4861) and period prevalence (n 5644) have increased by 4.3% and 4.4% respectively. The numbers of reporting centres have remained constant, suggesting a continuing rise in overall numbers of paediatric HETF patients per centre (Figure 2).

Figure 2: Paediatric HETF - Number of new registrations, point prevalence and period prevalence per centre, 2000 to 2005



- CNS conditions account for 36.3% of new cases, GI for 14.6% and respiratory 4.9%.
- HETF in children under 1 year old has risen progressively and represented 38.6% of new registrations in 2005, although only 3.9% of point prevalence is accounted for by this age group. The predominant age group in point prevalence remains 6 - 9 years.
- Full activity was reported in 44% of new cases and 50.4% had limited activity. Children were predominantly cared for in their own homes (97.5% new; 93.5% point prevalence).
- The route of enteral access was by gastrostomy in 34.3% of new cases compared to 53.9% of established ones (point prevalence) whereas nasogastric feeding accounted for 64.6% of new cases versus 45.5% established.
- A homecare company was involved in 84.7% of new cases but only 71.6% of established patients.

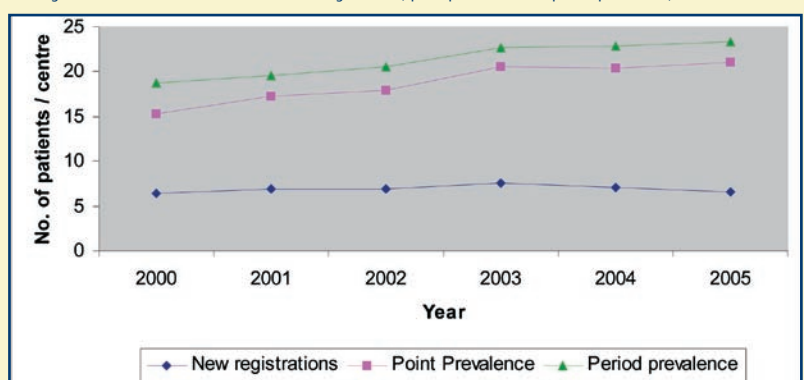
Adult HPN

- New registrations (n 112) were up from 2004 (n 79). Point prevalence (n 636) and period prevalence (n 667) continued to

grow (Figure 3). Period prevalence per million population also continues to rise (England 11.1; Scotland 14.6; N Ireland 5.4; Wales 5.4; UK 11.1/million). Period prevalence continues to rise in England only.

- The age distribution of new cases has not changed significantly.
- GI diagnoses account for 80.4% of new registrations. Crohn's disease is no longer the most common diagnosis in new registrants although absolute numbers grow. Small bowel infarction accounts for 21.4%, Crohn's disease 17%, motility disorders 6.3%, scleroderma 6.3% and radiation 1.8%.
- Indications for HPN were fistula (8.9%), obstruction (13.4%), malabsorption (16%) and short bowel syndrome (44%).

Figure 3: Adult HPN - Total number of new registrations, point prevalence and period prevalence, 2000 to 2005

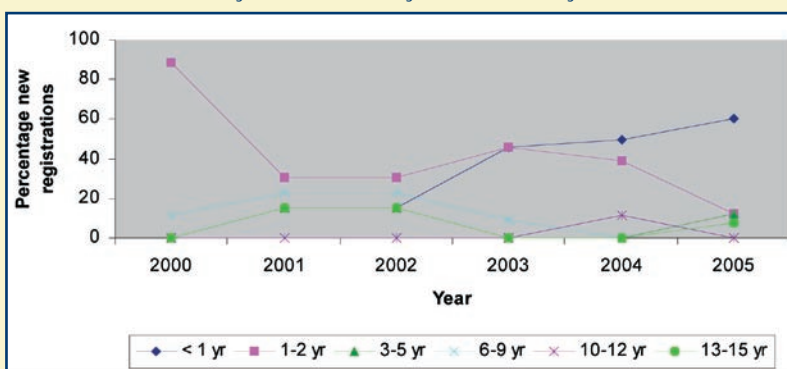


- Full activity was noted in 54% and limited activity in 38%. New patients were independent in 56% cases but totally dependent cases rose from 18% in 2004 to 33%. Almost all live in their own home (93%) but 2.7% resided in a nursing home.
- An external section catheter was used in 96%.
- A homecare company was involved in 97% of new cases and 84% of established cases.

