

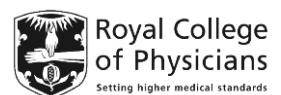


A Toolkit for Commissioners and Providers in England

Malnutrition Matters

Meeting Quality Standards in Nutritional Care

Ailsa Brotherton, Nicola Simmonds
and Mike Stroud
on behalf of the BAPEN Quality Group



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Enquiries to: BAPEN Office, Secure Hold Business Centre, Studley Road, Redditch, Worcs B98 7LG.

Tel: 01527-457850 bapen@sovereignconference.co.uk

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This document was produced on behalf of BAPEN by the BAPEN Quality Group -

Tim Bowling, Ailsa Brotherton, Nicola Simmonds, Rhonda Smith, Mike Stroud (Chair), Vera Todorovic

BAPEN (British Association for Parenteral and Enteral Nutrition) is a multidisciplinary charity with a membership of doctors, nurses, dietitians, pharmacists, patients and all interested in nutritional care. The charity has produced a number of reports on the causes and consequences of malnutrition as well as national surveys on the prevalence of malnutrition and current use of nutritional screening in hospitals, mental health units, care homes and sheltered housing, and health economic analyses. Membership is open to all with full details at www.bapen.org.uk.

This nutritional toolkit is endorsed by all of BAPEN's core organisations - the Parenteral and Enteral Nutrition Group (PENG) of the British Dietetic Association (BDA), the National Nurses Nutrition Group (NNNG), the British Pharmaceutical Nutrition Group (BPNG), BAPEN Medical, the Nutrition Society and Patients on Intravenous and Nasogastric Nutrition Therapy (PINNT).

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Foreword

Malnutrition* matters being both a cause and a consequence of disease, and leading to worse health and clinical outcomes in all social and NHS care settings. Yet most patients, carers, healthcare professionals, commissioners, senior managers and chief executives do not realise how common it is in the UK and so it goes unrecognised and untreated. BAPEN estimates that malnourishment affects over 3 million people in Britain at any one time and if ignored, this causes real problems. Malnourished individuals go to their GP more often, are admitted to hospital more frequently, stay on the wards for longer, succumb to infections, and can even end up being admitted to long-term care or dying unnecessarily. In children, it is also disastrous with profound effects on growth and development through childhood and later increased risks of major adult diseases.



Providing good nutritional care is therefore **a matter of quality**. Ensuring that malnourished individuals or those at risk of developing malnutrition are identified and treated, clearly delivers against safety, effectiveness, equality and the patient experience and indeed, organisations must now ensure high quality nutritional care if they are to meet the national standards set by the Care Quality Commission (CQC).

Good nutritional care also makes **sound financial sense**. BAPEN has estimated that public expenditure on malnutrition in the UK in 2007 was over £13 billion and so improved nutritional care could result in substantial financial returns; with even a 1% saving amounting to about £130 million per year. It is therefore no surprise that recent guidance from NICE has identified better nutritional care as the **fourth largest potential source of cost saving** to the NHS, and that nutrition and hydration are identified as one of the SHA Chief Nurse's eight **'high impact' clinical areas** yielding 'huge cost savings' if performance is improved.

The delivery of high quality nutritional care is no easy task and requires focused policies, multidisciplinary teams, clinical leadership, educational initiatives and new management approaches. BAPEN, however, through its reports, research, educational tools, conferences, regional representatives and collaborative work with the Department of Health and others, can support commissioners and providers in finding successful solutions. We have therefore produced this Toolkit, in collaboration with many groups, to help health and care organisations to develop and implement a variety of approaches to nutritional care. These revolve around four main tenets:

- Malnutrition must be actively identified through screening and assessment;
- Malnourished individuals and those at risk of malnutrition must have appropriate care pathways;
- Frontline staff in all care settings must receive appropriate training on the importance of good nutritional care; and
- Organisations must have management structures in place to ensure best nutritional practice.

Malnutrition does matter and no NHS or social care organisation can claim it is delivering safe, effective, quality care without appropriate nutritional care policies in place. These should be a priority for all and organisations that deliver good nutritional care will see improvements in clinical outcomes and patient experience whilst simultaneously achieving significant reductions in costs.

Dr Mike Stroud, Chair of BAPEN

*In the context of this document the meaning of the word malnutrition is confined to under-nutrition

Glossary

BANS	British Artificial Nutrition Survey (produced by BAPEN)
BAPEN	British Association for Parenteral and Enteral Nutrition
BDA	British Dietetic Association
BIFS	British Intestinal Failure Survey
BMI	Body mass index
BPNG	British Pharmaceutical Nutrition Group (core group of BAPEN)
BSPGHAN	British Society of Paediatric Gastroenterology, Hepatology and Nutrition
BPSU	British Paediatric Surveillance Unit
CEPOD	Confidential Enquiry into Perioperative Deaths
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation (payment framework)
DH	Department of Health
EoC	Essence of Care
ESPGHAN	European Society of Paediatric Gastroenterology, Hepatology and Nutrition
HQIP	Health Care Quality Improvement Partnership
KPIs	Key Performance Indicators
MDT	Multi-disciplinary team
'MUST'	'Malnutrition Universal Screening Tool' (produced by BAPEN)
NACC	National Association for Colitis and Crohn's Disease
The NACC	National Association of Care Catering
NICE	National Institute for Health and Clinical Excellence
NNNG	National Nutrition Nurses Group (core group of BAPEN)
NPSA	National Patient Safety Agency
PEAT	Patient Environment Action Teams
PENG	Parenteral and Enteral Nutrition Group of the BDA (core group of BAPEN)
PINNT	Patients on Intravenous, Naso-gastric Nutrition Treatments, Half-PINNT for children (core group of BAPEN)
PYMS	Paediatric Yorkhill Malnutrition Score
RCN	Royal College of Nursing
RCP	Royal College of Physicians
RCPCH	Royal College of Paediatrics and Child Health
SHA	Strategic Health Authority
STAMP	Screening Tool for the Assessment of Malnutrition in Paediatrics
WHO	World Health Organisation

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Document purpose	Commissioning Toolkit
Title	Malnutrition Matters - Meeting Quality Standards in Nutritional Care: A Toolkit for Commissioners and Providers in England
Author	BAPEN Quality Group
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Target audience	Primary Care Trust Chief Executives, Primary Care Trust Commissioners, Directors of Public Health, Local Authority Chief Executives, Directors of Adult Social Services, Directors of Children’s Social Services, Directors of Care Homes and Sheltered Housing, and providers of Nutritional Services in England
Circulation list	NHS Trust Chief Executives, Strategic Health Authority Chief Executives, Care Trust Chief Executives , Foundation Trust Chief Executives, Medical Directors, Directors of Nursing, Directors of Adult Social Services, Directors of Children’s Social Services, Primary Care Trust Professional Executive Committee Chairs, NHS Trust Board Chairs, Directors of Finance, Managers of Nutrition and Dietetic Services, Allied Health Professional Leads, General Practitioners, Communications Leads, Royal Colleges and Professional Bodies, Voluntary Organisations
Description	This Toolkit will assist commissioners and providers to deliver high quality nutritional care across all care settings and meet national nutritional quality targets including those of the Care Quality Commission
Contact details	BAPEN Quality Group BAPEN Office, Secure Hold Business Centre, Studley Road, Redditch, Worcs, B98 7LG. Tel: 01527-457850 bapen@sovereignconference.co.uk

