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BAPEN
Advancing Clinical Nutrition

InTouch
46

A focus on nutrition initiatives

Chairman of BAPEN Professor Marinos Elia reports...

Large-scale studies examining the prevalence of malnutrition in hospital have already been undertaken in the Netherlands, Germany and China. In addition, ESPEN has amassed data, such as the body mass index of patients in various wards in countries within the European Union including the UK. These studies have used different screening procedures and none have examined the prevalence of malnutrition outside hospital.

In the UK the prevalence of malnutrition, identified using 'MUST', has been reported in a limited number of locations. This means that a broad representative picture of malnutrition in the UK, established using a consistent screening procedure, is lacking.

National Nutrition Screening Week

This year BAPEN plans to lead a national Nutrition Screening Week (headed by Mrs Christine Russell) in collaboration with the British Dietetic Association and the Royal College of Nursing, with support from the National Patient Safety Agency. The survey is due to take place in September and the results linked to local policies and educational activities. The study aims to not only involve hospitals, but also care homes and sheltered housing. Feedback will be provided to local centres, but the data will not be used in any way as performance indicators. Anyone interested in participating should send an email to the BAPEN office or go to www.bapen.org.uk

Meeting with the Minister of Care Services

Note of the screening week was taken by the Undersecretary of State Mr Ivan Lewis MP (Minister of Care Services, who is heading the Dignity of Care Campaign, which has important nutritional components) both through correspondence with me and through a meeting in June 2007. This meeting was also attended by Rhonda Smith, who helped in preparing the agenda and notes for the meeting, and Rachel Walsh (DH), who has been closely involved in drafting the Nutrition Summit Action Plan.

Among the additional issues raised at the meeting were:

- The Integration of Clinical Nutrition into mainstream Nutrition Policy: everyone has a fundamental right to have their nutrition managed when in hospital and care (as fundamental as keeping free of infection whilst in hospital).
- Nutritional screening provides health and care workers with the 'tool' to identify malnutrition and implement a process and care plan. It must become embedded in routine practice as 'best practice' – the 'default' locally if no national mandatory policy is being put into place. There are current concerns about possible elimination of nutritional screening from Care Home policies (DH consultation).
- A meaningful inspection process (from development to follow-up) - not a tick box exercise – to be put into place.
- Payment By Results (PBR) and Healthcare Resource Grouping (labelling of malnutrition as a basis for PBR) – measure the implementation of nutrition policy.
- Embed representation in Department of Health (DH) for Clinical Nutrition, for example, with the Medical and Pharmaceutical Industries (MPI) and Purchasing and Supply Agency (PASA) to provide the patient perspective on the impact on patient choice and quality of services in primary care.

The Nutrition Summit

The Nutrition Summit, which involves DH and various professional and patient organisations including BAPEN, offers an opportunity to advance the nutrition agenda in a coherent way. Keeping in close contact with governmental and non-governmental organisations is necessary if we are to prevent malnutrition and improve the care of those with established malnutrition in an integrated and strategic manner.

In order to do this it is necessary to take into account the following:

- Malnutrition is often caused by an underlying clinical problem (e.g. a mechanical swallowing problem or disease), particularly, but not exclusively, in older people. Although a sole focus on food, menus, and support with eating may help improve patient experience and support the Dignity agenda, it will not address the underlying problem of malnutrition and its effective treatment.
- Malnutrition is not only a Dignity issue; it is now officially recognised by the Department of Health as a patient safety issue.

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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.

Continued from page 1

- Major inequalities in the incidence of malnutrition exist between geographic regions in England (North-South divide) as well as within the same geographic region. The latter are related to the index of multiple deprivation and to greater mortality in hospital. Major inequalities in provision of nutritional care also exist: in care homes (not only individual care homes but also between Local Councils) and in the use of enteral and parenteral nutrition. Standardisation of care provided by health care workers will not adequately address the underlying problems.
- About 97% or more of malnutrition exists outside hospital (in care and community settings). Interventions in these other settings could have an economic impact by reducing hospital admissions and readmissions. An integrated system of care which addresses both funding and continuity of care will make a significant difference.
- No one profession owns malnutrition. Malnutrition must be positioned as being the responsibility of everyone, and any campaign should involve all stakeholders.
- To be maximally effective, each new initiative on malnutrition must operate within an infrastructure that contributes to a delivery chain continuum - from ministers and government through health and social care gatekeepers and professionals and on to patients and residents. Co-operation within and between governmental and non-governmental organisations is essential. Each initiative must identify its audiences, clarify its objectives and fully recognise its limitations and strengths.

BAPEN looks forward to the draft Nutrition Action Plan from the DH, expected shortly, and to contributing to the next Nutrition Summit meeting in July.

NSW Nutrition Screening Week

Nutrition Screening Week

25th-27th September 2007

Help us to find out more about the number of malnourished people being admitted to hospital and care in the UK today.

If you would like to help and take part see www.bapen.org.uk for further information

What's in the Media?

Nutrition and malnutrition once again received their fair share of media attention, with BAPEN itself being featured and BAPEN officers quoted.

Prompted by news of Care Services Minister Ivan Lewis' Nutrition Action Plan, The Food Programme on BBC Radio 4 devoted one of their programmes to the issue of malnutrition in care homes. Professor Marinos Elia was interviewed to set the scene on prevalence and impact of malnutrition, whilst NACC (the National Association of Care Caterers) and the Caroline Walker Trust discussed the detail.

The launch of the RCN's Nutrition Now campaign - an initiative to raise awareness of the importance of nutrition amongst those in hospital and care – caused a media stir! Why?