Paediatric HPN

- New registrations (n 25), point prevalence (n 96) and period prevalence (n 111) for children on HPN have continued to rise.
- Between 2001 and 2005 the number of children starting HPN aged 0-1 year rose from 15.4% to 60%, while registrations for 1-2 year olds fell from 89% to 12%, demonstrating that children are starting and/or being discharged home on PN earlier (Figure 4).
- The majority of new cases had GI diagnoses (76%) with the reasons for feeding being short bowel syndrome (40%), malabsorption (28%), failure to thrive (12%) and improvement in nutrition (16%).
- 81% of children are reported as having normal activity and 19% have limited activity.
- 88% of new cases were fed via an external section.
- A homecare company was involved in 92% of new cases.

Figure 4: Paediatric HPN – Age distribution of new registrations between 2000 and 2005



Independent data

- Anonymised data from the major commercial homecare companies indicates that BANS data falls short of complete capture of all patients on HANS in the UK.
- The shortfall varies for point prevalence of each modality (Adult HETF 29%; Paediatric HETF 65%; Adult HPN 18%; Paediatric HPN 39%).
- Using correction factors calculated from this data, we estimate that total point prevalences in the UK (point prevalence /million population in brackets) are: Adult HETF 24129 (403); Paediatric HETF 11753 (196); Adult HPN 735 (12.3); Paediatric HPN 134 (2.2).
- Thus there are an estimated 36,751(614/million) adults and children receiving HANS.

Dementia and HETF

- Recent publications have cautioned against providing artificial nutrition support to those with advanced dementia yet BANS data indicates a continuing rise in numbers being fed by PEG and NG tube from 2000 – 2004. In 2005, there was a decline in numbers for the first time. Nevertheless, there were still 571 patients being fed at the end of 2005.
- These were characterised by total dependency and nursing home placement in the majority of cases.
- Artificial nutritional support of patients with dementia is controversial and the ethical deliberations required before offering such support continue to exercise the minds of all those involved in decision making on a daily basis.

To view the full report visit the BAPEN website: www.bapen.org.uk

Dr Barry JM Jones, Chair of BANS, August 2006.

European NutritionDay

Hopefully, by now, those of you who took part in this will have had your own data compared with the European reference set. The statistical analysis, which will provide us with bench marking information, is now well under way. We are hoping to receive the preliminary report at the ESPEN Congress in Istanbul and more detailed analyses will follow towards the end of the year.

This has all taken rather longer than we expected and this has been because there was such an amazing response right across Europe: 707 units from 24 different countries provided a cohort of 15,440 patients! The UK came third on the list with 1596 patients from 47 units – behind Germany (2105 patients/105 units) and Austria (3015 patients/125 units). The 707 units boasted 522 nutrition teams between them with the highest numbers being in General Medicine (157 units/128 teams), General Surgery (108 units/77 teams), Gastroenterology/Hepatology (62 units/49 teams) and Oncology/Radiotherapy (59 units/48 teams).