Executive summary

- Malnutrition, in terms of undernourishment, is both a cause and consequence of disease in adults and children. It is common and affects over 3 million people in the UK with associated health costs exceeding £13 billion annually.¹ It is often unrecognised and untreated, yet it has a substantial impact on health and disease in all community care settings and hospitals.^{2,3}
- The benefits of improving nutritional care and providing adequate hydration are immense, especially for those with long term conditions and problems such as stroke, pressure ulcers or falls. The evidence shows clearly that if nutritional needs are ignored health outcomes are worse and meta-analyses of trials suggest that provision of nutritional supplements to malnourished patients reduces complications such as infections and wound breakdown by 70% and mortality by 40%.³
- Better nutritional care for individuals at risk can result in substantial cost savings to the NHS⁴ and even a saving of 1% of the annual health care cost of malnutrition, would amount to £130 million annually.¹ Recent guidance from the NICE identifies better nutritional care as the fourth largest potential source of cost savings to the NHS⁵ and nutrition and hydration are identified in the SHA Chief Nurses eight 'high impact' clinical areas that could make huge cost savings for the NHS if Trusts and Care Homes improved performance.⁶
- It is crucial when redesigning nutritional care, to consider the overall health costs associated with malnourishment. For example, although it is tempting to create a simple target to reduce the prescribing costs of oral nutritional supplements (ONS), which have risen steeply in recent years, ill thought out measures to do so will be detrimental to some individuals and may result in increased overall costs. Properly planned nutritional care will reduce costs from inappropriate use or wastage of ONS but will also identify more individuals who will benefit from them. However, since the health care costs associated with malnutrition are primarily due to more frequent and expensive hospital in-patient spells, more primary care consultations and the greater long-term care needs of malnourished individuals⁴, even a net increase in use of ONS, enteral tube feeding and parenteral nutrition, will be more than offset by cost savings since the current costs of these nutrition support modalities only amounts to about 2% of overall malnutrition related costs.⁴
- Providing good nutritional care is therefore a matter of quality, clearly delivering against all elements of fair, personalised, safe and effective care⁷ as well as ensuring equality, improved outcomes and best patient experience.
- Improved nutritional care is dependent on effective management structures to ensure joined up multidisciplinary care pathways across acute and community settings. Clinical leadership, innovation and continual improvement are fundamental to the delivery of high quality nutritional care.
- NICE guidance on Nutrition Support in Adults⁸ sets out clear recommendations for nutritional screening in hospital and community and the development of personalised nutritional care pathways for patients at risk. There are also national minimum standards for food provision in care homes⁹, patient experience surveys¹⁰ and annual assessments of nutritional care in hospitals by the Patient Environment Action Team (PEAT),¹¹ and the Royal College of Nursing (RCN) has published a position statement on malnutrition in children and young people.¹² Many other organisations including the Council of Europe, the Department of Health, NICE, the National Patient Safety Agency (NPSA), the National Association of Care Catering (NACC), the Royal College of Physicians (RCP), and the RCN also recognise the importance of screening for malnutrition and treating all those at risk. Recently, the Care Quality Commission (CQC) produced guidance for healthcare and adult social care services on 'Essential standards of quality and safety' which include 'meeting nutritional needs'. These are much more detailed than the previous core standards.¹³
- BAPEN has produced a number of reports on the causes, consequences and health economics of malnutrition as well as national surveys on the prevalence of malnutrition and the use of nutritional screening in hospitals, mental health units, care homes and sheltered housing. The charity has also contributed to national government and NHS strategies, such as the Nutrition Action Plan¹⁴ and the NHS core learning¹⁵ units on nutrition. We are therefore in a good position to provide commissioners and providers with information on nutritional care and standards.

- The BAPEN Nutritional Care Tools in this document were developed in consultation with many organisations including all the Core groups that make up BAPEN. The generic issues that surround commissioning for adults and children are similar but some specifics of childhood nutritional needs and monitoring are different with issues such as poor parenting needing to be addressed. Child specific contributions were therefore made by the Nutrition Working Group of the British Society of Paediatric Gastroenterology, Hepatology and Nutrition (BSPGHAN) and the document contains a specific appendix focused on paediatric issues and transitional care to adult services.
- The principles underlying the tools are that potentially vulnerable individuals should be screened for malnutrition and that those identified as at risk should be offered individualised nutritional care plans appropriate to their needs. To achieve this all care staff must understand the importance of nutritional care and be trained to identify those at risk, a training need that can be met by e-learning modules available from BAPEN. All health or social care organisations must also have management structures in place to ensure best nutritional practice.
- This BAPEN Toolkit is based on world-class commissioning competencies¹⁶ and enables commissioners and providers in local authorities, primary care organisations, hospital trusts and foundation hospitals to include best nutritional care when commissioning / redesigning all care services in all health and care settings. It will help service providers to include nutritional care in the development of new business cases and support them in collecting the data needed to prove they meet nutritional quality standards and recommendations. It will also assist commissioners to set appropriate and achievable key performance indicators (KPIs) and to effectively contract and monitor services against an appropriate quality specification.
- The BAPEN Toolkit contains guidance for commissioners and providers on defining the relevant, measurable outcomes related to nutritional care within services in order to gain value for money, a summary of national nutritional care standards and recommendations and the following tools:
 - **Tool 1: Assessment of population at risk of malnutrition** – Guidance on quantifying the numbers in the local population likely to be malnourished or at risk of malnutrition and hence the scale of need for nutritional care.
 - **Tool 2: Assessment of current screening and provision of nutritional care** – Guidance on the assessment of current levels of local nutritional care provision.
 - **Tool 3: Development of nutritional screening, assessment and care pathways** – Guidance on how to ensure that nutritional care pathways meet agreed standards and recommendations, based on available evidence for effective and efficient identification of malnutrition in patients and subsequent management.
 - **Tool 4: Education and training: Knowledge, skills and competencies of staff involved in nutritional screening, assessment and care planning** – Guidance to ensure that staff are appropriately trained to deliver high standards of nutritional care that are appropriate to the needs of individuals in health and social care settings.
 - **Tool 5: Service specifications and management structures for nutritional care** – A checklist to assist teams in developing specifications for nutritional care within services for adults and children across all local settings.
 - **Tool 6: Quality frameworks for nutritional care** – A framework to check that organisations involved in providing care to the local population put nutrition at the heart of that care.
 - **Tool 7: Quality indicators, monitoring and review** – Guidance on measurable markers of quality in nutritional care and information to assist in the development of data collection systems embedded in routine care wherever possible (rather than systems requiring specific ad hoc audits). The markers will also permit confirmation of quality and will enable commissioners to set appropriate KPIs, ensuring value for money.

Background

Malnutrition is a state in which a deficiency, excess or imbalance of energy, protein and other nutrients causes measurable adverse effects on tissue/body form (body shape, size and composition), function or clinical outcome.¹⁷ Although the term 'malnutrition' can encompass both overnutrition/obesity and undernutrition, for the remainder of this document the term is only used to mean undernutrition.

Malnutrition is **often under-recognised and under-treated** to the detriment and cost of individuals, the health and social care services and society as a whole. It is a common problem with more than 3 million people at any one time in the UK malnourished.¹ Around 30% of admissions to acute hospitals and care homes are at risk when evaluated using criteria based on the 'Malnutrition Universal Screening Tool' ('MUST')^{18,19} as well as 10 -14% of the 700,000 people living in sheltered accommodation;^{20,21} and 14% of the elderly at home or in care,²² whilst evaluation based on body mass index shows that even in individuals living at home, 5% of the elderly are underweight (BMI <20kg/m²), a figure that rises to 9% for those with chronic diseases.²³ **The prevalence of malnutrition is therefore set to rise as the population ages.**

In children the prevalence of acute malnutrition varies between 6-14% in hospitalised children surveyed in Germany, France and the United Kingdom^{24,25,26} and the overall prevalence of malnutrition including chronically growth restricted children was 19% of admissions in the Netherlands.²⁷ Additionally an important feature of much of malnutrition in children relates to micronutrient deficiency, especially iron and vitamin D.²⁸ Management of weight faltering often requires a multi-agency approach in which health visitors and social workers intervene to support parents with poor parenting skills and nutritional problems of their own such as obesity (Appendix 2).

All malnutrition is inevitably accompanied by **increased vulnerability to illness, increased clinical complications and even death** (Table 1). However, these risks can be significantly reduced if it is recognised early and specifically treated with relatively simple measures. For example, meta-analyses on the effectiveness of using oral nutritional supplements in malnourished patients, suggest that **clinical complications associated with malnutrition can be decreased by as much as 70% and mortality reduced by around 40%.**^{3,29} Effective nutritional screening, nutritional care planning, high standards of food service delivery and appropriate nutritional support are therefore essential in all settings, and there is no doubt that a health service seeking to increase safety and clinical effectiveness must take nutritional care seriously - a conclusion shared by NICE in their analysis of the relevant scientific literature.⁸

EFFECT	CONSEQUENCE
Impaired immune response	Impaired ability to fight infection
Reduced muscle strength and fatigue	Inactivity and reduced ability to work, shop, cook and self-care. Poor muscle function may result in falls, and in the case of poor respiratory muscle function result in poor cough pressure – delaying expectoration and recovery from chest infection
Inactivity	In bed-bound patients, this may result in pressure ulcers and venous blood clots, which can break loose and embolise
Loss of temperature regulation	Hypothermia with consequent further loss of muscle strength
Impaired wound healing	Increased wound-related complications, such as infections and un-united fractures
Impaired ability to regulate salt and fluid	Predisposes to over-hydration, or dehydration
Impaired ability to regulate periods	Impaired reproductive function
Impaired fetal and infant programming	Malnutrition during pregnancy predisposes to common chronic diseases, such as cardiovascular disease, stroke and diabetes (in adulthood)
Specific nutrient deficiencies	Anaemia and other consequences of iron, vitamin and trace element deficiency
Impaired psycho-social function	Even when uncomplicated by disease, malnutrition causes apathy, depression, introversion, self-neglect, hypochondriasis, loss of libido and deterioration in social interactions (including mother-child bonding)
Additional effects on children and adolescents	Growth failure and stunting, delayed sexual development, reduced muscle mass and strength, impaired neuro-cognitive development, rickets and increased lifetime osteoporosis risk

Table 1 – Clinical effects of malnutrition (adapted from Combating Malnutrition: Recommendations for Action, BAPEN 2009¹)

The prevalence of malnutrition

Screening for malnutrition is not routinely carried out in every care setting and so opportunities for intervention are missed. BAPEN and other organisations have carried out a number of large surveys to identify the prevalence of nutritional problems in adults in different care settings and these are illustrated in Figure 1. This figure also conveys the adverse consequences and costs that can ensue if malnutrition is not prevented, recognised or treated appropriately.

