Dietetics TODAY

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JUNE 2023

CLINICAL PRACTICE

- Weight management in learning disabilities
- CVD in children with type 1 diabetes

Workforce development
Using funding to advance the profession

Sarcopenia
The role of nutrition

Member survey
How we're using your feedback

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Tell the world

Dietitians Week is the perfect chance to shout about all that we do

The highlight campaign week of the BDA year is upon us and is, once again, another great opportunity to showcase all that is great about dietetics to the public, wider healthcare, and each other.

Our popular Dietetic Bake Off competition has returned and there have been some fantastic entries using the medium of cake to express what being a dietitian means to you.

The entries have had the judges drooling. Unfortunately, as it's a photographic competition, the proof of these puddings hasn't been in the eating. But I'm sure they all tasted great anyway!

Dietitians Week kicks off a summer of activities that give us an opportunity to celebrate the profession. The BDA Awards take place next month, and I'm looking forward to seeing so many friends and colleagues as we honour some more amazing achievements. And I'm delighted to say that our next Elsie Widdowson lecturer has been confirmed – Jacqueline Walker will be giving us 'A public health approach to dietetics' at the event held during the AGM on 19 September.

This month has also seen Volunteers Week and BDA staff have been doing their bit by doing a litter pick on the streets of Birmingham. As I said in last month's Dietetics Today, we're always grateful to the work volunteers do for the BDA. This month's Volunteer Corner article is a profile of Vicky Dagnan (page 10), who does fantastic work for the Learning Disabilities Sub Group.

We're also fortunate to benefit from the time given by non-members. Abdul Elghedafi sits on our Board of Directors as a lay member, and he gives a valuable perspective from someone whose career falls outside of healthcare. You can read more about why he got involved on page 12.

Elsewhere in this issue, you can see the results of our Member Survey and what we are doing based on your feedback (page 24). More than 1,400 members took part in the survey, which has given us a vital insight into what you think. The BDA is a member-led organisation and we rely on your feedback – thanks to everyone who took part.

Best wishes

Caroline Bovey

Caroline Bovey
Chair, BDA

Dietetics Today

Dietetics Today is published ten times a year in print and digital formats. It is the official magazine for BDA members. Packed with relevant articles and features about the BDA, nutrition and dietetics, it keeps our valued member readers in touch with the wider membership and profession.

Have your say

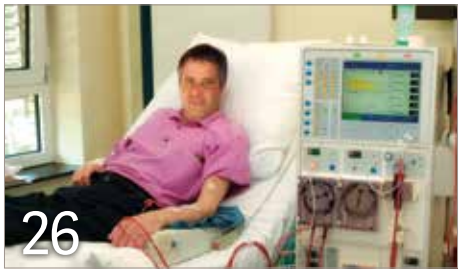
We love to hear from members who are keen to feed back on or write for the magazine. So if you have a new piece of research to share, have identified an issue within the profession or wish to highlight some great work, you can email us at **editor@bda.uk.com**

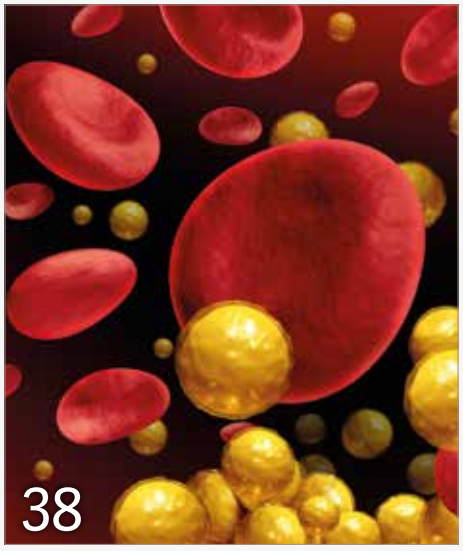
Join our online community

Come and join the nutrition and dietetic conversation across your favourite social media channels

bda.uk.com | **@BritishDieteticAssociation** | **@BDA_Dietitians** | **http://bit.ly/2GxiFhJ**

Inside this issue





Member focus

Clinical practice

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1. Healthy Childrens Taste Testing 2016 (n=122), data on file.
2. Paediatric Dietetic Survey 2016 (n=106), data on file.
3. Correct as of Oct 2021, Data on File.
+ Oral nutritional supplement
*Product can be provided to patients upon the request of a Healthcare Professional. They are intended for the purpose of professional evaluation only.
Accurate at time of publication, February 2023 21-099

AWARDS

Nominations open for BDA Awards

Time is limited to get your nominations in for this year's BDA Awards.