Needless to say, the NutritionDay Organisers and Office are thrilled to bits – but daunted by the huge amount of work that has been involved, and this is nowhere near finished! There are two further NutritionDays (one in 2007 and one in 2008) to complete the project so, if you missed out the first time around, this is your chance to become involved in the biggest study of this kind that has ever been undertaken. If you participated this year, then you will want to compare your data on an annual basis and track your progress. Data collection will be undertaken across Europe on **THURSDAY 25 JANUARY 2007. Put the date in your diary now!**

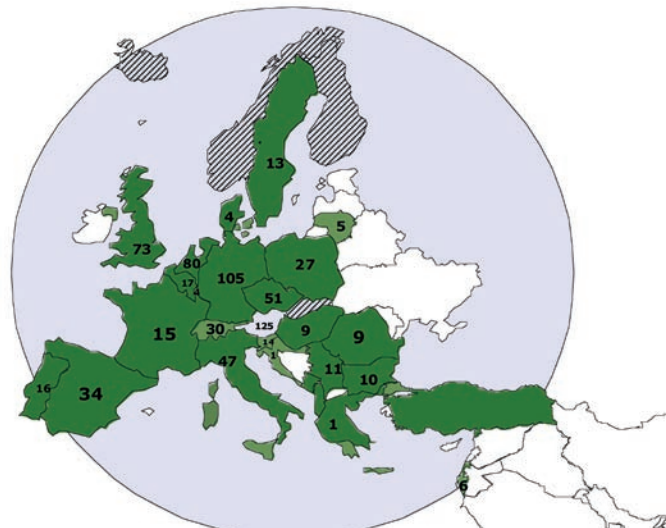
Either way, there will be information available at the BAPEN Conference or you can e-mail me directly - and please head it 'NutritionDay'. In the meantime, very many thanks to all of you who have made this such a successful undertaking.

Pat Howard, ESPEN Liaison Officer
pat.howard@ubht.nhs.uk



Nutrition Day Team

Left to right:
Romana Schlaffer,
Jasmin Kehrberg,
Professor Michael Hiesmayr,
Almuth Schöniger-Hekele,
Karin Schindler.



Food Matters - An update on initiatives



Council of Europe Alliance

The Council of Europe Alliance is a UK wide group of Government and Non-Government organisations, who have a key role to play in the implementation of the Council of Europe's recommendations on food service and nutritional care in hospitals. The Alliance held a workshop event on 18th May. At that meeting stakeholder organisations got the opportunity to feedback to the main group on the idea of breaking down the recommendations of the resolution into manageable pieces for implementation. They also got the opportunity to take responsibility as the "lead organisation" for particular elements of the resolutions recommendations. It was a difficult day to manage and a learning experience in terms of getting quite so many organisations together and beginning to get everyone singing from the same hymn sheet. The outcomes of the day have been disseminated and are being "moulded" into a proposed plan of action for all the stakeholder groups. The big learning outcome of the day was that nutrition is very topical and the improvement of patient nutrition is a priority - so we should be able to get somewhere if we can successfully marshal our resources.

It is proposed that the Alliance group action takes the form of two key initiatives:

- The adoption and endorsement by all stakeholder organisations of "10 Key Points" for successful nutritional care on the ward.
- The development by each key stakeholder organisation of elements of an action plan drawn up from the outcomes of the study day held on 18th May 2006. (BAPEN colleagues will be particularly pleased to note the emphasis on education and the universal adoption of nutritional risk screening).

The group believe that there is great strength in numbers and that if all the key stakeholders represented in the Alliance work together on implementation then progress is assured.

National Patient Safety Agency (NPSA) stakeholder meeting 21st July 2006

The BDA and BAPEN amongst others were stakeholders at this event and the NPSA mapped out its vision of the way forward with regard to nutritional

care. Caroline Lecko (Lead for Nutrition) advised that improving the implementation of nutritional risk screening would be a work stream for the NPSA on nutrition as well as the following topics:

1. Promoting protected mealtimes and undertaking a review of where this has worked or failed and the reasons why.
A questionnaire to all Directors of Nursing is planned.
2. Pre-registration education of nurses - working with the NMC to include nutritional care is a fundamental part of nurse education.
3. Identify the issues and support needed to address nutrition patient safety issues e.g. dehydration, NBM regimens, older people's specific needs and swallowing problems.
4. Other projects include cost of malnutrition and the need to understand the facts and further work on pre-procedure fasting.