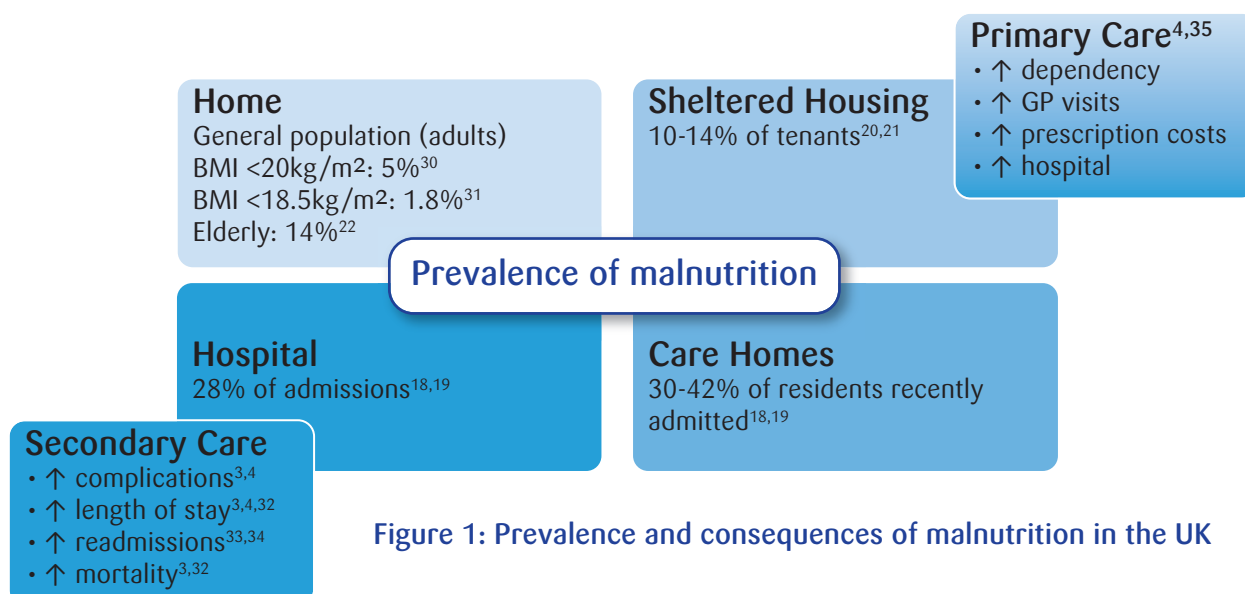


Figure 1: Prevalence and consequences of malnutrition in the UK

The costs associated with malnutrition

The health and social care costs associated with malnutrition are estimated to amount to at least £13 billion annually.¹ Many of these costs are inevitable since loss of appetite and metabolic derangements always accompany serious illness or injury. However, simple interventions, such as oral nutritional supplements in appropriate patients, are highly effective and small fractional savings will result in substantial absolute cost savings.⁴ Even if these were as little as 1%, this would still represent spending reductions of £130 million annually. It is therefore unsurprising that recently published NICE Guidance identified nutrition as the fourth largest potential cost saving to the NHS⁵ and that nutrition has also been identified in the SHA Chief Nurses eight 'high impact' clinical areas that could make huge cost savings for the NHS, if Trusts and Care Homes improved performance.⁶

It is crucial when redesigning nutritional care, to consider the overall costs associated with malnutrition. For example, although tempting to create a simple target of reducing prescribing costs of oral nutritional supplements (ONS), which have risen steeply in recent years, ill thought out measures to do so will be detrimental to some individuals and could result in increased overall costs. Properly planned nutritional care can reduce costs from inappropriate use or wastage of ONS but will also identify more individuals who will benefit from them. However, since the annual health care costs associated with malnutrition are primarily due to more frequent and expensive hospital in-patient spells, more primary care consultations and the greater long-term care needs of malnourished individuals,⁴ even a net increase in use of ONS, enteral tube feeding and parenteral nutrition, will be more than offset since the current costs of these treatments only amount to about 2% of total malnutrition related costs.⁴

Appropriate nutritional support should therefore be provided for individuals who require it and the challenge is to develop seamless systems across acute and community settings to ensure, for example, that individuals needing oral nutritional supplements receive them for the correct length of time, whilst inappropriate or prolonged supplement usage is avoided. BAPEN is to undertake further work on guidance to support organisations to achieve this.

Current standards and guidelines in nutritional care

Over recent years there has been increasing interest in nutritional care with the publication of numerous initiatives, standards and nutritional indicators referred to in many service frameworks and commissioning guidelines. However there has been no overall approach or analysis of the evidence. Some of the published documents are listed below:

- Patient Environment Action Teams (PEAT), 2000 annual assessment¹¹
- Better Hospital Food, 2001³⁶
- Essence of Care, 2001³⁷
- National minimum standards, 2001⁹
- Nutrition and Patients: A doctor's responsibility, 2002³⁸
- Council of Europe Resolution on food and nutritional care in hospitals,³⁹ 10 key characteristics of good nutritional care, 2003⁴⁰
- The cost of disease-related malnutrition in the UK and economic considerations for the use of oral nutritional supplements (ONS) in adults, 2005⁴
- NICE guidance on nutrition support in adults, 2006⁸
- Delivering Nutritional Care through Food and Beverage Services, 2006⁴¹
- Malnutrition among Older People in the Community. Policy recommendations for change, 2006⁴²
- Malnutrition, what nurses working with children and young people need to know and do, 2006¹²
- Good Practice Guide, Healthcare Food and Beverage Service Standards: A guide to ward level services, 2006⁴³

- Improving nutritional care. A joint action plan from the Department of Health and Nutrition Summit stakeholders, 2007¹⁴
- Nutrition Now, 2007⁴⁴
- Organisation of Food and Nutritional Support in Hospitals (OFNoSH), 2007⁴⁵
- Care Services Improvement Partnership factsheet 22; Catering arrangements in Extra Care Housing, 2007⁴⁶
- NICE Guidance on maternal and child nutrition, 2008⁴⁷
- NPSA factsheets on the 10 key characteristics of good nutritional care, 2009⁴⁸
- Social Care Institute for Excellence Guide 15: Dignity in Care; Nutritional Care and Hydration, 2009⁴⁹
- Combating Malnutrition: Recommendations for Action, 2009¹
- Improving nutritional care and treatment. Perspectives and recommendations from population groups, patients and carers, 2009⁵⁰
- Appropriate Use of Oral Nutritional Supplements in Older People, 2009⁵¹
- A.S.P.E.N clinical guidelines: nutrition support of the critically ill child, 2009⁵²

The adoption of these initiatives, guidelines, standards and recommendations has been very variable and with so many standards and processes already in place, another challenge for commissioners is to mandate the robust implementation of these standards to ensure best and most cost-effective outcomes. The nutritional care that results must be focussed on each individual and must be comprehensive and seamless across all care settings. Good communication between commissioners, healthcare professionals, social services and the voluntary sector is essential and processes must be in place to ensure this.

Table 2 analyses the current situation, summarising the current standards and initiatives and some of the barriers to their implementation. It supports the analysis stage of the commissioning cycle.

<p>Strengths</p> <ul style="list-style-type: none"> • Good evidence for nutritional interventions in both hospital and community settings • Multiple recommendations and initiatives from Department of Health and professional bodies <p>Opportunities</p> <ul style="list-style-type: none"> • Promoting nutritional care as an integral part of all care pathways could reduce admissions and readmissions and shorten hospital stay • Promoting nutritional care could promote independent living and quality of life • Promoting nutritional care could reduce health inequalities • Promoting nutritional care could lead to substantial financial savings • Promoting nutritional care could reduce requirements for Domiciliary Care • Promoting nutritional care could reduce Care Home admissions 	<p>Weaknesses</p> <ul style="list-style-type: none"> • Too many national initiatives and recommendations from Department of Health and professional bodies causing confusion • Lack of overall structure • Focus on systems and processes rather than outcomes and the experience of service users • Lack of communication across different community and healthcare boundaries • Services not sufficiently patient-focussed • Opportunities for intervention missed • Nutrition screening patchy • Education and training in nutrition patchy <p>Threats</p> <ul style="list-style-type: none"> • Nutritional care seen as a low priority by many organisations • Lack of awareness re: causes and impact of malnutrition • Nutrition not 'disease specific' • Lack of mechanism for coding nutritional care – no specific HRG • Lack of adequately trained staff • Collaborative working not promoted by purchaser/provider split • Difficult to define and realise benefits • Inappropriate use of oral nutritional supplements sometimes leading to unnecessary cost • The national focus on obesity which although essential, should not over-shadow the separate problem of malnutrition.
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Table 2: SWOT analysis of current standards and initiatives in nutritional care

Implementing Standards and Guidelines in Nutritional Care

Key standards and guidelines: Embedding good nutritional care into the commissioning of every service is crucial in meeting current nutritional standards and guidelines. These and other recommendations are effectively summarised by the NICE Guidelines,⁸ Essence of Care benchmarking³⁷ and the CQC standards.¹³

Implementation guidance: Many of the other publications and initiatives listed [on page 5] provide guidance on how standards and recommendations can be implemented across a variety of settings to improve the quality of nutritional care delivered; for example OFNoSH⁴⁵ provides guidance for hospitals.