The survey showed that almost half (46%) of nurses who responded said that there were not enough staff to help patients who may need help with eating and drinking. 49% of nurses also said inadequate availability of food outside mealtimes was a factor in poor nutrition.

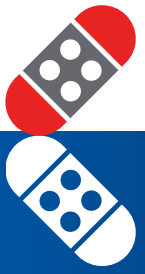
A call came from the Hospital Caterers Association in May at their national conference for doctors to take 'more lead over nutrition'. Dr Sumantra Ray, a clinical research and teaching fellow at the University of Dundee, said catering and nutritional intake needed to be seen as a clinical discipline, with doctors taking the lead on advising patients. He was critical that currently only basic nutrition is taught to trainee doctors, which has led to a lack of competency and interest.

An article in the British Medical Journal at the beginning of May by McMurdo & Witham from the University of Dundee gave a warning that major reforms are needed in care for older people. The article called for a reform of the whole system, rather than just commissioners and champions, in order to see the greatest improvements. Reforms are long overdue and would involve changes in areas such as legislation, regulation, standard-setting, infrastructure, procedures and training.

The Independent published a story which was picked up widely throughout the media. The article was entitled 'We are eating ourselves ill: Treating malnutrition costs NHS more than obesity'. The author reported that we are constantly warned about watching our weight, but that many of us are not eating enough nutrients to stay healthy. The huge rise in cases and cost of malnutrition in the UK is being partially blamed on the nation's addiction to salty, fatty, junk food. BAPEN was quoted widely in this coverage.

The BAPEN Malnutrition Matters Conference 2007 (26/28 November) is starting to appear in listings in a variety of publications – please go to www.bapen.org.uk to find out more information!

Rhonda Smith
PR and media officer



A NICE/BAPEN Shared Learning Initiative – your experience counts!

Have you had experience of implementing recent nutritional guidelines e.g. NICE, Quality Improvement Scotland, Council of Europe?

Are you able to share that experience – whether successful or challenging?

Have you a few moments to submit a short summary for consideration for BAPEN 2007 and the BAPEN website?

Your professional colleagues would love to learn from your experience and BAPEN will provide the platform to disseminate that experience.

As well as being uploaded onto the BAPEN website and discussed at the BAPEN Conference, successful summaries will also be forwarded to NICE for consideration for their Shared Learning website. Log onto **www.bapen.org.uk** for full details. Next deadline for submission is 28th February 2008.

Where to next with the Council of Europe Work?

Many readers will be thinking – as I am – well... what next with the implementation of the Council of Europe Resolution 'Food and Nutritional Care in Hospitals'. BAPEN has been working collaboratively with several key stakeholders in each of the four home countries to promote the implementation of the 100+ recommendations for improvement identified in the Resolution. A lot of things are happening – but it is not a 'big bang', instead there is a quiet revolution going on which is being led by stakeholder groups on several fronts.

Education & Training

In education and training several stakeholders – including BAPEN – are involved in-high level, round-table discussions aimed at developing National Occupational Standards for Nutritional Care. A big skills gap in the UK workforce has been identified and recognised at high level. This gap in nutritional care skills and knowledge is adversely affecting nutritional care in the health sector and other sectors such as schools. To put this right infrastructure development is required, needing the collaboration of the Sector Skills Councils – principally People 1st, Skills for Care and Skills for Health. Once the infrastructure is in place then educational award-making bodies can configure their offerings to meet the skills gap.

Other 'content' initiatives are also underway – the RCN's 'Nutrition Now' campaign, BAPEN's 'Organisation of Nutritional Care in Hospitals' (coming soon), and the BDA's 'Delivering Nutritional Care Through Food and Beverage Services'.

Screening

Screening for malnutrition is recommended by several regulatory bodies across the UK and a programme of awareness raising to improve implementation is required. BAPEN is working with the BDA, the RCN and the National Patient Safety Agency (NPSA) on Nutrition Screening Week to be held in September this year.

Protected Mealtimes

The Protected Mealtimes initiative is regarded as useful and successful where it is implemented. Its effects are being formally evaluated in England by the NPSA and they have re-launched the video and CDROM created by the Better Hospital Food Project. Further work in England is being carried out by the National Centre for Innovation and Improvement. At several pilot sites they have been implementing lessons learned from the car industry to make more effective use of time on the wards. This project is called the Productive Ward and more information can be found at:
www.institute.nhs.uk/quality_and_value/productivity_series/productive_ward.html

10 Key Characteristics

This document is a short description on one side of A4 of what good nutritional care looks like. It is designed to communicate this at several levels in a Trust and be meaningful at all levels – from bedside to boardroom.

Mechanism for co-branding

The joint working which has evolved through the CoE Alliance will continue and we aim to strengthen and sustain our communications so that we can co-badge initiatives where there is shared benefit.

Risk Management

Patient safety is of great concern. A recent review of patient safety in England revealed that approximately 2,000 patients per year die as a result of errors. This is completely unacceptable and would cause a furore in any other industry – imagine the headlines if 2,000 people died as a result of an error on the railways! The NPSA in England is taking the lead in raising awareness on how important nutritional care is to patient safety. A missed or wrong meal is just as likely to cause the patient harm as a missed or wrong medicine – this is a message we all need to take on board. Reporting errors in the provision of nutritional care will help us to learn from our mistakes and improve our patients' outcome.

The Department of Health in England recognises that the proper provision of food, fluid and nutritional care is a big part of the Dignity and Respect agenda. Failure to meet someone's basic needs in this regard shows a fundamental disregard for their dignity and human rights. It is expected that a second Nutrition Summit called by the Minister for Social Care and Development, Ivan Lewis, will result in an action plan reinforcing the steps needed to improve nutritional care in all our hospitals and care homes.