Organisation of Nutritional Care in Hospitals

Jeremy Powell-Tuck and I have brought together a small working group to revise this BAPEN document. Jeremy invited me to join him in his initiative and suggested we include the revision of Hospital Food as Treatment in the same piece. I agreed that this made a great deal of sense and gives a more holistic view of nutritional care and support in hospitals. The working party has had a one day meeting and we are agreed that the new document will be an online publication; interactive and not paper. We think that this will make the resource more useful, more accessible and allow us to utilise links to other resources rather than re-invent them. The team have more or less scoped out the content of the work and we are now pulling it all together with the aim of having something useful to share at the November meeting and publishing six months or so after that.

Rick Wilson, Council of Europe Alliance UK Chair

Food Counts! - Doesn't it?

Introduction

The NHS plan for modernisation and reform, that began back in 2000 and which includes the Better Hospital Food initiative, put food provision in hospitals back on the boardroom agenda. As a dietician interested in "food as treatment" this, for me, was the first step in the right direction. Following on from the Lloyd Grossman revolution, it was only a matter of time before myself and like-minded dietitians got together to make a commitment to carry this initiative forward, by sharing best practice and cross boundary working.

Background

Initially formed as an interest group, **Food Counts!** later developed into a British Dietetic Association (BDA) specialist group. Our aim is to promote good nutrition through effective food provision in both healthcare and community settings.

It has always been our objective to focus on food provision in hospitals by setting standards and guidelines that can be implemented across the NHS, to help improve nutrition at ward level.

Developing such standards began with some members contributing to the BDA consensus statement '**A Dietetic Interface with Food Service**'. More recently, members of Food Counts! have been collaborating with the Hospital Caterers Association to produce a much-needed toolkit for dietitians who do not work exclusively in the area of food provision. Likewise, the document provides guidance for hospital caterers trying to compile menus which will meet the nutritional needs of all of their patients.

Malnutrition

Awareness of malnutrition amongst healthcare professionals, together with its financial and clinical consequences, has been on the increase during recent years. However, the recent publication from Age Concern 'Hungry to be Heard' suggests that the modern NHS still has much to do to combat this problem. What this document does highlight are the many facets of food provision. The anecdotes from patients demonstrate that to comply with Core Healthcare standards, score high in PEAT assessments and meet national nutritional standards is not enough. In fact, the social and environmental factors surrounding eating are just as important in the fight against malnutrition.

Other surveys have suggested that food presentation and service to the patient accounts for almost 50% of the patient's perception of total food provision, and patients believe that if the food service is poor, so also is the clinical care.

The aetiology of malnutrition is multi factorial with unfamiliar food, lack of patient choice and physical access to food all being contributory factors. Adherence to Core Healthcare Standards 15A and 15B and the provision of food that meets the nutritional needs of all patients should be the first line of defence for any Trust trying to prevent and treat malnutrition. Hospitals should identify experts in menu planning who can assist in the compilation of patient menus that will not only meet national nutritional standards, but also provide choice as well as being cost effective.

A quality food service is paramount in the treatment of malnutrition, since there is no nutrition in food that is not eaten. Hospitals should, therefore, develop food and nutrition policies and performance manage these as suggested by The Council of Europe Alliance UK.

Education

In 2004, the focus on hospital food moved slightly to consider food provision, not only for patients, but also for staff. This presents one of the most challenging paradoxes of dietetic practice. Patients and staff are two very distinct groups, with very different nutritional needs. Whilst the principles of healthy eating are not appropriate for most patients, many staff will try to have their five portions of fruit and vegetables each day. Food and Nutrition policies that are in place to prevent malnutrition must, therefore, also contain an explicit educational component which will clarify the nutritional needs of a healthy individual versus that of a patient - because this is often where confusion about food provision in healthcare begins.