Evidence of delivery of good nutritional care: There are a number of audits and monitoring systems and processes to enable organisations to record evidence and report on achievement of key targets and KPIs, for example, PEAT annual assessments.¹¹

Work streams and frameworks: National work streams provided through the National Quality Board provide leadership to drive the quality agenda within the NHS and frameworks such as the Commissioning for Quality and Innovation⁵³ (CQUIN) payment framework provide incentives to achieve improved quality and innovation in the delivery of nutritional care.

1. The NICE Guidance⁸ provides recommendations on:

- Malnutrition and the principles of nutrition support
- Organisation of nutrition support in hospital and the community
- Screening for malnutrition and the risk of malnutrition in hospital and the community
- Indications for nutrition support
- What to give in hospital and the community
- Monitoring of nutrition support in hospital and the community
- Oral nutrition support in hospital and the community
- Enteral tube feeding in hospital and the community
- Parenteral nutrition in hospital and the community
- Supporting patients in the community

2. Essence of Care Benchmarking

The Essence of Care benchmark for food and drink (previously nutrition)⁵⁴ has recently been out for consultation and review to ensure it is has a person focused outcome. The revised version will be designed to ensure individuals are enabled to consume food and drink (orally) which meets their needs and preferences. Benchmarks of best practice will be identified for ten factors which are summarised below:

- **Screening:** individuals identified as at risk on screening have a full nutritional assessment
- **Care:** care is planned, implemented, continuously evaluated and revised to meet individual needs and preferences for food and drink
- **Monitoring:** food and drink intake is monitored and recorded
- **Environment:** the environment is conducive to eating and drinking
- **Assistance:** individuals are provided with the care and assistance they require with eating and drinking
- **Information:** sufficient information is provided to enable individuals and their carers to obtain their food and drink
- **Provision:** food and drink is provided to meet an individual's needs and preferences
- **Availability:** individuals can access food and drink at any time according to their needs and preferences
- **Presentation:** food and drink are presented in a way that is appealing to individuals
- **Promoting Health:** individuals are encouraged to eat and drink in a way that promotes health

3. Care Quality Commission (CQC)

The CQC's *Essential Standards of Quality and Safety*¹³ specify nutritional outcomes that apply to all providers focussing on service user experience. The outcomes clearly state that individuals who use services should be supported to have adequate nutrition and hydration. Compliance to these regulations will:

- Reduce the risk of poor nutrition and dehydration by encouraging and supporting people to receive adequate nutrition and hydration.
- Provide choices of food and drink for people to meet their diverse needs, making sure the food and drink is nutritionally balanced and supports their health.

The CQC provide very detailed prompts for registered providers where they prepare, or support people who use services to prepare food and drink to ensure personalised care by providing adequate nutrition, hydration and support and to promote an individual's rights and choices.

4. BAPEN make the following recommendations, based on the NICE Nutrition Support Guidelines⁸ and best practice:

- **Information on** healthy living and the importance of maintaining a healthy weight should be available in all care settings and in the community.
- **Prevention of** malnutrition should be an integral part of preventative health care and should be located within the public health agenda.
- **Nutritional screening** should be undertaken in:
 - All hospital inpatients - on admission and weekly or when there is clinical concern
 - All hospital outpatients - at first outpatient appointment and where there is clinical concern
 - All residents of care homes - on admission and repeated monthly given the high prevalence and general frailty of residents (particularly in nursing homes)
 - At initial registration in GP surgeries, annually for those aged over 75 years, where there is clinical concern, and at other opportunities such as health checks or vaccinations

It is however also important to identify nutritional risk in care settings beyond those addressed by NICE including day care, sheltered housing and domiciliary settings.

- Agreed local procedures and policies should be in place which ensure that a detailed nutritional assessment is undertaken and recorded for all individuals identified as malnourished, or at risk of malnutrition, when screened.
- **Care plans:** All individuals identified as malnourished or at risk should have an appropriate care plan containing clearly identified goals of treatment which must be recorded. This may include social measures to ensure provision of meals, help with cooking or feeding, food and fluid intake records, modified menus, dietetic advice, oral nutritional supplements and or artificial nutritional support. They should then be monitored to ensure goals are met with further action as necessary.
- **Discharge/transition planning:** the flow of nutritional information from one setting to another is crucial to the delivery of good nutritional care. BAPEN's Nutrition Screening Week 2008 found that nutrition information regarding patients identified as malnourished during their hospital stay was not routinely included in discharge communications.¹⁹ This omission could result in nutritional care being overlooked at one of the most vulnerable points during a patient's journey.
- **Training:** All healthcare professionals should receive appropriate training in the importance of nutritional care, how to screen for malnutrition, basic nutritional care measures and the indications for onward referral for nutritional assessment and support. E-learning modules that all hospital staff can use to complete training on the principles and practice of 'MUST' are available from BAPEN and 'MUST' training modules suitable for community and social care staff will become available during 2010. Fluid balance is also an integral part of the nutritional management of individuals and training for staff should include a focus on fluid management, as both fluid overload and dehydration should be avoided to prevent unnecessary clinical complications.

- **Multi-disciplinary teams:** MDTs are needed to ensure that care pathways are appropriate and followed. In some situations this will require specific nutritional MDTs (e.g. nutrition steering committees and Nutrition Support Teams in acute hospital trusts), whilst in others, such as long-term conditions, mental health, older people and cancer, it will be appropriate for a dietitian or other clinical professional with nutritional expertise to sit on existing MDTs.

Barriers to Implementation

There are a number of current barriers to the effective implementation of good nutritional care in some organisations and communities. These are lack of management structures for ensuring delivery of good nutritional care; lack of resources; lack of nutrition teams and poor communication between primary and secondary care. However, there are examples of excellent practice where these barriers have been overcome and good nutritional care is being delivered across clinical networks.⁵⁵

The key challenges for commissioners include:

- Working collaboratively with local partners to commission joined-up, multidisciplinary nutritional care for the local population
- Identifying the nutritional needs of the local population
- Identifying the nutritional standards that must be delivered across all services in all settings
- Ensuring equity of access across the services delivered
- Ensuring nutritional care is delivered to a high standard in each service across all settings
- Developing realistic and achievable KPIs to ensure service providers meet the required standards
- Effective contract monitoring to ensure standards and KPIs are achieved

The key challenges for providers include:

- Developing management structures that facilitate the delivery of joined-up, multi-disciplinary nutritional care across acute and community settings
- Incorporating nutritional care into every clinical business case that is developed
- Identifying individuals who are potentially vulnerable and who should be nutritionally screened and assessed
- Delivery of high quality nutritional services that include the development of personalised nutritional care plans to meet an individual's nutritional and fluid requirements
- Continuity of care across settings
- Gathering appropriate evidence to demonstrate delivery of high quality care

Shaping Priorities

There are 10 key issues that shape the CQC priorities⁵⁶ and mapping current nutritional services against these will enable the identification of areas of both good practice and of gaps in current services. When collecting the evidence to demonstrate that an organisation is meeting CQC standards the following fundamental nutritional areas should be considered:

No.	10 key issues	Issues to consider in nutritional care
1.	Fair access to care	How do you ensure fair access to nutritional screening, assessment and care: <ol style="list-style-type: none"> Does your Trust have a nutrition team? Do you provide multidisciplinary nutritional services across all areas to ensure equality of access? Do you undertake nutritional screening across all wards/ departments/ care homes/ areas of the community?
2.	Person centred care that supports independence and choice	How do you ensure that your service users: <ol style="list-style-type: none"> Are well informed about the nutrition services you provide and the importance of good nutritional care? Contribute to the design of your nutritional care pathways?
3.	Prevention and early intervention	How have you ensured that your organisation: <ol style="list-style-type: none"> Embeds prevention of malnutrition into the public health agenda? Detects malnutrition early, in all areas? Delivers effective early interventions to treat malnutrition?
4.	Reducing health inequalities	How are you ensuring that: <ol style="list-style-type: none"> Individuals living in lower socio economic groups can access services? You identify high nutritional risk groups?
5.	Tackling poor performance	How do ensure that: <ol style="list-style-type: none"> All nutritional care delivered in your organisation is evidence based and safe? Management of an individual's fluid balance is safe and appropriate to their needs to avoid dehydration and fluid overload? Outcome measures that you collect, across all areas, demonstrate that the care delivered is effective?
6.	Openness about quality and safe care	How do you ensure that: <ol style="list-style-type: none"> Safe nutritional care is delivered consistently across all areas? Communication about quality and safety of nutritional care across the organisation is effective and transparent? Communication about quality and safety of nutritional care with service users is open?
7.	Staff training	How do you ensure that: <ol style="list-style-type: none"> Staff within your organisation are trained to deliver nutritional screening, assessment and care? You can demonstrate that staff have the required competencies to deliver safe nutritional care?
8.	Leadership	How do you demonstrate effective leadership (at all levels) to move away from systems and processes in the delivery of nutritional care to focus on outcomes and user experiences?
9.	Working across health and social care	Joined up nutritional care across health and social care is essential; achievement is difficult. How do you <ol style="list-style-type: none"> Achieve this? Demonstrate your achievement of this?
10.	Supporting vulnerable individuals	How do you demonstrate: <ol style="list-style-type: none"> Good nutritional care for vulnerable adults and children? There is access to food and fluid that meets an individual's needs?