The tools to do the job are now taking shape and becoming more widely available – we all need to reflect upon the services we offer in our institution and identify a course of action for improvement.

Rick Wilson

Journal Watch
May - June 2007

McGarr S.E. & Kirby D.F. (2007) Percutaneous Endoscopic Gastrostomy (PEG) Placement in the Overweight and Obese Patient. JPEN. Vol 31, No.3, pgs 212-216

Traditionally, obesity has been considered a relative contraindication to PEG placement. The reasons for this have largely been due to technical difficulties with gastric transillumination, locating anatomical landmarks and approximating the abdominal and gastric wall. However, with more of the population becoming obese or overweight, it is inevitable that more overweight patients will require nutritional support and consideration for a PEG.

This American study evaluated 355 consecutive patients who had PEG placement at a single centre. Of this group 134 were considered overweight (BMI>27 kg/m^2) with 80 of these considered obese (BMI >30 kg/m^2). In the obese group BMI ranged from 30-63 kg/m^2. Reasons for PEG insertion included neurological (69% of patients), trauma (15%) and Malignancies (15%). The 'pull' technique was used for PEG insertion for all patients with a 20FR or 24FR kit.

The procedure was successful in 130 of the 134 overweight/obese patients. There were no procedure-related deaths or major complications at 30 days post PEG. Minor complications were encountered in 3 patients, one of these being inflammation at the site. The authors did not feel that the increased distance between the internal and external flange in overweight patients correlated with any increase in complications. The authors recognise that their impressive success rate may be due in part to careful selection and follow-up of patients by a nutrition support team.

Of the 4 patients in whom PEG placement was not successful, the procedure was abandoned due to an inability to transilluminate the abdominal wall and a paucity of anatomical landmarks. It would have been interesting to know which BMI range these 4 patients fell into and if these difficulties occurred only in the most obese patients or not.

Overall this is a very useful study and shows that, with careful selection and follow up, PEG placement can be safely considered for overweight or obese patients.

Bader S., Balke P., Jonkers-Schuitema C.F., Tirzah A.J. Tas, Sauerwein H.P. (2007) Evaluation of 6 years' use of sodium hydroxide solution to clear partially occluded central venous catheters. Clinical Nutrition. February 2007. Vol 26. pgs 141-144.

Central venous catheter occlusion is a common complication in patients on long-term parenteral nutrition (PN). Causes include thrombus formation, drug precipitation and lipid deposition. Urokinase may be useful in clearing partially occluded lines when thrombus formation is suspected. Hydrochloric acid or ethanol may be useful in clearing lipid deposits.

It is recognized that lipid-containing PN is an important risk factor in catheter occlusion. However, the authors of this study suggest that occlusions are likely to be multi-factorial and as such, any solvent used should be effective on both proteins and lipids. They suggest that sodium hydroxide meets the criteria. During the 6-year evaluation period of this study, sodium hydroxide was effective in unblocking 73 out of 95 partially occluded catheters. They conclude that the use of sodium hydroxide for this purpose showed a significant long-term improvement in catheter care.

These findings may be of interest to centres where catheter occlusion is not successfully managed with traditional drugs or solvents.

Shikora S.A., Kim J.J. & Tarnoff M. E. (2007) Nutrition and Gastrointestinal Complications of Bariatric Surgery. Nutrition in Clinical Practice. Vol. 22, No.1. pgs 29-40.

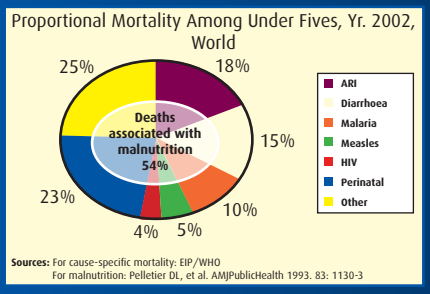
This invited review gives a useful and fascinating overview of some of the current operative procedures used in bariatric surgery and their related complications. The authors suggest that, in recent years, there has been a 600% increase in the use of this type of surgery to treat patients with weight problems. With this in mind, a basic understanding of the procedure and aftercare would be useful to all not currently familiar with the key issues.

Jane Fletcher
Nutrition Nurse Specialist
University Hospital, Birmingham

Malnutrition – another continent, another world

Malnutrition is the underlying cause in more than half of all child deaths. Changes in child survival are strongly associated with decreases in malnutrition in countries characterized by high rates of general malnutrition[1].

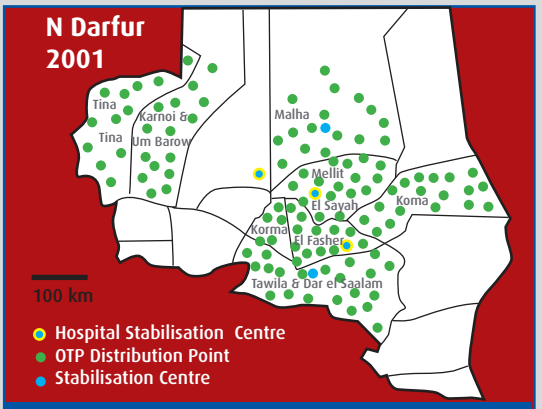
Ethiopia is the third most populous country in Africa, with an estimated population of 77.4 million – of which 15,480,000 are children under 5.
The under-5 mortality rate of 169/1,000 live births ranks it 20th in the world and corresponds to 506,000 under-5 deaths annually, many of which are rooted in malnutrition. Malnutrition among children in Ethiopia remains unacceptably high; they are stunted (46.5%), underweight (38.4%) and wasted (10.5%)[2]. These malnutrition rates have either remained stagnant, or worsened, since the mid 1980s (e.g. low weight-for-age was 37.3% in 1982/83 compared to 47.2% in 2000). Rural and urban differences are pronounced, with the rural poor being the most disadvantaged.