Following the completion of the toolkit 'Delivering Nutritional Care through Food and Beverage Service', Food Counts! will be developing this as a stand-alone educational programme. Our strategy is to continue to educate healthcare professionals about the value of ordinary food as the first choice.



Conclusion

The issue of addressing malnutrition within the NHS requires a multidisciplinary, cross boundary approach that incorporates all aspects of food provision - from the procurement of quality produce, to the use of quality management systems to continually monitor this. Screening to identify those at risk of malnutrition is integral to this process and food provision to redress undernutrition must also be available. Dietitians, alongside other clinicians and everyone else involved in patient care, must work alongside Catering and Hotel Services staff to provide practical solutions.

Food Counts! run study days twice a year. The next, in November 2006, will consider the use of a food policy to address malnutrition. It will also consider the role of National Patient Safety Agency in the context of the age Concern report. For further details of study days or membership details please contact helen.andrews@bradfordhospitals.nhs.uk or meetings organiser said@btinternet.com

Toni Osmane, Vice Chair Food Counts
toni.osmanet@ubht.nhs.uk

Patients in hospital are 'Hungry to be heard'

So declared Age Concern England, when they launched their campaign to raise awareness of the concerns about lack of attention to food and nutrition, experienced by many older hospital patients and their families.

Gordon Lishman, Director-General of Age Concern said: "Hospitals are in danger of becoming bad for the health of older people. The majority of older patients are being denied some of the basic care they need, leaving hundreds of thousands of older patients malnourished. It is shocking that the dignity of patients is being overlooked, and that Age Concern has to run a campaign to fight for the implementation of such simple measures.

From ward to board, everyone needs to address this problem. Food and help with eating should be recognised by ward staff as an essential part of care, and they should be given time to perform this task."

BAPEN welcomed Age Concern's 'Hungry to be Heard' campaign and continues to support its seven steps to end malnutrition, the most important of which is to ensure that all older people are screened for malnutrition, or risk of malnutrition on admission to hospital. Such screening will help ensure that appropriate nutritional care & treatment and nourishment regimens are implemented.

Nutritional Care - Everyone's responsibility

BAPEN supports Age Concern's call to Health Trusts to make nutritional care and treatment a top priority, and to improve the nutritional care of patients in hospital. Whilst front-line nursing staff have a key role to play, all healthcare professionals from clinicians to dietitians, catering managers to care assistants must take responsibility for ensuring that patients in hospital have access to the food and nutritional care they need.

Age Concern's strategy was to highlight that 9 out of 10 nurses, in response to a telephone poll, said that they do not always have time to help patients who need assistance with eating.

Age Concern's press release stated: "This lack of nursing time and the failure by hospitals to introduce simple safeguards has hit the most vulnerable. Hard-hitting statistics show that six out of ten older patients are at risk of becoming malnourished or their situation getting worse while in hospital. It means older patients, who occupy two thirds of general hospital beds, are at risk of malnutrition while in hospital."

Malnutrition – not an instant condition

As all involved with nutritional care and treatment know, for most older patients, malnutrition does not happen instantly on admission to hospital – for many it is a condition that has taken weeks, and in many instances, months to develop. And for many older patients, an underlying disease is often a major contributing factor. Many professionals working in this area believe that more malnourished patients should be identified, not only on admission to hospital, but also earlier, such as when support and care services are being provided to older people in their own homes.

Only then will malnutrition be effectively tackled where it really starts – in the community and at home.

Age Concern's Seven Steps:

1. Hospital staff must listen to older people, their relatives and carers
2. All ward staff must become 'food aware'
3. Hospital staff must follow their own professional codes and guidance from other bodies
4. Older people must be screened for the signs or risk of malnutrition on admission and at regular intervals during their stay
5. Introduce 'protected mealtimes'
6. Implement a 'red tray system' and ensure that it works in practice
7. Use volunteers where appropriate



AGE
Concern

Hungry to be Heard
The scandal of malnourished older people in hospital

As part of their campaign, Age Concern is urging older people and their families to visit www.ageconcern.org.uk/hungrytobeheard and record their own experience of eating in hospital.