Table 3: Shaping priorities

Aims and Structure of the Toolkit

BAPEN has produced this Toolkit to help commissioners and providers ensure that nutritional issues are being met within all service plans and that best nutritional care is embedded in all UK health and care settings.

The four principles underlying the tools are that:

- potentially vulnerable individuals should be screened for malnutrition;
- those identified as at risk should be offered individual nutritional care plans;
- all care staff should understand the importance of nutritional care; and
- all staff are appropriately trained to meet the needs of the individuals in their health or social care setting.

The Tools do not attempt to dictate the detail of all nutritional care since the commissioners we consulted preferred a ‘framework of thinking’ that would permit a logical approach to the incorporation of nutritional care and outcome measures when discussing all types of care services with their providers and service users.

The Toolkit is therefore designed to encourage commissioners and providers to:

- Increase awareness of malnutrition
- Collate evidence on nutritional care in all settings, in order to support the case for nutritional care as a fundamental indicator of quality
- Help commissioners to draw up service specifications that embed nutritional care in all services, and in all health and social care settings
- Reduce inequalities in nutritional care
- Provide guidance to service providers to enable them to embed nutritional care in all business cases for new services and development of existing services
- Facilitate assessment and monitoring of nutritionally related health outcomes
- Demonstrate value for money for nutritional care

Meeting World Class commissioning competencies: Key steps in commissioning nutritional services⁵⁷

The BAPEN Toolkit has been structured to provide a comprehensive list of commissioning activities to ensure the commissioning of nutritional services is based on assessment of local need and strategic planning, using ‘the Analyse, Plan, Do, Review’ approach of World Class Commissioning. Table 4 summarises the activities needed and commissioners and providers should begin by undertaking an assessment of their current provision of nutritional services.

Step 1 - Analyse	Relevant policy documents and tools
Assess local population needs for nutritional services in order to meet required standards	Tool 1: Assessment of local population at risk
Public and patient experience and engagement	Accountability: Demonstrating responsiveness and accountability. Guidance on the NHS duty to report on consultation ⁵⁸
Evaluate how much the service costs and whether it is cost-effective	NICE Guideline 32: Nutrition support in adults, Costing Template ⁵⁹ NICE: Costing statement. ⁶⁰ Maternal and child nutrition
Assess staff training needs to enable nutritional screening, assessment and the development of care pathways	Tool 4: Education and training. Staff appraisal and development planning should include training needs analysis for the delivery of good nutritional care.
Identify local and national priorities	Local commissioning plans and national standards and guidance
Map current provision of nutritional care in acute and community services	Tool 2: Assessment of current screening and provision of nutritional care
Agree resources required to address gaps between current provision and needs within acute Trusts, PCTs and local authority facilities	Local world class commissioning frameworks
Step 2 - Plan	
Form a strategic commissioning partnership with all providers and users, aiming to increase awareness of the benefits of malnutrition detection, prevention and treatment in social settings and primary and secondary care	Set up a strategic nutrition commissioning steering committee or board
Design care pathways focussing on prevention and effective treatment of malnutrition, matching identified needs with planned resources and agreed priorities.	Tool 3: Development of nutritional screening, assessment and care pathways
Transform existing services so that 'every encounter counts' (e.g. district nurses complete nutritional screening using 'MUST' when undertaking routine visits, occupational therapists focus on nutrition whilst assessing cooking skills, weighing scales and height measures are used in community pharmacies to detect individuals at risk of malnutrition, nutrition screening and care planning is incorporated into services offered by 'One Stop Shops' for older people).	Transforming Community Services & World Class Commissioning: Resource Pack for Commissioners of Community Services ⁵⁷
Develop service specifications and structures across all acute and community settings to ensure gaps and inequalities are addressed within resources identified	Tool 5: Service specifications and management structures for nutritional care Tool 6: Quality frameworks for nutritional care
Agree key performance indicators and clinical outcomes and incorporate into the CQUIN	Tool 7: Quality indicators, monitoring and review
Include a range of service options to ensure patient choice	
Step 3 - Do	
Follow world class commissioning principles to ensure that nutritional care priorities and targets are planned, contracted and delivered efficiently and effectively.	World Class commissioning competencies ⁶¹
Step 4 - Review	
Monitor service performance against agreed key indicators and clinical outcomes	Local contract monitoring processes
Review outcomes and impact of the improved nutritional care	
Identify innovation to increase effectiveness and efficiency	Clinical Leadership and Health Improvement

Table 4: Key steps in commissioning nutritional services

BAPEN Tools for Commissioning Nutritional Care

Tool 1 – Assessment of population at risk of malnutrition

Purpose: To quantify the numbers in the local population who are malnourished or at risk of malnutrition, and who may therefore need nutritional care.

Step 1 - Source overall population data from local joint needs assessments

Step 2 - account for projected population growth, particularly for those aged ≥65 (since 60% of this group will have one or more long-term conditions likely to increase nutritional risks).

Step 3 – Source hospital admissions data (HES statistics),⁶² numbers of residents in care homes and numbers of tenants in sheltered housing (DH care network data).⁶³

Step 4 - using these data, estimate overall numbers at risk of malnutrition using the figures in the table.

ADULTS

*Prevalence of malnutrition varies from area to area and local figures should be used if available

	Prevalence of malnutrition*	Source of information
General population	~5% (BMI <20kg/m ²) 1.8% (BMI<18.5kg/m ²)	Elia & Russell, 2009 ¹ Erens & Primatessta 1999 ³⁰ Health Survey for England 2008 ³¹
Population aged 65 yrs and over	14%	Elia & Stratton, 2005 ²²
Sheltered housing	10-14%	Harris 2008 ²¹ BAPEN 2009 ²⁰
Care at home	25%	BAPEN 2009 ¹
Care homes	30-42%	BAPEN Nutrition
Recent admissions (<6mths)		Screening Week Surveys 2007/8 ^{18,19}
Mental health units admissions	~20%	BAPEN Nutrition Screening Week Surveys 2007/8 ^{18,19}
Hospital admissions (adults)	28%	BAPEN Nutrition screening week 2007/8 ^{18,19}

Providers should be asked to participate in BAPEN's National Screening Weeks to ensure accurate and comparable local prevalence data are available

Note: When estimating the prevalence of malnutrition in the local community it is important to consider the definition of 'underweight' as in some studies and reports this is defined as BMI<18.5kg/m² and in others <20.0kg/m². All data given in the table above are derived from screening using 'MUST' unless specifically stated.

PAEDIATRICS

Paediatrics	Prevalence of malnutrition	Source of information
Acute malnutrition (wt for ht SDS <-2)	11%	Joosten 2010 ²⁷
Chronic malnutrition (ht for age SDS <-2)	9%	Joosten 2010 ²⁷
Overall malnutrition	19%	Joosten 2010 ²⁷
Co-morbidity	28%	Joosten 2010 ²⁷
Non white ethnic background	28%	Joosten 2010 ²⁷
Hospital admissions (paediatrics)	16-24% 18%	Puntis, 2009 ²⁴ McCarthy, 2008 ²⁵
Specialist children's hospital in UK	14%	Moy 1990 ²⁶
PICU	20%	Mehta 2009 ⁵²
Community paediatrics	10%	Wright 2006 ⁶⁴
Infants - weight faltering	(4% sustained)	
Preschool children (BMI <2nd centile)	3.3%	Armstrong 2003 ⁶⁵

The paediatric table should be used in the same way as the adult table to quantify the numbers in the local population who are malnourished or at risk of malnutrition, and who may therefore need nutritional care.

Tool 2 – Assessment of current screening and provision of nutritional care

Purpose: To assess current local provision of nutritional care.

The Table identifies settings where nutritional screening and support should occur and provides a structure to assess current provision within services. Use of the resulting data with the data from the needs assessment in Tool 1, will identify the gaps in provision of nutritional care that need to be addressed.

Setting	Population group	Numbers of clients / contacts in this group per annum	Availability of nutrition screening (Yes / no)	% of clients screened	Availability of nutrition support (Yes / no)	% receiving nutrition support	Staff involved (profession / grade)	Staff trained (%)	Training available (Yes / no)	Type of training available
Community	Sheltered housing									
	Residential homes									
	Nursing homes									
	Day care facilities									
	Vulnerable children and young adults									
Community	Health visitor or district nurse visits									
	Practice nurse contacts									
	GP contacts									
	Community Dietetic contacts									
	Pharmacists contacts									
Secondary care	Outpatients – adult									
	Outpatients - paediatric									
	Day care									
	Inpatients- adults									
	Inpatients - paediatrics									

Tool 3 – Development of nutritional screening, assessment and care pathways

Purpose: To ensure that nutritional screening, assessment and care pathways meet agreed standards or recommendations based on available evidence for effective and efficient identification of malnutrition in patients and subsequent management.