If you know someone who excels in any of the seven categories open for nomination, then you have until 12 June to let us know.

BDA Awards celebrate outstanding individuals within the dietetic profession. Nominations are open for Digital Innovation, The Dorothy Hopwood Award (for dietetic support workers), Outstanding Achiever, Rising Star, Social Media Influencer, Student Champion and BDA PEN Achiever.

The deadline for submissions is 10am on Monday 12 June. The awards will be presented at our awards ceremony on the evening of Tuesday 4 July 2023 in Birmingham.

For more information on the Awards and how to nominate, go to **bda.uk.com/about-us/honours-and-awards.html**.

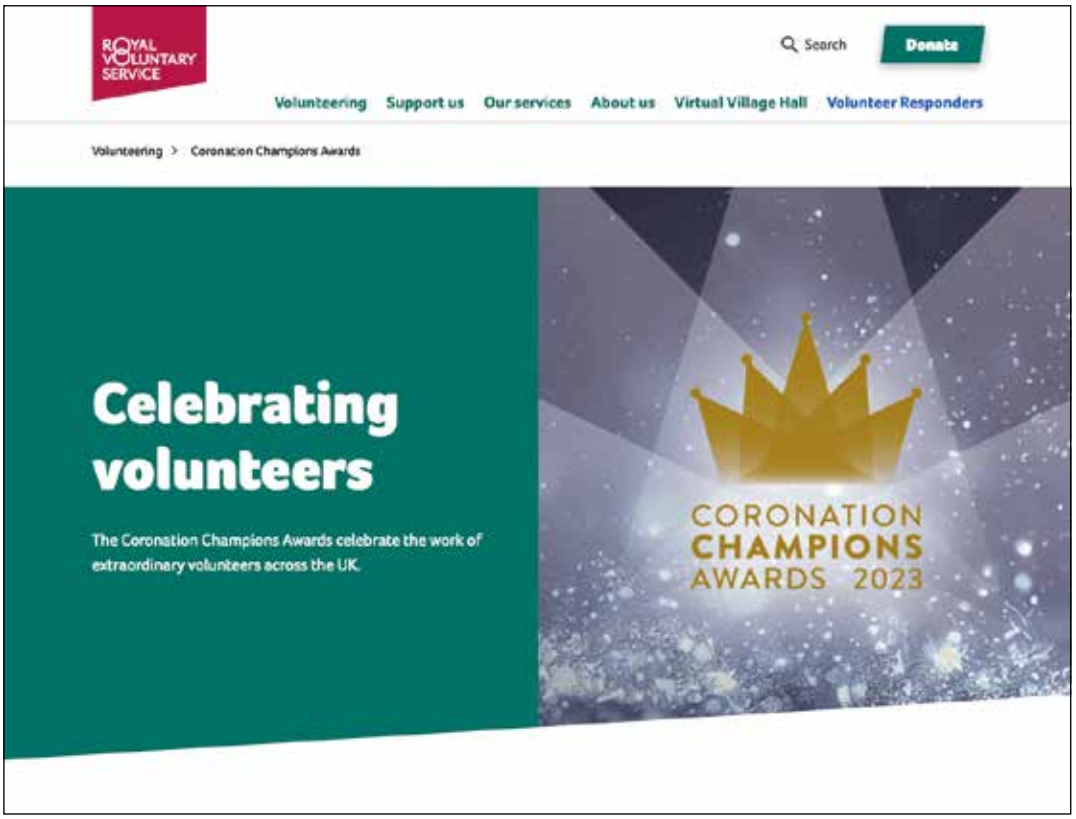
AGM

Elsie Widdowson Memorial Lecture speaker announced

We are delighted that Jacqueline Walker MSc BSc RD - Moray Dietetic Lead, NHS Grampian and Scottish Government Professional Adviser, is this year's Elsie Widdowson Memorial Lecture speaker. Jacqueline will present The Public Health Approach to Dietetics virtually on Tuesday 19 September alongside our AGM.

To register for the event, go to **bda.uk.com/events/upcoming-events/annual-general-meeting.html**.