On a national level, the prevalence of acute malnutrition is estimated to be 11% (moderate and severe) (i.e. 1.7 million children under five) and chronic malnutrition 52% (i.e. 8.0 million children). In addition to the widespread problems of child mortality and malnutrition in general, Ethiopia is recurrently affected by drought emergencies. About 5.2 million people are estimated to be 'chronically' food insecure and in need of food or cash assistance to survive, and this number increases by an additional 2-10 million people, depending on harvests and/or other factors such as displacement, floods, drought, and diseases.

In November 2005, a WHO, UNICEF and SCN informal consultation attended by nutrition experts from the UN agencies, NGOs and academic institutions agreed on guiding principles for the implementation of community-based management of severe acute malnutrition and next steps for updating global recommendations and country-level health policies for the inclusion of management of severe acute malnutrition as an essential intervention towards achieving the Millennium Development Goals for poverty and child mortality reduction.

The development of the community-based therapeutic care (CTC) approach to acute malnutrition arose from research by Valid International into the limited impact of selective feeding during the 1998 famine in Southern Sudan. Based on public health principles it aims to address some of the challenges that traditional centre-based approaches face[3] providing rapid effective assistance with minimal social disruption. Through a focus on decentralising distributions, out-reach and community mobilisation, CTC improves access to services, case-finding and follow up while providing rapid effective assistance with minimal social disruption. The approach maximises impact and coverage by bringing services closer to the household and reducing opportunity costs to carers.



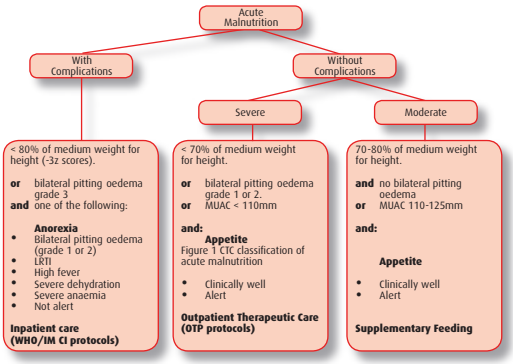
Source: Dr. Steve Collins, Valid International

[1]Pelletier D.L et al AMJPublicHealth, 1993, 83 1130-3.
[2]Ethiopia DHS, 2005.
[3]Collins, S. "Changing the way we address severe malnutrition during famine. 'The Lancet'. 2001. 358: 498-501.

CTC was first implemented in Ethiopia during 2000 in conjunction with Oxfam and Concern Worldwide. CTC has now been implemented successfully in a range of field conditions, both in humanitarian emergencies and beyond, by a range of NGO implementers. These programs have succeeded in providing treatment that meets SPHERE standards[1] for over 127,800 moderate and 26,000 severely malnourished children.

[1]Internationally accepted standards

The CTC classification of acute malnutrition[5]



Source: Collins, S. Community-based therapeutic care: A newparadigm for selective feeding in nutritional crises 48. 2004. London: Humanitarian Practice Network. Overseas Development Institute. Network Paper.

CTC consists of the following components:

Supplementary feeding
A dry take-home ration for children with moderate acute malnutrition without complications

OTP - Out-patient therapeutic program (out-patient care)
Severe acutely malnourished patients who have appetite and who do not have any serious medical complications can be treated as out-patients. At admission, children receive a medical check and undergo an appetite test to determine if they warrant direct referral for

in-patient care. If they are well enough to be treated as an outpatient, they receive routine drugs (antibiotic, vitamin A, folic acid, anti-helminitic, anti-malarial (if required) and a ration of Ready to Use Therapeutic Food (RUTF) - according to their body weight. Carers are also educated in RUTF feeding and basic hygiene practices. Registered children are seen on a weekly basis, but carers will be encouraged to return to the clinic if the child's condition deteriorates during that time. In addition, community volunteers are encouraged to make support visits to the home of any child the clinic worker feels is at risk or is not responding as expected to treatment. Emphasis is placed on checking all OTP children for completed vaccinations so that the clinic worker may administer any that are missing.

Stabilisation Centre (in-patient care)

This is for severe acutely malnourished children with medical complications and/or no appetite. Cases are treated with therapeutic milk and routine medicines (Vitamin A, antibiotic, folic acid, anti-malarial if required). Medical complications are treated as they arise. Usually, following the treatment of complications, the patient would then progress to out-patient care.

Community mobilisation

A strong community volunteer network can have a significant impact on community-based therapeutic programs by supporting and sustaining programs, creating community demand for programs and feeding into longer-term strategies. Different contexts will need different strategies.

Internationally accepted standards

Not only is it essential that individuals seek treatment for malnutrition as soon after onset as possible, but it is also imperative that communities understand the principles underlying malnutrition and the service provided to treat it, in order to be able to access care appropriately and obtain the maximum benefits. Therefore, early and comprehensive case-finding is a key component to the therapeutic care program as is a well-informed and responsive community. Community mobilization aims to encompass these aspects through identifying functioning community networks and enabling and training existing active community members to detect cases of malnutrition. Such communities are also informed of the basics of malnutrition, the process of self-referral and the responsible management of malnutrition and its prevention. Studies continue to be carried out to understand the dynamics of the community and what may persuade or dissuade communities to access healthcare, in order to tailor programming accordingly.