Readers may also be interested to read BAPEN's Policy Report 'Malnutrition among older people in the community', published jointly with the ILC-UK and the ENHA. Access this report from BAPEN's home page at www.bapen.org.uk

In-Touch – Software article

Software to enable healthcare professionals (HCPs) to calculate nutritional intake is available from a number of companies, but enteral feeding products have not traditionally been included in these programmes.

Manufacturers of nutritional drinks and enteral tube feeds have realised the value and

importance of providing product information to dietetic software companies to enable HCPs to calculate a patient's overall dietary intake more easily. Abbott Nutrition and Nutricia are amongst those companies that have for a number of years provided product information to companies such as CompEat, Microdiet, Tinuviel WISP, and Diet Plan.

HCPs should be encouraged to check with their software provider in the first instance to ensure that the enteral feeding products they are using are available on these programmes.

The importance of EARNEST

Early Nutrition Programming and Health Outcomes in Later Life: Obesity and Beyond - Budapest, Hungary 20th - 21st April 2007

On behalf of the EARNEST partners and the European Academy of Nutritional Science (EANS), the Organising Committee is pleased to invite readers to the 'Early Nutrition Programming & Health outcomes in later Life: Obesity & beyond', conference to be held 20th - 21st April in Budapest.

Nutrition during pregnancy and infancy can exert important long-term effects on development and health. These 'programming' effects are an important topic in biomedical research, nutritional and health care practice and health policy in the near future. This International Conference provides up-to-date information on basic scientific research, epidemiological data and clinical findings on the fascinating relationship of maternal and infantile dietary intakes, to various functions at later ages.

With the support of the European Commission (EARNEST Food-CT-2005-007036) scientists, clinicians, representatives of recommending bodies and food manufacturers will be brought together to discuss findings and develop new synergistic approaches for further advances in this field. Invited experts will provide state-of-the-art lectures on major topics and young scientists will present their original research.

The Conference is being held as a satellite of the 15th European Congress on Obesity and will cover maternal/infant diet in relation to cardiovascular risk, obesity and diabetes, nutrient-gene interactions and the mechanistic basis of early life programming. Confirmed speakers include Cyrus Cooper, George Davey-Smith, Tams Decsi, J Stewart Forsyth, David Gardner, Berthold Koletzko, Jan Kopecky, Rudiger von Kries, David Leon, Alan Lucas, Richard Martin, Cornelia Metges, Denes Molnar, Sjurdur F Olson, Andreu Polson, Lucilla Poston, Brigitte Reusens, Griffin Rodgers, Atul Singhal, Piotr Socha, Michael Symonds, Antonio Vidal-Puig and Francesco Villarroya.

Log on to www.metabolic-programming.org for more information about EARNEST and the work of its partners and to access full information regarding the Conference. Abstracts should be submitted in English and on-line only. Deadline, 10 January 2007 with acceptances confirmed by 31 January 2007.



PRAGUE

29th ESPEN Congress

8th - 11th September 2007

Important Dates and Deadlines

Opening of abstract submission: **27 January 2007**
Closing of abstract submission: **11 April 2007**
Early registration deadline: **25 May 2007**
Deadline for late breaking abstracts (posters only): **7 July 2007**
No refunds for cancellation after: **8 July 2007**

Website: www.espen.org

Organising Secretariat

MCI has been selected by Central ESPEN as the official Congress Organiser to process registrations, hotel reservations, excursions. Information on the commercial exhibition as well as organisation and sponsorship of special events may also be obtained from the organising secretariat: All correspondence should be sent to: **ESPEN 2007**
c/o MCI
Rue de Lyon 75
CH-1211 Geneva 13
Switzerland
Tel. +41 22 33 99 580
Fax +41 22 33 99 601
E-mail: espen2007@mci-group.com
Information regarding the programme of the congress will be available on the ESPEN website: www.espen.org from January 2007