VOLUNTEERING



Coronation awards joy

An outstanding BDA volunteer has been recognised by Their Majesties The King and The Queen Consort as part of the official Coronation celebrations in conjunction with Royal Voluntary Service.

Lorna Breeze, who works as the Bariatric Team Lead Dietitian at University Hospital Ayr, within NHS Ayrshire & Arran, volunteers with the BDA and is Chair of the Glasgow & West Scotland Branch. She has been recognised for her contribution and crowned a Coronation Champion. This follows a call-out to the nation to nominate their volunteer heroes. Almost 5,000 entries were received, including fellow BDA volunteers Nusrat Kauser and Julie Taplin.

Lorna impressed judges due to her leadership, motivation and coordination for the branch committee. Lorna has been instrumental in organising continuous professional development and networking events for dietitians from Dumfries to the Outer Hebrides. These educational events are vital to support BDA members to provide current evidence-based nutritional advice to patients to improve their nutritional status, health, and wellbeing. Lorna actively supported student dietitians during the COVID-19 pandemic too.

With the support of Her Majesty The Queen Consort, a passionate advocate of volunteering and President of Royal Voluntary Service, the Coronation Champions Awards were launched to recognise exceptional volunteers from across the country at this momentous point in history. Across the UK, 500 Champions dazzled the judging panel with the impact of their work, their inspirational stories and unwavering commitment to volunteering.

All Coronation Champions, including Lorna have been invited to attend one of the official Coronation celebrations. Lorna will attend Holyrood Palace. She will also receive a specially designed official Coronation Champions pin and a certificate signed by Their Majesties.

Commenting on becoming a Coronation Champion, Lorna said: "I am delighted to be receiving the Coronation Champion Award from the Royal Voluntary Service. This award is not just for me but also for the rest of our wonderful volunteers in the West of Scotland. A huge thank you to the BDA for the nomination."

Liz Stockley, CEO of the BDA said: "A huge congratulations to Lorna on her much-deserved award. It's only through the work of our dedicated volunteers that we are able to make a difference to food and nutrition. Hundreds of our members put so much time into supporting the development of dietetics, supporting at an individual and wider public health level. We're so grateful for all that they do."

SPORT

Behavioural science in sports nutrition practice

Behavioural science is the systematic study of human behaviour. The field offers great value to sport nutrition practice although intervention(s) are typically designed and implemented without adopting an evidence-based or theory-informed approach (Bentley et al., 2020). As a result, we are unable to identify how and why sports nutrition intervention(s) bring about their effects and thus their active ingredients for change remain unknown.

We have collaborated with several sports organisations to support the application of behavioural science in sports nutrition practice. During these projects we have conducted nutritional behavioural analyses through focus group discussions with approximately 80 athletes. The conversations with the athlete community enabled a greater understanding of the factors that affect their dietary behaviours, which facilitated the enhancement of the sports nutrition service through the design and development of evidence-based actions.

Our work has enabled us to establish the value of using behavioural science to advance sports nutrition service design. But we have identified that there are gaps in the training and education of sport and exercise nutritionists in terms of understanding human behaviour and behaviour change, as well as knowledge and skills surrounding establishing and enhancing nutritionist-athlete relationships.

Though the process of collaboration with the community, we are passionate about developing sports nutrition professional practice and are already taking action to shape the professional training that sports nutritionists can engage with and have access to. For example, we have designed and delivered a behavioural science training and education day for the British Dietetic Association, to help practitioners develop an understanding of athletes' dietary behaviour through conducting a behavioural analysis. The next course is scheduled for Friday 16 June 2023. Further details can be found at **bda.uk.com/events/calendar/introducing-behavioural-science-to-understand-and-change-the-dietary-behaviours-of-athletesmar23.html**.

L-R: Professor Sue Backhouse, (Leeds Beckett), Dr Meghan Bentley (Leeds Beckett), Kathryn Brown (Sport Wales), and Louise Sutton (Leeds Beckett) at the launch of the behavioural science course in October last year.

Additionally, we have embedded the findings from our research into the undergraduate and postgraduate curriculum at the Carnegie School of Sport at Leeds Beckett University. As part of this work, we supervise doctoral students in the implementation of behavioural science within high-performance and professional sports. Therefore, we are excited to be exchanging our knowledge with the next generation of practitioners to help develop their capability, knowledge, skills, and competencies.