In Ethiopia the treatment capacity has increased considerably in recent years. Treatment is provided through NGO programmes and through Ministry of Health (MoH) facilities. The Ethiopian Government is now recognising that nutrition and malnutrition is not only a food problem but a public health problem needing full attention. This has led to the development of a national protocol for the management of severe acute malnutrition and the strengthening of therapeutic care provision through MoH facilities.

YEAR	Range of SAM rates in food insecure areas	SAM treatment capacity (per month)
2003	1 to 3% (70 to 210,000)	3,500
2004	0.8 to 2% (56 to 140,000)	4,300
2005	0.5 to 1.5% (35 to 105,000)	10,000
2006	1 to 2.5% (70 to 175,000)	18,480

Treatment capacity versus needs (Source UNICEF Ethiopia)

This began with in-patient care being offered in hospitals and some health centres with the support of UNICEF, but now that the internationally accepted way of treating severe acute malnutrition is through community-based therapeutic care, the response has expanded to include the provision of out-patient care (OTP), in-patient care and community mobilisation with the support of Concern Worldwide and Valid International.

Many programmes in Ethiopia use imported Plumpy'nut®, the RUTF made by NUTRISET in France. Plumpy'nut® is recognised for its good quality, but is very expensive (cost per MT: USD 3722.97[1] + transport costs + taxation) and there have been considerable problems with the importation and taxation process.

Since November 2004, efforts have been made to produce RUTF in-country in order to bring the cost down and therefore make the produce more affordable, especially for the MoH. Research is ongoing into alternative recipes that do not compromise on quality or effectiveness but are least-cost. Policy makers and programme implementers in Ethiopia are beginning to address the question of malnutrition in relation to HIV/AIDS. There is increasing evidence that the provision of high-quality therapeutic food of a high-energy density and an optimal balance of essential micronu-trients can prolong productive life and increase the time to AIDS-defining illness and death. The CTC model contains many features that are appropriate for the care and support of HIV-affected people and can provide very effective physical care for many PLWHA. The CTC model is currently being adapted to make it more suitable for the support of PLWHA in the longer term. This includes developing RUTF suitable for this group.

Source: Concern Ethiopia

Source: Concern Ethiopia

[1]This is an average price, source NUTRISET.

[2]The first RUTF produced in Ethiopia was called BEZA.

Correspondence: Jane Keylock
Valid International
jane@validinternational.org

Nutrition Now – the RCN launches its campaign for better patient nutrition

Patient nutrition is rated as being extremely important by 95% of nurses in a survey of over two thousand across the UK, yet almost half (42%) feel they do not have enough time to ensure patients get good nutrition during their working day. The Royal College of Nursing (RCN) identified the main barriers facing nurses helping patients to get good nutrition were the lack of availability of food outside of mealtimes (49%) and too few staff to ensure patients get the help needed to eat and drink (46%). Over a quarter (28%) of nurses said there is not a requirement in the nursing documentation for them to record the nutritional needs of patients.

Nutrition Now is a new clinical campaign launched by the RCN to raise the standards of nutrition and hydration in hospitals and the community. The campaign will run throughout 2007 and aims to raise awareness of the importance of nutrition and hydration to patient health and ensure that patients get good nutritional care. The RCN has developed a series of key messages and principles for nutrition and hydration (Tables 1 and 2) that provide nurses with a set of basic guiding values to enable them to improve patient nutrition where they work. The principles have been developed in partnership with frontline nurses, patient groups and other key stakeholders.

Table 1: Nutrition Now Key Messages

- Nutrition and hydration are essential to care, as vital as medication and other types of treatment.
- It is our responsibility as members of a multi-disciplinary team to ensure patients in our care have the right nutrition and hydration at the right time.
- Working practices that prioritise nutrition and hydration can overcome the challenges that stand in the way of excellence.

In addition to giving nurses the practical tools, support and evidence they need to make nutrition a priority in the area where they work, the campaign also calls on the Government and local employers to ensure sufficient funding is allocated to nutrition in the NHS to improve the quality, choice and nutritional content of food that is offered to patients; ensure there are enough nursing staff on wards and in the community to ensure patients receive the right food at the right time with the right supervision and assistance; and give nurses and other members of the multi-disciplinary team more time to make nutrition a priority.

The RCN will be holding a number of Nutrition Now events throughout the remainder of 2007. For further information e-mail the RCN via nutrition@rcn.org.uk
Further information on this event can be obtained by emailing the RCN via nutrition@rcn.org.uk. The RCN Nutrition Now campaign is supported by Abbott Nutrition.

Full details of the campaign and a range of tools can be viewed and downloaded from the RCN's Nutrition Now website:
www.rcn.org.uk/nutritionnow

Carole Glencorse
Head of Nutritional Services
Abbott Nutrition

Table 2: RCN Principles for Nutrition and Hydration

Accountability
Every member of the nursing team is accountable for:

- Providing some aspect of nutritional care, be it front line delivery or executive board level
- Assessing, planning, implementing and evaluating the nutritional and hydration needs of patients, clients and users
- Contributing to ongoing monitoring, evaluation and review of the nutrition of patients, clients and users through clinical governance systems

Responsibility
All nurses are responsible for:

- Providing person-centred and evidence-based care. In relation to nutrition this means ensuring that all aspects of nutrition are taken into account and acted upon in the context of the person's individual needs
- Keeping up to date through accessing and using quality information and evidence about nutrition and hydration through continuous professional development
- Challenging poor practice in relation to nutrition and hydration
- Assessing the environment and ensuring it supports good nutritional care
- Evaluating the impact of nutrition and hydration care plans and making the necessary changes
- Contributing to multi-professional and multi-agency working that achieves seamless nutritional care
- Dedicating time to prioritise the nutritional needs of patients, clients and users with protected meal times
- Knowing the recognised process in each organisation for anticipating, minimising, recording and reporting nutritional risks to patients, clients and users

Leadership and management

- Executive nurses have the responsibility for ensuring that nutritional care is prioritised at board level and that systems are in place to support this
- Team leaders are responsible for enabling effective organisation of care so that the provision of food and nutrition will be prioritised and patients, clients and users experience care that meets their needs as they see them
- All nurses in their leadership role are responsible for enabling others to provide good nutritional care

BAPEN 2007 Annual Meeting

Provisional Programme

Monday 26th November 2007

BAPEN MEDICAL Post-graduate Teaching Day

10:00 – 10:45	**Perioperative saline: endocrine and renal effects on balance: what goes in must come out** Dr Peter Gosling, Consultant Clinical Biochemist - Birmingham
10:45 – 11:00	Discussion
11:00 – 11:45	**The oedematous post-operative patient with complications** - a case-based discussion Professor Gordon Carlson, Department of Surgery - Hope Hospital, Salford
11:45 – 12:00	Coffee
12:00 – 12:40	**NICE nutrition support guidelines** Dr Jeremy Nightingale, Consultant Gastroenterologist – St. Marks Hospital, Harrow
12:40 – 13:00	**Implementing NICE – the view from a DGH** Dr Emma Greig, Consultant Gastroenterologist- Taunton & Somerset Hospital
13:00 – 13:15	Discussion
13:15 – 14:00	Lunch
14:00 – 15:30	**PEGs and ethics – a debate** Dr. Barry Jones, Consultant Gastroenterologist - Russell Hall Hospital, Dudley and Dr. Simon Gabe, Consultant Gastroenterologist/Hon. Senior Lecturer – St. Marks Hospital, Harrow
15:30 – 16:00	**Biochemical reprise – the refeeding syndrome** Dr Michael Colley, Consultant Clinical Biochemist - Swindon
16:00 – 16:15	Discussion
	Evening informal curry or chinese at a local restaurant – optional

BAPEN MEDICAL Post-graduate Teaching Day Monday 26th November 2007 - Harrogate

The BAPEN Medical Post-graduate Teaching Day is aimed at clinicians of any discipline interested in nutritional support at SpR or Consultant level. All professional groups however are welcome.

The Teaching Day will be held from 10:00 – 16:30 on Monday 26th November at the Harrogate International Centre.

Programme will include:

- Saline and colloid management in the surgical patient
- PEGs and ethics
- NICE guidelines in relation to nutritional support
- Refeeding syndrome

Registration Fees

Non-Members
£40.00 + VAT = £47.00

BAPEN Medical or BAPEN Individual Affiliate Members
£20.00 + VAT = £23.50

Registration fees inclusive of lunch and refreshments.

To reserve your place please complete the appropriate section on the Registration Form. Confirmation of your place will be shown on the Invoice/Receipt which will be forwarded as confirmation of booking.

The Mental Capacity Act Workshop

This year BAPEN will host a one-hour practical workshop on The Mental Capacity Act during the Annual Conference on Tuesday 27th November, 2007.

The session will outline the key requirements of the Mental Capacity Act (2005) and explore its implications for nutritional support in clinical practice. This will include issues such as assessment of capacity, best interest decision making, the role of lasting power of attorneys, Independent Mental Capacity Advocates (IMCAs) and multidisciplinary roles. Group discussion will form an integral part of this workshop with identification of how your practice may need to develop to meet the requirements of the Act and how the DH national training materials might be used.

Speakers: Dr. Christina Lyons and Dr. Ailsa Brotherton.

Should you be interested in attending The Mental Capacity Act Workshop please tick the appropriate box on the Registration Form. Whilst the numbers are limited, should there be sufficient demand the workshop will be repeated throughout the day and confirmation of your time slot will be advised prior to arrival at the Conference.