Journal Watch from a doctor's perspective

To PEG or not to PEG. A review of evidence for placing feeding tubes in advanced dementia and the decision-making process. Cervo FA, Bryan L and Farber S. *Geriatrics* 2006 Vol 61(6) p 30-35

This review article provides a comprehensive summary of nutritional problems frequently encountered in the management of the patient with advanced dementia. This situation is recognised to occur frequently in everyday clinical practice, not just by the nutrition support team but by many physicians and health care professionals, especially those caring for the elderly population. The authors estimate that patients with dementia account for 30% of feeding tube placements and that up to 10% of institutionalised patients in the USA are tube fed, many of these possibly without benefit. Mortality rates reported around the time of insertion are high with a 23.5% risk of mortality during the hospital admission when the tube was inserted and a median survival of 7.5 months post-insertion. The reasons for PEG tube placement are discussed and they review the lack of evidence for measurable nutritional improvement, maintained skin integrity and reduction of aspiration risk following tube insertion - common reasons for the referral of the patient to the endoscopy department. The possibility that as a result of tube feeding these patients experience loss of social interaction associated with mealtimes and removal of the pleasure of eating is raised and proposed to reduce quality of life. The crucial role of the physician as educator in particular of family members is emphasised such that the feelings of guilt and desperation often reported by next-of-kin are minimised and where possible the disease can be allowed to run its natural course. A pathway to guide the decision making process for patients with advanced dementia is outlined.

Early enteral nutrition in severe acute pancreatitis: A prospective randomized controlled trial comparing nasojejunal and nasogastric routes. Kumar ADM et al (2006). *Journal of Clinical Gastroenterology*, Vol 40(5), 431-434.

Nasojejunal (NJ) feeding is widely practiced for nutritional support of patients with acute severe pancreatitis, however as this small, randomized study of thirty-one patients demonstrates, nasogastric (NG) feeding is likely to be just as effective. Both NG and NJ tubes were endoscopically placed and a semi-elemental feed, Peptamen administered. Through use of slow initial infusions and small feed volumes, feeding was well tolerated in both groups with no difference in severity of pancreatitis or recurrence of pain. The infusions seemed to be tolerated even in those patients with ileus. The nutritional parameters measured unsurprisingly showed no differences or improvements over the 7-day study period.

What this study does provide is further evidence that early enteral feeding is well tolerated in patients with severe pancreatitis and that post-pancreatic feeding is not necessarily any better than NG feeding. The conclusions are particularly welcome given the logistical difficulties experienced in organizing NJ tube placement in many institutions.

Percutaneous endoscopic gastrostomy placement without skin incision: results of a randomized trial.

Sedlack, RE, Pochron NL and Baron TH. *Journal of Parenteral and Enteral Nutrition*; May/June 2006;30,3, p 240-245

PEG placement techniques were developed in the early 1980s. Since then the tube technology has developed such that the tip of the PEG tube has a durable dilating tip. This single blind, prospective study was performed to determine whether skin incision is required for successful PEG placement and whether there is any difference in peristomal complications. There were 25 patients in each group with follow up at day 2 and 7. Unfortunately there was a high drop out rate and day 7 complication data was incomplete. The rate of successful PEG tube placement with incision omission (IOPEG) was reduced (but not significantly so) to 88% due to perceived excessive tension required to pull through the device compared with a success rate of 96% for standard PEG insertion (SPEG). Unfortunately data recording pull force tension is incomplete but suggestive of substantially increased pull force for IOPEG. Risk of stomal complications did not appear to be affected by skin incision. The authors suggested that a change in standard insertion technique be considered.

The study utilized 20Ch PEG tubes which seems much larger than those commonly inserted for feeding in our clinical practice and the thought of pulling through a tube of this caliber without a skin incision is daunting. It is good practice to review our endoscopic techniques periodically however it does not seem that this particular change would offer any substantial clinical benefit.