Dr Meghan Bentley, Professor Sue Backhouse, Kathryn Brown, Louise Sutton and Dr Laurie Patterson

RESOURCES

New guide to open up conversations between parents and kids about weight

A new resource offers guidance for parents and caregivers on what they can say, do, and what may be best to avoid when talking about weight.

Authored by researchers at the University of Bath with the BDA's Obesity and Paediatric Specialist Groups, the new resources is designed to help overcome some of these challenging questions faced by many parents and caregivers.

Reducing childhood obesity in the UK is a growing challenge. NHS Digital data from 2021 found that there was a substantial rise in the number of children living with obesity in England during the pandemic. Currently, in the last year of primary school (Year 6) over a quarter of all children are living with obesity, and rates are highest in the poorest areas.

In 1990, just 5% of children in year 6 would have been classified as living with obesity, which highlights a marked increase in the past 30 years.

Helping more children to achieve a healthy weight can reduce their risk of developing diseases, such as diabetes or hypertension, in later life. Physical activity and healthy eating can also help to improve children's self-esteem and wellbeing, so are important to encourage in their own right, as well as for maintaining a healthy weight.

Acknowledging that some parents may be concerned about how to avoid making children feel bad about themselves when talking about weight, the researchers behind the guidance 'Talking to your child about weight', offer practical suggestions that can help frame these conversations more positively.

It covers themes such as understanding what influences children's thoughts around weight, reducing blame, and talking more positively about food and physical activity in the home and family setting. The guidance was developed by combining extensive research with expert input, including the views of children and parents.

Lead researcher Professor Fiona Gillison of the Department for Health at the University of Bath, explained: "Creating the guidance has been the result of many years of work to try and reduce some of the anxiety, and help families to have open and constructive conversations about weight – if and when they need to. It is great to see it finally published, and we hope it will be helpful to many parents and caregivers who want to support their children around this topic."

Dr Laura Stewart, a member of the BDA's Obesity Specialist Group, said: "Registered dietitians understand the importance of supporting parents in discussing the topic of weight with their children. The BDA's Obesity and Paediatric Specialist Groups were pleased to work with the University of Bath on getting this new resource available for parents. We are glad that it will be widely available to help with open and constructive family conversations."

News Impact

BDA Media Spokespeople making the news and ensuring the expert dietetic voice is heard

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Check out
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Media hotline
0121 200 8018
pr@bda.uk.com

Please note:
The following are extracts from various media publications where journalists have asked BDA media spokespeople to comment on the latest nutrition headlines and fads. Many journalists come to the BDA seeking the expert advice of our media spokespeople, because they recognise dietitians as the experts in nutrition advice.

BBC GOOD FOOD

Emer Delaney wrote an article for BBC Good Food Online talking about stress affecting weight.

TELEGRAPH

Priya Tew was quoted in a story about how healthy fats can help you lose weight.

INEWS

Helen Bond was featured in an article about the 11 super-easy ways to make every meal just a little bit healthier.

TELEGRAPH

Nichola Ludlam-Raine explained why eating slowly helps.

MIRROR

Kirsten Jackson spoke about IBS.

MAIL ONLINE

Linia Patel commented on the celebrity fasting trend that Rishi Sunak is supposed to be following.

TELEGRAPH

Priya Tew was quoted in an article on how steaks, eggs and nuts could help prevent midlife spread.

EXPRESS

Sian Porter was featured on Express.co.uk talking about how a handful of walnuts could bust your cholesterol levels in 'weeks'.

HUFFPOST

Hannah Whittaker was featured on HuffPost (UK) talking about cow's milk allergy.

MAIL ONLINE

Priya Tew was featured on MailOnline covering the everyday foods that are packed with 'ultra processed' ingredients.

THE TIMES

Helen Bond was featured discussing liquid diets: can soups and shakes really make you lose weight?

MAILONLINE

Nichola Ludlam-Raine was quoted on MailOnline discussing bloating.

BBC GOOD FOOD

Frankie Phillips wrote an article entitled 'What can't I eat when pregnant?'

EXPRESS

Lynne Garton was quoted in a story about food swaps to help lower cholesterol and promote heart health.

WOMEN'S HEALTH

Laura Tilt spoke about hangover cures.

BBC RADIO WALES

Aisling Pigott was interviewed by BBC Radio Wales about the benefits of frozen food in the cost of living crisis.