- Planned care pathways should provide a framework for ensuring quality of service for all users and reduce health inequalities and the variations in quality of care.
- Agreed pathways must be focussed on an individual's needs accounting for their health problems. They should aim to ensure best care in order to prevent, limit or reverse weight loss depending on an individual's specific case.
- Pathways should use the simplest, sustainable, effective treatment that allows maintained autonomy and independent living if possible.
- Pathways should incorporate a logical approach to identification of the malnourished using screening and assessment steps, followed by treatment of those found to be malnourished or at risk starting with food intake where possible, and moving on to oral nutritional supplements or artificial nutrition support where indicated.
- The Map of Medicine supports the development of care pathways and is available to NHS staff⁶⁶ and the public.⁶⁷

Step 1 – Screen for malnutrition using a reliable, validated screening tool, such as the 'Malnutrition Universal Screening Tool' ('MUST'). 'MUST' includes management guidelines for each nutritional risk category which provide a good starting point for the further development of individual care pathways. Validated paediatric tools should be used for children (See Appendix 2).

Step 2 – Individuals identified as malnourished or at risk in step 1 should have further nutritional assessment including evaluation of current nutritional intake and factors preventing adequate intake (e.g. social isolation or inability to shop or cook, poorly fitting dentures, difficulty swallowing, abdominal pain on eating) and in children recurrent tonsillitis, social factors, and anorexia secondary to undiagnosed pathology such as Crohn's disease).

Step 3 – For those with inadequate intake, a 'food and drink first' approach should be adopted where appropriate with social help and dietary advice. However, it is important when using nutrient dense snacks or food fortification that overall dietary intakes are as complete and balanced as possible, which can be difficult to achieve in patients with very little appetite. Individuals in care homes or hospital should be started on food and fluid record charts.

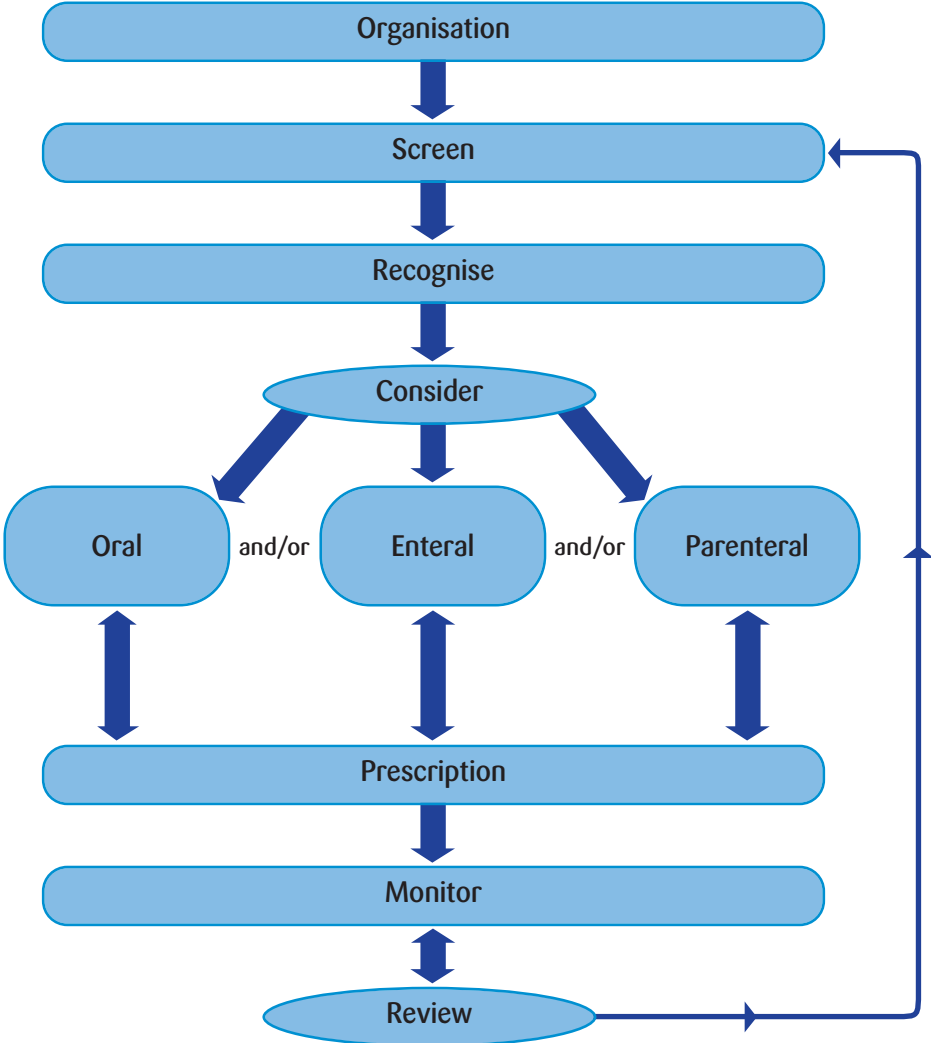
Step 4 – If the measures in step 3 are inappropriate, fail or are impractical, oral nutritional supplements should be considered (some guidance for these steps can be found in *Appropriate Use of Oral Nutritional Supplements in Older People, 2009*⁵¹ and *Nutritional support for adults and children 2004*⁶⁸, and BAPEN is working on further guidance).

Step 5 – If the measures in steps 3 and/or 4 fail or are impractical, refer to dietitians or follow local policies and protocols. Enteral tube feeding or even parenteral nutrition may be needed.

Step 6 – Maintain documentation for all individuals including results of nutritional screening and assessments, along with consequent action plans and treatment goals. If the patient is transferred to another care setting, this information should be readily available to all new carers.

Step 7 – Review care pathways regularly using feedback from users to identify gaps in the service and any improvements required.

Figure 2: NICE Clinical Guideline 32: Nutritional support in adults



Source: National Institute for Health and Clinical Excellence: Clinical Guideline 32: Nutritional support in adults. Quick reference guide, February 2006⁶⁹

Tool 4 – Education and training: Knowledge, skills and competencies of staff involved in nutritional screening, assessment and care planning

Purpose: To ensure that all staff are appropriately trained to deliver high standards of nutritional care appropriate to the needs of the patient and care setting.

NICE Guidance⁸ outlines the education and training needs of staff involved in the organisation and delivery of nutritional care in hospital and the community. It is not possible, however, to be specific in recommending staff training programmes as their nutritional training needs must be assessed for each service that is commissioned. This guidance tool therefore highlights the issues to be considered. Dietitians should have a key role in the nutritional training needs analysis and the delivery of nutrition education to health and social care professionals.

Who should be trained?	What should the education and training include?	Impact of the education on patient care: following the education and training professionals should ensure that care provides:
All staff who are directly involved in patient care	<ul style="list-style-type: none"> • Causes and consequences of malnutrition in the UK • The importance of providing adequate nutrition • Nutritional screening • Assessment of nutritional needs • Nutrition care planning and treatment • Ethical and legal issues • Potential risks and benefits • When and where to seek expert advice <p>The level of education and training should be relevant to the post</p>	<ul style="list-style-type: none"> • Food and fluid of adequate quantity and quality in an environment conducive to eating • Appropriate support e.g. assistance with eating and drinking, modified equipment • Appropriate use of oral nutritional supplements and enteral tube feeding where required • Coordinated care from a multidisciplinary team for all individuals who require artificial nutritional support

Providers should be able to provide evidence that staff have attained competences appropriate to their role. This could include demonstration of:

- Participation in local study days
- Achievement of competencies identified by Skills for Care,⁷⁰ Skills for Health⁷¹ and completion of the nutrition modules provided by the NHS Core Learning Unit¹⁵
- Completion of the BAPEN 'MUST' e-learning module^{*72}
- Compliance with the BPNG competency framework⁷³

* E-learning modules that all hospital staff can use to complete training on the principles and practice of 'MUST' are available from BAPEN and 'MUST' training modules suitable for community and social care staff will become available during 2010. BAPEN is also undertaking further work to bring together and complete a competency framework for all professions involved in providing nutritional care.

Tool 5 – Service specifications and management structures for nutritional care

Purpose: To provide a checklist to assist teams in developing specifications for nutritional care in all local settings and the management structures that will deliver them.