BAPEN 2007 Annual Meeting

Provisional Programme

Tuesday 27th November 2007

08:30 – 09:30	Registration	
09:30 – 09:40	**Welcome & BAPEN Initiatives** - Professor Marinos Elia – Honorary Chairman – BAPEN	
09:40 – 10:10	**National Nutrition Action Plan** - Ivan Lewis MP - Parliamentary Under Secretary of State for Care Services	
10:10 – 11:20	Symposium 1 **"Feeding in pancreatitis"**	Symposium 2 **"Feeding the older person in the community"**
	What is the best route for providing artificial nutrition in acute pancreatitis? - Mr Ross Carter, Consultant Surgeon, Glasgow Royal Infirmary	**Micronutrient status in the older person** Anne Holdoway, Research Dietitian, Royal National Hospital for Rheumatic Diseases NHS Foundation Trust
	What is the evidence for prescribing naso-jejunal feeds? Dr Sorrel Burden. Lead Dietitian in Nutrition Support and Gastroenterology, Manchester	**Appetite control and body composition changes during ageing: implications for clinical practice** Dr Mary Hickson, Therapy Research Facilitator, Hammersmith Hospitals NHS Trust
	Differential effects of nutrient administration on human pancreatic exocrine function Professor Peter Layer. Professor of Medicine Israelitic Hospital, University of Hamburg	**Feeding in early dementia** Carole Barker, Advanced Nurse Practitioner – Memory Clinic Derbyshire Mental Health NHS Trust
	Discussion	Questions & Answers
11:20 – 11:40	Coffee and Exhibition	
11:40 – 12:20	**THE PENNINGTON LECTURE**	
12:20 – 12:40	**BAPEN nutricia research fellowship award 2007** Joint Winners from 2005 Lucy Martin and Amanda Judd, Bristol Royal Infirmary **Development of dependency score to be used by a dietitian working with patients on a home enteral tube feeding scheme to assess case dependency** Caroline Anderson, Southampton General Hospital **Novel technique for measuring energy expenditure in children with renal failure**	
12:40 – 13:40	Lunch and Exhibition **E-poster presentations. BAPEN Annual General Meeting**	
13:40 – 15:30	Symposium 3 **"Fluid and nutrition support of the pre-term infant in the first week of life"**	Symposium 4 **"Nutrition and liver disease"**
Chair	Dr Pamela Cairns Consultant Neonatologist, St Michael's Hospital, Bristol	Dr Mike Stroud, Consultant Gastroenterologist, Institute of Human Nutrition, Southampton
	Guidelines for the provision of amino acids in the preterm infant during the first week of life Professor Patti Thureen, Professor of Paediatrics, University of Colorado Health Sciences Centre, USA	**The liver as a nutritional organ** Professor Alan Jackson, Director, Institute of Human Nutrition, Southampton
	Choice of lipid emulsion in the preterm infant Dr Susan Hill, Consultant Gastroenterologist, Great Ormond Street Children's Hospital, London	**Nutrition support in liver disease** Dr Marcia Morgan, Reader in Medicine and Honorary Consultant Physician, The UCL Institute of Hepatology, London
	Enteral nutritional support in the preterm infant during the first weeks of life Caroline King, Chief Dietitian, Hammersmith Hospital, London	**Thinking differently about feeding patients with liver disease** Professor Rosemary Richardson, Practice Development Lead – Dietetics, NHS Greater Glasgow Adult Acute Services
	Questions	
15:30 – 16:00	Tea and Exhibition	
16:00 – 17:30	Symposium 5 **"Ethical and legal issues – an interactive, case-based symposium"**	Satellite Symposium **Sponsored by Fresenius-Kabi**
Chair	Professor John MacFie and Dr Mike Stroud	Tony Murphy, Pharmacy, University College Hospital, London
	The principles of ethical practice John MacFie, Professor of Surgery, Scarborough	**Managing fluids and electrolytes in the preterm infant during the first week of life** Dr Pamela Cairns, Consultant Neonatologist, St Michael's Hospital, Bristol
	Case presentations and discussion Pamela Barker, Matron Manager for Medicine & Endoscopy, Scarborough. Emily Waters, Chief Dietitian, Southampton	**Practical guidelines for managing intravenous glucose in the preterm infant** Dr Jane Hawdon, Consultant Neonatologist, University College London Hospitals NHS Trust
	John MacFie, Professor of Surgery, Scarborough	**Formulating a standard baby TPN feed for the preterm infant** Tony Murphy, Prinicipal Pharmacist, University College Hospital, London
20:00	Mike Stroud, Consultant Gastroenterologist, Southampton	Open forum and questions to the panel
	BAPEN ANNUAL DINNER	

Continued on page 12

BAPEN 2007 Annual Meeting

Provisional Programme

Wednesday 28th November 2007

08:30 - 9.00	Registration	
09:00 - 11.00	Symposium 6 – Part I Nutrition Society/BAPEN Medical **"Nutrition support in cancer therapy"**	Symposium 7 **"Enteral nutrition – safer practice"**
Chair	Professor Jeremy Powell-Tuck, Centre for Adult and Paediatric Gastoenterology, Barts and the London, School of Medicine and Dentistry	Dr Jeremy Woodward, Consultant Gastroenterologist, Addenbrookes Hospital, Cambridge
	Nutritional management of radiation enteritis Dr Jervoise Andreyev, Department of Gastroenterology, Chelsea & Westminster	**Nasogastric tube misplacement: the continuing story** Dr Patricia Bain, Patient Safety Manager, Yorkshire and Humber Region, NPSA
	The nutrition management of the complications of chemotherapy Dr Clare Shaw, Consultant Dietitian, The Royal Marsden Hospital **HPN in cancer** Dr Jon Shaffer, Intestinal Failure Unit, Hope Hospital, Salford	**Examples of bad practice with tubes and medicines - an interactive session** Kate Pickering, Lead Nutrition Nurse Specialist, Leicester General Hospital And Becky White, Pharmacy Team Manager Surgery, John Radcliffe Hospital, Oxford
	Questions & Answers	**Future options** Lynne Colagiovanni, Nutrition Nurse Specialist, Queen Elizabeth Hospital, Birmingham
		Discussion
11:00 – 11:30	Coffee and Exhibition	
11:30 – 13:00	Symposium 6 – Part II BAPEN Medical/Nutrition Society. **"Cancer and Nutritional Sciencer"**	Symposium **Original communications**
Chair	Professor Gary Frost, Professor of Nutrition and Dietetics, University of Surrey	
	The second WCRF/AICR expert report – food, nutrition, physical activity and the prevention of cancer: a global perspective Professor Martin Wiseman, Medical and Scientific Advisor, WRCF International, University of Southampton	
	Inflammation-based prognostic score and its role in the nutrition management of people with cancer Mr Donald McMillan, Department of Surgery, Royal Infirmary Glasgow	
	The role of gut hormones and appetite regulation Dr Damien Ashby, Imperial College, London	
13:30 – 14:30	Lunch and Exhibition **E-poster presentations. PEN group annual general meeting.** **BAPEN medical annual general meeting**	
14:30 – 15:15	**CUTHBERTSON MEDAL LECTURE**	
15:15 – 16:15	Symposium 9 **"Choosing enteral feeds – evidence based or gut reaction"**	
Chair	Ian **"The Terminator"** Fellows Consultant Gastroenterologist, Norfolk and Norwich University Hospital	
	Debate 1 – All enteral feeds should contain fibre Ceri **"Crusher"** Green v Tim **"Maximum Impaction"** Bowling	
	Debate 2 – Peptide based-formula must always be used for jejeunal feeding. David **"QC"** Silk v Pete **"The Terrier"** Turner	
	Debate 3 – Intensive care unit patients should be given high-protein enteral feed Richard **"Glutaminus Maximus"** Griffiths v Mike **"The Iceman"** Stroud	
16:15	**Close of conference followed by tea**	