THE SUN

Kirsten Jackson was featured in an article about a controversial new menu item in Starbucks.

FOOD UNWRAPPED

Clare Thornton-Wood was featured on the Channel 4 programme Food Unwrapped.

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BDA Volunteer Corner

Vicky Dagnan explains what she has got out of volunteering with the Learning Disabilities Sub Group

Volunteer Name: **Vicky Dagnan**
Place of work: **Dudley Integrated Care NHS Trust**
Position: **Primary Care Dietitian**
BDA volunteer role: **Resources Officer – Learning Disabilities Sub Group**

Q How did you get started volunteering with the BDA?
A I joined as a member of the Mental Health Specialist Group back in 2021 to gain access to what was then the Learning Disabilities Special Interest Group. I was keen to connect with other dietitians working in this area for support and advice. I attended a few of the online meetings and case study sessions and was energised by the passion within the group to raise awareness of dietitians working in this area. In 2022, through the drive and determination of Briony Caffrey (Chair) the Learning Disabilities Sub Group was founded and I knew I wanted to be part of it.

Briefly describe your BDA volunteer role
A As the Resources Officer, I will be working with the committee and its members to consider the use of current resources: how we plan, develop, and coordinate resources in this area to support group members and those working with disabilities in practice. As part of a newly formed committee, I will also be raising awareness of membership, supporting other committee members, and continuing the work of highlighting the role of dietitians working in learning disabilities, championing nutrition and dietetics within primary care, and to the wider AHP primary care community.

Q What's the best thing about volunteering for the BDA?
A I have met some fantastic colleagues through the Learning Disabilities Sub Group who share a passion for advocating evidence-based practice, service improvement and increased accessibility to dietitians for people with a learning disability. I get to be part of a committee that will be improving access to events, resources, training and awareness for all dietitians, not just those working in learning disabilities, and that feels like progress! I also got to visit the BDA head office, which was a real treat, nestled into the bustling Birmingham city centre!

Q What didn't you know about the BDA before you started volunteering?
A Apart from the impressive offices...I was not aware the variety of volunteer opportunities on offer to get involved with the BDA for many specialist groups and sub groups within them. I was also not aware of the bounty of resources available through the website, including the BDA App Library of health and care apps that can be searched, downloaded and recommended to patients and carers, and a whole host of practice and education resources that support digital and remote working.

Q Would you encourage other members to volunteer for the BDA?
A I would recommend that dietitians, newly qualified or more experienced, get involved and volunteer for the BDA. I have a brand-new awareness and affiliation with the trade union, into which I have been paying membership since 2014. It has become much more than just a resource to download Food Fact Sheets! So, reach out to a specialist group or sub group that you want to work with and look at volunteering opportunities on the BDA website or in *Dietetics Today*. You don't have to have specific skills or knowledge – there is lots of support available.

WANT TO VOLUNTEER?

Why not check out our volunteer opportunities online: **bda.uk.com/news-campaigns/get-involved/volunteers.html** and look out for vacancies in our Members' Monthly e-zine.

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Nutrison Protein Shot is a Food for Special Medical Purposes for the dietary management of disease related malnutrition for tube fed patients with increased protein requirements and must be used under medical supervision.

References:
1. Hurt RT, *et al. Nutr Clin Pract.* 2017;**32**(1_suppl):142s–151s.
2. De Waele E, *et al. Clin Nutr.* 2021;**40**(5):2958–2973.
3. Oikawa SY, *et al. Am J Clin Nutr.* 2020;**111**(3):708–718.
4. de Aguilar-Nascimento JE, *et al. Nutrition.* 2011;**27**(4):440–444.
5. Compared to other modular protein top-ups on the UK market, MIMS May 2023.

Accurate at time of publication: May 2023.

This information is intended for healthcare professionals only.

NUTRICIA
Nutrison Protein Shot

Meet your directors

The BDA Board of Directors (BoD) is made up of BDA members and non-members who are appointed to provide strategic leadership of the BDA

Name: **Abdul Elghedafi**
Position: **Lay member**
Member: **No**

Q How do you view your role on the BDA Board of Directors?

A As a solicitor by profession, based in Aberdeen and specialising in public sector procurement and data protection law, I am a lay member of the Board. I see it is a substantial privilege and a pleasure to offer a lay perspective to the current and future direction of the dietetic profession, and it is very encouraging to see this lay perspective valued by both BDA staff and membership alike.