- Service specification must define outcomes that clinicians and commissioners are seeking to achieve
- Service providers must outline how they will deliver and manage these outcomes
- Individual Trusts will have needs and priorities that vary with the needs assessment of their local population

The guidance in the Table below is drawn from the NICE Guidance on Nutrition Support in Adults⁸ and the position statement of the Royal College of Nursing¹²

<p>Step 1: Agree the aims and objectives of the nutrition service in the area</p>	<p>Service developments should ensure nutritional screening is undertaken in accordance with NICE⁸ guidance and current nutritional standards across all care settings (see Implementing Current Standards and Guidelines in Nutritional Care). The objectives of the nutritional care commissioned will vary for different health settings and patient groups.</p> <ul style="list-style-type: none"> • Individuals identified as malnourished on screening should have a more detailed nutritional assessment with identification of a nutritional care pathway if appropriate. • All healthcare professionals should receive appropriate training in nutritional screening and indications for further referral for nutrition support • Dietitians should be included as part of MDTs to ensure delivery of nutritional care. • Paediatric dietitians should be included as part of MDTs for children who are identified as malnourished and also those with chronic disorders (e.g. congenital heart disease, diabetes, cystic fibrosis, cancer, cerebral palsy)
<p>Step 2: Identify who service is for</p>	<ul style="list-style-type: none"> • Local teams need to identify the target group for the service
<p>Step 3: Determine how individuals will access the services</p>	<ul style="list-style-type: none"> • Referral criteria should be agreed with clear referral mechanisms. • Consider self referral where appropriate
<p>Step 4: Identify how service should be delivered</p>	<p>Every commissioning PCT should ensure that local providers have structures to deliver good nutritional care. In many areas this is likely to require additional resources or re-allocation of current resources. Service delivery must be led by multidisciplinary teams</p> <p>Hospital Trusts should have:⁴⁵</p> <ul style="list-style-type: none"> • A nutrition steering committee working within the clinical governance framework and including representation from trust management, senior medical staff, catering, nursing, dietetics, pharmacy and other healthcare professionals as appropriate e.g. speech and language therapists. • A multidisciplinary nutrition support team • At least one specialist nutrition support nurse working alongside nursing staff, dietitians and other experts in nutrition to: <ul style="list-style-type: none"> • minimise complications related to enteral tube feeding and parenteral nutrition • ensure optimal ward-based training of nurses • ensure adherence to nutrition support protocols • support coordination of care between the hospital and the community. • Systems in place to facilitate the delivery of nutritional care pathways across different settings

Step 4: (continued)	<p>Every provider PCT should have:</p> <ul style="list-style-type: none"> • A nutrition steering committee working within the clinical governance framework and including representation from the Trust senior management team, senior medical staff representation from the Clinical Executive Committee/Professional Executive Team (PEC), social services and representation from the key disciplines at a senior level including dietetics, nursing, pharmacists, speech and language therapists. • A multidisciplinary nutrition team in the community. • Systems in place to facilitate the delivery of nutritional care pathways across different settings
Step 5: Agree quality assurance standards and monitoring parameters	<ul style="list-style-type: none"> • See Tools 6 & 7

Note: It is particularly important to identify individuals who are admitted to hospital for a short period of time but who have ongoing nutritional needs and to ensure that systems are in place to transfer nutritional care plans across settings. This is especially relevant to children: a recent survey of acute paediatric admissions in the Netherlands showed that the median length of stay was 2 days and yet the overall prevalence of malnutrition was 19%.²⁷

Tool 6 – Quality frameworks for nutritional care

Purpose: To provide a framework for Commissioners to check that organisations providing care to the local population put nutrition at the heart of that care. Nutritional parameters should be included within quality indicators such as CQUIN and QIPP. Examples to consider are shown in the Table.

<p>Capacity to:</p> <ul style="list-style-type: none"> • deliver focussed services • focus on target groups 	<p>Providers should have the staff and equipment to be able to identify and treat individuals at risk of malnutrition.</p> <p>Providers should demonstrate that they have adequate processes in place to ensure that guidance on nutritional care is followed.</p> <p>Providers should have systems in place for collecting data to demonstrate activity and effectiveness of nutritional care.</p>
<p>Knowledge of:</p> <ul style="list-style-type: none"> • all aspects of nutritional screening, monitoring and treatment 	<p>Providers should be familiar with current national guidance on nutrition.</p> <p>Providers should be aware of nutritional issues within the wider context of personalised care for individuals with long term conditions and national service frameworks for specific conditions.</p> <p>Providers should be able to provide evidence of appropriate nutritional training for all staff involved in social or NHS care.</p>
<p>Experience of:</p> <ul style="list-style-type: none"> • delivering PEAT standards • delivering results from patient experience surveys • delivering core quality indicators relating to nutrition e.g. NICE quality standards 	<p>Providers should be able to demonstrate adherence to the Essence of Care Benchmarks³⁷ and the 10 key characteristics of good nutritional care in hospitals.⁴⁰</p> <p>Providers (where appropriate) should be able to demonstrate adherence to national standards and guidance for hospital,^{8,43,45} care home,^{9,74} social care catering,⁷⁵ and maternal and child nutrition.⁴⁷ CQC is responsible for inspecting social care services including domiciliary care and Extra Care housing.</p> <p>Trusts should include nutritional standards in their Commissioning for Quality and Innovation⁵³ (CQUIN) payment framework.</p> <p>Hospital providers should be able to demonstrate good PEAT¹¹ scores for all measures relating to food and nutrition.</p> <p>Providers should be able to demonstrate satisfactory patient experience survey results for all measures relating to food and nutrition.¹⁰</p>
<p>Ability to</p> <ul style="list-style-type: none"> • provide personalised care plans • deliver nutritional care safely • continuously improve services 	<p>Providers need to provide evidence of individualised nutritional care plans that follow the individual.</p> <p>Providers need to report, investigate and respond to adverse incidents relating to nutritional care, including the failure to detect nutritional risk.</p> <p>Providers need to investigate, respond to and monitor complaints relating to nutritional care.</p> <p>Providers need to ensure good communication at both local and national levels to share good practice in nutritional care.</p> <p>Providers need to provide evidence of communicating information about the nutritional care of individuals across different care settings.</p>
<p>Potential to</p> <ul style="list-style-type: none"> • contribute to the development of nutritional care on a national level • help improve the evidence base for the effectiveness of nutritional care 	<p>Providers need to provide evidence of involvement in the development and awareness of national guidelines and standards in nutritional care.</p> <p>Providers should be encouraged to publish evidence-based research and innovation in nutritional care.</p>

Tool 7 – Quality indicators, monitoring and review

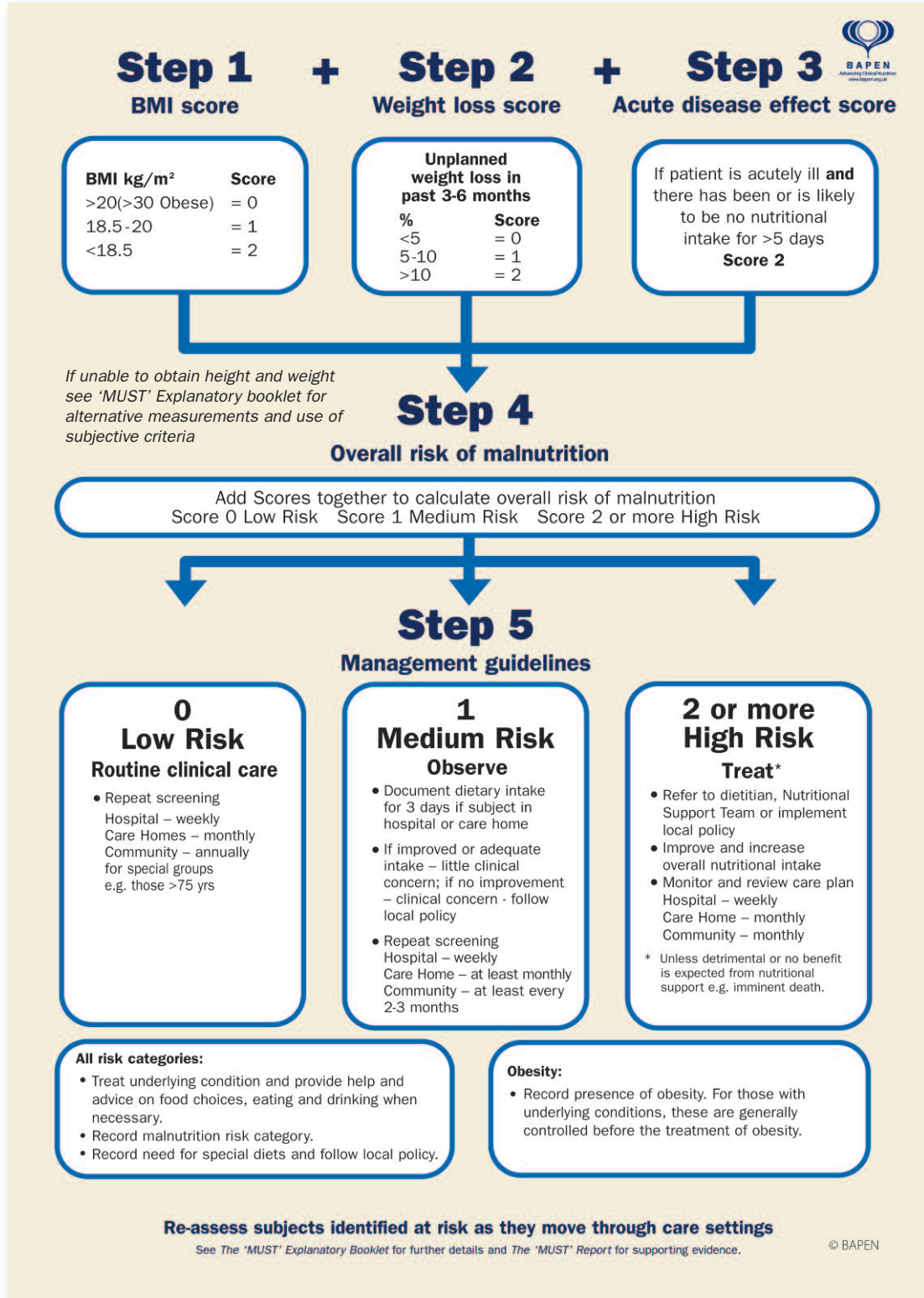
Purpose: To define measurable markers of quality in nutritional care and to assist in the development of data collection systems that are part of routine working practice wherever possible rather than systems needing specific ad hoc audits. The monitoring is needed to confirm quality, ensure value for money and hold providers to account.