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Equal opportunities for specialised services – commissioning provides opportunities

Availability of specialised services is subject to unacceptable variation across the country, says the Specialised Healthcare Alliance (SHCA) in a recent issue of the Health Service Journal. The absence of national guidelines or targets for specialised services means that there is considerable variation in implementation among primary care trusts – to the detriment of patient experience and outcomes as many members of membership groups such as PINNT will no doubt testify.

Devolution within the NHS means local priorities increasingly drive resource allocation, and while this development has many benefits, it can unfairly disadvantage patients with rare conditions and treatments - such as those on total parenteral nutrition (TPN). Such patient groups will be smaller in number and have a less powerful voice locally. What is required, says the SHCA, is that local priorities must be established with clear patient involvement in that process with local commissioners and clinical staff to ensure there is no 'lost tribe' of patients. In addition, the current financial climate is driving decisions about whether to fund treatment or not without considering the additional costs that may arise as a result - such as hospital care, social services support and lost employment.

The new commissioning framework provides a valuable opportunity to adopt a holistic approach to services from practice through to tertiary level, and as part of that process the SHCA is calling for support for the following key principles:

- the standard and availability of specialised services being accepted as fundamental to a properly functioning NHS
- the new commissioning arrangements for specialised services being implemented at the earliest opportunity with sufficient pooled budgets attached
- services and treatments not covered by payment by results invariably being subject to pooled budgets
- the DoH encouraging more consistency of provision of specialised treatments across the country by developing the national definition set and including standards of care where appropriate
- more transparent decision-making where treatment is denied, including a clear appeals process for patients with support provided
- recognition of the role of specialised services in providing a pathway for innovation as part of the government's strategy for medical research

BAPEN and PINNT are members of the Specialised Healthcare Alliance (SHCA), a broad coalition of patient groups supported by a smaller number of corporate members. It has been set up to campaign on behalf of people with conditions and treatments which require specialised medical care, usually complex and expensive to treat. **www.shca.info**

The Award of the John Lennard-Jones Medal

The BAPEN Officers and Council and any individual member with two seconders may be permitted to submit, with reasons, applications to the Faculty for the award of a John Lennard-Jones (JL-J) medal. The JL-J medal would normally be awarded for outstanding contributions to the Association. The award will not necessarily be restricted to one per annum and will not necessarily be awarded if, in the opinion of the Faculty, no suitable candidate is proposed. In order to avoid any suggestion of bias and conflict of interest, the decision of the Faculty, who act as an independent body, will be binding. The medal will be publicly presented by a member of the Faculty at the dinner of the Annual BAPEN meeting. Applications, which should not exceed 500 words in length, should be submitted to the Chairman of the Faculty, Professor D.B.A. Silk, c/o BAPEN Office – and marked John Lennard-Jones Medal.

BAPEN

Advancing Clinical Nutrition

2007 Annual Conference

of

The British Association for Parenteral and Enteral Nutrition

to be held at

Harrogate International Centre

on

Monday 26th, Tuesday 27th & Wednesday 28th November 2007

ABSTRACTS will be considered by **BAPEN** for Oral, E-Poster and Static Poster Sessions. Method of presentation will be decided by the Bapen Programmes Committee.

ABSTRACTS should be submitted online according to the published guidelines, available on the BAPEN website.

www.bapen.org.uk

Diary Dates 2007

National Dates	Meetings - National	Venue and Contact Details
16th - 19th July	**Nutrition Society Summer Meeting** Diet and chronic disease	University of Coleraine, Northern Ireland. **www.nutritionsociety.org**
6th August	**Home Artificial Nutrition**	Manchester. **www.peng.org.uk**
4th - 7th September	**25th Leeds Course in Clinical Nutrition**	St James University Hospital, Leeds. **Email:clinicalnutrition@leeds.ac.uk** **Website:www.clinical-nutrition.co.uk**
10 - 14th September	**The Intercollegiate Course on Human Nutrition**	Nottingham. **www.icgnutrition.org.uk**
26th - 28th November	**BAPEN 2007 Annual Conference**	Harrogate. **www.bapen.org.uk**
	Meetings – International	
8th - 11th September	**29th ESPEN Congress 2007**	Prague. **www.espen.org**

29th ESPEN Congress 8th - 11th September 2007

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

Important Dates and Deadlines

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27 January 2007
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7 July 2007
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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:
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c/o MCI
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CH-1211 Geneva 13
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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

BAPEN
Advancing Clinical Nutrition

BAPEN 2007

26th/27th/28th November

2007
Harrogate

For further information see
www.bapen.org.uk

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