I see my role as one of governance; being a critical friend to the executive; a guardian to ensure that the BDA as a company acts in a way that faithfully represents the interests of the members and operates fully within the confines and protections of the law. As a proud Scot, a key role within my Director portfolio is to act as link to the BDA Scotland Country Board, and to represent and reflect the concerns and interests of members in Scotland as a constituent nation of the BDA.

The BDA is the third board of directors I've served on, having previously been appointed by Scottish Ministers to sit on the NHS Western Isles board, and on the North East of Scotland College's Regional Board. I feel that these appointments have further equipped me to contribute to both health service and academic considerations of the BDA board.

Q What inspired you take a position on the BDA Board of Directors?

A At the time I became aware that the BDA were seeking lay members to join ITS Board of Directors, I had served about nine months on the board of NHS Western Isles, which prompted me to reflect on the importance of good health, its impact on life expectancy, and indeed on the life chances of the individual healthcare service users. It occurs to me that, for the most part, people don't think about how important the role a healthy diet plays in leading a full and meaningful life, and indeed how dietitians have so much to offer to achieving such a goal. An analogy from the world of IT, specific to the activity of coding, comes to mind: "garbage in, garbage out!"

Reflecting on my time served as an NHS Non-Executive Director, discussions around core decisions and strategic direction always seemed to focus on the concerns and interests of nurses and doctors rather than, amongst others, dietitians. It seems to me that less time and consideration is devoted to the myriad other professions active within public healthcare services and, indeed, in upholding the health of the nation. Joining the BDA Board has galvanised my thinking on this; I feel privileged to be able to witness first-hand the value of the dietetic profession's contribution to society. It's so encouraging to see the excellent work being done, and I'm excited to offer my skills, knowledge and experience to bring the achievements of the BDA and its members more into the general domain.

Since joining BDA Board of Directors, what has particularly impressed you about the BDA and its overall offer to members?

I am particularly impressed by the trade union activities of the BDA, not only to support its members in being fairly considered across the breadth of employment possibilities and settings open to dietitians, but also to protect and support them in their hour of need. This aspect of the BDA's work, and the ways in which it is undertaken, correlates very closely with my own professional views and values, and I really enjoy and celebrate that confluence in carrying out my duties as a BDA Board member.

Q What would you like to come from your term of office?

A I would like to see BDA Board continuing to foster meaningful engagement with grassroot BDA members. I believe that a Board of Directors must be consistently visible and accountable to its members, and I'd like to see an increasing sense of ownership throughout the organisation, within reach of every individual member. I'm pleased to say that, already in this first term of office, I can see governance processes strengthening within the BDA. I'm hopeful that this strengthening will afford the BDA and its membership more opportunities to engage with the 'big players' – including nationwide policy makers and the giants of the food industry – to influence, and thus to positively shape, the day-to-day food supply, dietary choices and the overall health of the whole nation across the UK.

I support the view that the BDA should be at the forefront, indeed the go-to source, for advice and information on health and food, at all points in the food chain. To achieve this, I'd like to see BDA strengthening relationships within the food and retail sector, increasing visibility of dietitians at all possible points across food retail, consumer choice, health information and food- and health-focused media platforms.

Q What message do you have for BDA members, on behalf of Board of Directors?

A Being on the BDA Board affords me a privileged overview of just how much is achieved by members, often in their own time, and how well that work is supported by both the staff team and the senior leadership and governance structures within BDA. I come away very well informed from each Board meeting, and I'd love that well-informed feeling to be the default experience for all BDA members. I'm energised by being part of this process, and I'd encourage all members to draw similar energy from the BDA for themselves in their day-to-day practice. I'd suggest one simple way to achieve this is to access the minutes of our BDA Board of Directors meetings, which are readily available on the BDA website. Moreover, I'm hopeful that learning a little more about what the Board do on behalf of the membership, might encourage more of our members to get involved!

Q Since becoming a BDA director, what do you know now, that you didn't know before (as a lay person) about the dietetic profession?

A I attended my first BDA Awards ceremony last summer, and it really brought home to me the diversity of specialism within dietetics, and the level of detail invested in dietetics for specific health conditions. I was struck not only by the importance of dietary intervention within the delivery of highly specialised healthcare, but also by just how much the input of dietitians can enhance the work of fellow health professionals. I was also surprised to see how much dietitians are at the forefront of research and innovation within healthcare, and the difference dietitians can make to improve individual lives.