The following suggested outcomes must be discussed with all providers to ensure they are relevant and measurable:

Assessment Parameters	Assessment Criteria
The presence of nutritional care MDTs or input from individuals with appropriate nutritional expertise with documented policies under regular review	Published nutrition care policies covering screening, assessment and care pathways. Records of MDT meetings including minutes of nutrition steering committee, nutrition support team and dietetic department for acute Trusts, nutrition MDTs for Mental Health and Community Trusts; and minutes demonstrating discussion of nutritional issues within MDTs for long-term conditions, paediatrics, elderly and cancer etc.
Adherence to policies on nutritional screening/ assessment	Audit showing achievement of screening and linked assessments with reporting of the incidence of malnutrition/nutritional risk on: admission for in-patients in hospitals; 1 st attendance at OP clinics; registration with GP surgeries; and initial move into a care home. Screening should be repeated weekly for inpatients and where there is clinical concern for outpatients and in care homes. ⁸
Adherence to policies on individual nutritional care pathways for those at risk	Reports demonstrating monitoring of food/nutrient intake, ongoing measurement of body weight and BMI (e.g. weekly for acute hospital in-patients, monthly within care homes or 3/6 monthly within domiciliary care); use/costs of oral nutritional supplements and enteral/parenteral feeding.
Communication of nutritional information e.g. 'MUST' score across care boundaries	Presence of nutritional information in referral letters, outpatient letters and discharge summaries (i.e. weight and height measurements in children, 'MUST' score / BMI in adults).
PEAT and Essence of Care benchmarking	PEAT scores and EoC elements relating to food and nutrition within Trust Quality and other relevant organizational annual reports.
Patient surveys	Results from surveys.
Staff training on nutritional care appropriate to their professional group and work setting	Records of study day attendance, completion of Skills for Care, ⁷⁰ Skills for Health, ⁷¹ the NHS core learning units, ¹⁵ 'MUST' training ⁷² etc. In children the use of new WHO growth charts (weights, heights/lengths /head circumference measurements) and the use of a validated screening tool should be demonstrated.
Patient information sheets	Presence of appropriate nutritional information sheets for patients/residents, young people and their families.
Menu capacity	Where food and beverages are provided the nutritional capacity of the menu should be assessed and shown to be capable of delivering the nutritional needs of service users.

Appendix 1

BAPEN's 'MUST' - 'Malnutrition Universal Screening Tool'



Appendix 2

Nutritional matters of particular relevance to paediatrics

The foregoing document primarily focuses on detection and treatment of malnutrition in adults. This Appendix highlights some of the additional issues which should be considered when commissioning paediatric services.

There are some key nutritional differences in children listed below. These are primarily related to the higher energy needs from infancy until puberty has finished and linear growth is complete; micronutrient deficiency; and the management of weight faltering (operationally defined as a downward shift of 1.3SD or 2 centile spaces on the growth chart), which require a multi-agency approach in which health visitors and social workers and hospital specialists intervene to support parents whose parenting skills are inadequate as a consequence of social and educational deprivation.

- a) Higher energy needs to allow for growth as well as resting metabolic rate and activity
- b) micronutrient deficiency (especially vitamin D, vitamin A, zinc and iron)^{2,28}
- c) energy deficiency (e.g. use of low fat products meant for consumption by adults)
- d) parenting skills, educational and social deprivation
- e) transition from paediatric to adult services
- f) Paediatric malnutrition screening tools: STAMP⁷⁶, PYMS⁷⁷ and STRONGkids⁷⁸
- g) appreciation that long term physical, mental and developmental outcomes in adult life are influenced by malnutrition in childhood⁷⁹

Key steps in commissioning nutritional support services:

Define high risk groups e.g.

- children with neurodisabilities
- children born prematurely
- children living in deprived circumstances
- children with black and ethnic or cultural minority backgrounds²⁷
- children with chronic intestinal disorders (gluten intolerance, inflammatory bowel disease, cholestatic liver disease, cystic fibrosis, intestinal failure)^{80,81}
- children with chronic illness impacting on nutrition (congenital heart disease, cerebral palsy, juvenile onset diabetes, chronic renal failure)²⁷
- young people in transition from paediatric to adult services

Bench mark local services against those provided in centres of excellence, using evidence acquired from registries and outcome audits

The following issues should therefore be considered when using the Guidance Tools for commissioning paediatric services:

Clinical standards for nutritional care services

- train health visitors, paediatric nurses, social workers, dietitians and paediatricians in nutritional screening and the indications for onward referral for nutritional assessment and support
- all children admitted to hospital to have height and weight measured, recorded and plotted on UK-WHO growth chart
- previous growth measurements to be sought actively from parent held child health record, GP records, hospital records and plotted on UK-WHO growth chart
- growth measurements to be related to UK WHO growth chart for 0-4 year olds or UK 1990 reference population growth charts for 4-18 year olds, and use of specific paediatric screening tools for malnutrition ie PYMS^{77,82} (1-16yrs), STRONGkids⁷⁸ (0-18yrs) and STAMP⁷⁶ (0-16yrs)

- clear referral guidelines for nutritional assessments of children considered potentially to be suffering from malnutrition i.e. weight for height <-2SDS or height for age <-2sds
- in children older than 2 years of age, BMI should be evaluated using either the BMI converter on the new UK-WHO (0-4) growth charts or the UK 1990 reference population growth charts for 4-18 year olds for BMI and referral made for nutritional assessment if BMI is <-2SDS or >+2SDS.

Tool 1: Assessment of population at risk of malnutrition

- prevalence of growth faltering (defined as a downward shift of 1.3SD or 2 centile spaces on the growth chart)
- prevalence of acute (weight for height <-2SDS) and chronic malnutrition (height for age <-2SDS)
- prevalence of obesity by age 5yrs
- prevalence of iron deficiency anaemia at 18 months
- prevalence of clinical and sub-clinical rickets at age 5yrs
- define number receiving specialised nutritional support (ie enteral and parenteral nutrition)

Tool 2: Assessment of current provision of nutritional care

- use of registry and audit data eg BANS, BIFS

Tool 3: Development of nutritional care pathways

- review of the literature, consensus documents published by ESPGHAN and other learned societies

Tool 4: Education and training: Knowledge, skills and competencies of staff involved in nutritional screening, assessment and care planning

- staff working with children will need to have gained specifically appropriate knowledge, skills and competencies.

Tool 5: Service specification for nutritional care

- multi-disciplinary teams are needed to ensure that care pathways are followed and parents are supported in delivering the treatment for their child. In some situations this will require specific nutritional MDTs (e.g. nutrition steering committees and nutrition support teams in acute hospital trusts), whilst in other long-term conditions such as inflammatory bowel disease cooperation between local paediatric services (e.g. local paediatrician and paediatric dietitian) and tertiary hospital IBD specialists (e.g. paediatric gastroenterologist and paediatric IBD specialist dietitian) will be commissioned.
- specific staffing specification for parenteral nutrition support team has been described by BSPGHAN in collaboration with DH⁸⁰

Tool 6: Quality frameworks for nutritional care

- evidence of appropriate training and teaching undertaken by members of nutritional support team (e.g. study day attendance)
- participation in National audits eg audits emanating from BSPGHAN, BPSU, CEPOD, HQIP, BIFS & BANS
- availability of protocols and care plans for children with or at risk of malnutrition

Tool 7: Quality indicators, monitoring and review

- patient surveys including Quality of Life questionnaires for child and parents/carers
- appropriate information for children and their families using multi-media
- documentation of use of nutritional screening tool (STAMP, PYMS or STRONGkids) and results recorded in clinical record and in letters communicated with GP and other members of the multi-disciplinary team

Tool 7: *(continued)*

- patients have access to multi-disciplinary teams and support provided according to agreed care plans
- audit of outcome parameters such as: percentage of children with growth faltering who are followed up by a multi-disciplinary team; prevalence of 1-3 yr olds with iron deficiency; percentage of patients with Crohn's disease where growth is regularly monitored and have access to a paediatric IBD specialist dietitian; percentage of young people at risk of malnutrition who proceed through transition clinics according to RCPCH guidelines; time taken to discharge a child on home parenteral nutrition after commencing initial presentation with intestinal failure.

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