Jacqueline Binnie, SpR Gastroenterology, St George's Hospital

Diary Dates 2006

National Dates	Meetings - National	Venue and Contact Details
1st – 2nd November	16th Annual BAPEN Meeting	Hotel Metropole, Brighton. Further information: www.bapen.org.uk
8th November	Royal Society of Medicine – Food and Health Forum; Slowing the ageing process – dietary and other interventions	Venue: Royal Society of Medicine. For further information: Lindsay Michael Tel: 020 7290 3943 Fax: 020 7290 2989 email: food@rsm.ac.uk www.rsm.ac.uk/food
24th – 25th November	7th National Nutrition and Health Conference 2006	Venue: Olympia, London. Cost: £115 for the 2 day event or £75 for 1 day. Low budget accommodation available - see website. For further information: Tel: 0870 7663216 email: admin@nutritionandhealth.co.uk www.nutritionandhealth.co.uk
28th November	Royal Institute of Public Health. Preventing Malnutrition in the Community - What works	London. Contact: Jennifer Tatman Tel: 020 7291 8353 www.jtatman@riph.org.uk
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.nutritionandsociety.org
Dates – September to December 2006	Hungry for Information?	Hotline: 0870 890 5005 www.infantandtoddlerforum.org Freeport: RLXH-HXJX-LLSZ, Infant and Toddler Forum, Bradford, BD6 1YA

Meetings – International		
22nd November 2006	Conference - From Malnutrition to Wellnutrition	Le Meridien, Carefour de l'Europe, Brussels. Further information from www.european-nutrition.org/malnutrition.cfm
28th – 31st January 2007	ASPEN Clinical Nutrition Week	Phoenix, USA. Further information www.nutritioncare.org

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BAPEN Nutricia Research Fellowship Award 2006 Winners!

This year for the first time, members of the BAPEN Research and Sciences Committee as well as representatives from Nutricia Clinical Care, judged the 12 submissions that were received. The submissions were judged anonymously, and no judges were co-authors on any of the submissions.

The winner of the 2006 award is Rebecca Hartley, Senior Dietitian at Papworth NHS Trust, Cambridge (Co-investigators Alain Vuylsteke and Jo Armstrong). Their project is entitled: *'The Impact of a bedside Computerised Information System on the adequacy of Nutritional Support in Critically Ill Patients. - A single prospective non-randomised study'*. Rebecca wins an award of £5000 to fund her research.

Summary of proposed research: Although the optimal nutritional requirements of critically ill patients are yet to be defined, it is well established that patients frequently receive less than the prescribed volumes of feeds. This study will investigate the impact of a Computerised Clinical Information System (CIS) on the adequacy of feeding in patients who remain mechanically ventilated for a minimum of 96 hours. During the four months prior to implementation of the CIS, thirty patients will be recruited, and adequacy of feeding reviewed compared with thirty patients after the implementation of the CIS. Primary outcome will be the adequacy of feeding, and secondary outcomes will look at length of mechanical ventilation, time on Critical Care and the impact on dietic workload. The results of the research will be presented at BAPEN in two year's time.

Two runners-up prizes have also been awarded to Michelle Davies, Senior Haematology Research Nurse at the Christie Hospital, Manchester and Lowri Lloyd-Jones, Head of Wirral Primary Care Dietetic Services at St Catherine's Hospital, Birkenhead, who both receive a paid place at BAPEN Conference 2006.

Next years award will open in March 2007. We require 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. Please contact Dr Gary Hubbard (Clinical Research, Nutricia) for further details contact g Hubbard@nutricia.co.uk

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21st birthday

2007 Spring conference

Knebworth Barns conference and banqueting centre



'Don't look back in hunger.....'
27th and 28th June 2007

email jane.fletcher@uhb.nhs.uk for details