I'm constantly impressed by the reach of the BDA across a breadth of sectors beyond healthcare provision – for me, that was totally unexpected – the incredible behind the scenes work done on issues of national importance such as in impact of Brexit on pharmaceutical and food supply chains; the BDA's trade union activity, not just on the more obvious matters such as Agenda for Change and pay claims, but so much more. The BDA also works tirelessly to promote continuity and sustainability within the profession, developing meaningful progression pathways within professional practice and development, and diversity of routes to qualification and registration, encompassing support worker, assistant practitioner, apprenticeship and postgraduate programmes – all in all, working towards dietetics as a profession that's fit for the future.

Tell us something about yourself that might interest other people…

A Whilst five years of academic studies threatened to rob me of my love of reading – a love I thought I'd never rekindle – it's back! I find that reading for pleasure relaxes me, yet I still like to be constantly learning, and this is definitely reflected in my book choices. I'm currently reading "In the Thick of It: The Private Diaries of a Minister" by Sir Alan Duncan; so far, it's delivering a refreshing dose of honesty about our political landscape. I'm reminded that there are times when having the courage to engage in some straight talking is essential to good governance and finding the best way forward. Sir Alan's reflections also reinforce my belief that reaching a well-considered decision, even if it may seem like the wrong one to some people around the table, is key to making progress – lack of a decision can only result in unhelpful inertia. Moreover, having heard and considered all viewpoints, if we still truly believe that we are making a sound decision, we must persevere; the unpopular decision, often dubiously received by the majority, may quite well turn out to be the right one to bring about the greater good.

I also very much enjoy the theatre, and I try to catch a show whenever I'm in London – and if I can squeeze in a visit to an art gallery or a museum, while I'm in a big city, all the better!

How can we AHPs help carers?

The UK's care system relies on the unpaid work of thousands of carers. **Hazel Jurd** considers how those of us working in public health can support them

When we visit a patient in the community, or they visit us in a clinic or hospital setting, how often are they with someone who looks after them?

Their carer may be helping for a few hours a week, or they may be with them up to 24 hours a day, every day. Carers are not always with the person they are caring for; they may be attending their appointment with you for their own health. Either way, there is always an opportunity for us as AHPs to ask the right questions and check in with carers, choosing our moment and asking discretely if they need any support.

Carers do not only look after older people. Adults and children with physical disabilities, learning difficulties and mental health needs may often need extra help. These carers may be teenagers, working age adults, or older adults.

Caring for another person is associated with poverty, due to a lack of flexible employment opportunities for the carer. It is also associated with poor mental health exacerbated by social isolation and loneliness, and a lack of time to complete meaningful activity. Physical health can also decline when caring for another person, as time available for exercise or physical activity is minimal. In February 2022, The Carers Trust reported that 51% of 1,550 surveyed unpaid carers had to 'give up hobbies or personal interests due to their caring role' (Carers Trust 2022).

During the pandemic, unpaid carers saved the health and social care system £530m a day (Employers for Carers, 2020). This has continued, as a recent report by Carers UK found that carers save the social and health care system in England and Wales '£162 billion a year, 29% more in real terms than 2011' and those contributions are roughly 'equivalent to the budget for NHS health service spending' (Carers UK 2023). Unpaid carers provide care which would otherwise be provided by community carers or in residential settings through the social care system.

It is important to help carers and get them the support they are entitled to. Being a carer can be a very lonely journey, and if just one person asks how they are, this can have a huge impact on their wellbeing. So how can we – as AHPs – help carers?

- Make every contact count – ask the right question. Don't ask, 'Are you a carer?' Instead ask, 'Do you look after a someone who needs help because of their illness, frailty, disability, a mental health problem or an addiction and cannot cope without your support?'
- Not all carers identify as carers – they may need help to see this is what they are doing
- Know where to signpost and find resources for your local area – see postcode finder below
- Don't be afraid to admit you don't know the answer – but find out
- Remember not all carers are looking after elderly relatives
- Be aware of the different groups of carers: young carers, parent carers of children with a physical or mental illness or disability, older people caring for relatives
- Understand carers' assessment rights
- If you see carers in a primary care setting and coding indicates they are a carer, always ask how they are doing within this role
- If you work in acute care, be aware that people can become carers very suddenly
- See carers as individual people with their own lives
- But also involve carers in the patent's care and decision making
- Value lived experience in employees and managers
- Managers – identify who your carers are and who may approach you for carers leave
- Employers – use Carers' Passports to open the conversation with staff about their caring responsibilities
- Provide flexible working opportunities
- Provide training to employees

Useful resources

Carers UK: **carersuk.org**
Carers Trust: **carers.org**
Local service finder for your area: **carers.org/help-and-info/carer-services-near-you**
NHS Guide for Young Carers: **nhs.uk/conditions/social-care-and-support-guide/support-and-benefits-for-carers/help-for-young-carers/**
Carers Assessments: **carersuk.org/help-and-advice/practical-support/carers-assessment/**
Carers at work: **carersfirst.org.uk/help-and-advice/topics/working-when-you-are-caring/**

Hazel Jurd is an occupational therapy student at the University of Lincoln

REFERENCES

Carers Trust (2022) Pushed to the edge. Available from carers.org/our-social-care-campaign/carers-trust-social-care-survey-findings-2022 [Accessed 22/5/23]

Carers UK (2023) Valuing Carers research report. Available from carersuk.org/reports/valuing-carers-research-report/ [Accessed 22/5/23]

Employers for Carers (2022) Unpaid carers save UK state £530 million every day of the pandemic. Available from employersforcarers.org/news/unpaid-carers-save-uk-state-530-million-every-day-of-the-pandemic/ [Accessed 23/5/23]

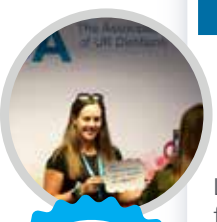
Dietitians Week

5-9 June 2023
#WeAreDietetics

Welcome your DW2023 activity planner!

Here are the BDA's daily themes to help you with your planning. Don't forget to tag us in your social media posts and use this year's hashtags, **#DW2023** & **#WeAreDietetics**

MONDAY



05/06 - 8pm - join @RDUKChat The faces of dietetics

« #WeAre » Dietetics

Let's flood our social media feeds with all of your selfies, demonstrating the breadth and diversity in our profession. Download the DW sign and take a photo to show what someone working in dietetics looks like.

TUESDAY

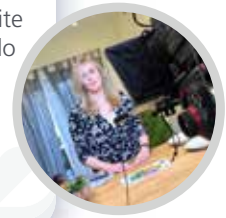
Day in the life...

Share a day in your life by filming yourself and all the things your role entails. Tag us in so we can share! A great way to show off your specialism and role and demonstrate how far-reaching the profession is!

WEDNESDAY

My positive FOOD HACKS

Time to talk about our favourite subject – food! What swaps do you enjoy making? What are your favourite things to eat? What advice do you give to make things easier for service users in your area?



THURSDAY

ORDER BDA MERCH from our new shop and wear it with pride!

bda.uk.com/shop

Why are you PROUD to work in dietetics?

Pat yourself on the back and tell us why you are proud to work in dietetics! What key wins have you had this year? Do you have a patient case study (if you have all the appropriate permissions) that you could share as well?

FRIDAY

WINNING!

We'll be sharing the winners of our baking competition and summing up the week. Show some love for our baking competition winner (as voted for by you). Keep on shouting about dietetics and your vital roles!

Disclaimer: by sharing your photos you consent to them being used in future BDA communications

- Visit bda.uk.com/dietitiansweek for digital resources to add to your workplace display!
- Tag us in a photo of your display on social media – so we can see and share!*

- Share our public facing postcards with service users to highlight why they might seek the support of a dietitian and show what resources are available to help them.
- Run a Lunch & Learn session with colleagues to talk about the role of dietetics and what you do. Are there any demos you can do to showcase your specialism to other AHPs?

Share our FREE, evidence based Food Fact Sheets with colleagues and patients! bda.uk.com/foodfacts

Find digital resources & follow us!

bda.uk.com/dietitiansweek

- @BDA_Dietitians
- @BDA_Dietitians
- BritishDieteticAssociation
- British Dietetic Association (BDA)

Dietetic
Workforce Development
Programme

Fit for the future

Aimee Davis gives an update on the progress the BDA has achieved on a range of projects implemented as a result of funding from Health Education England

ABOVE
The Future Dietitian Scoping Report (for internal use)

ABOVE
Watch the BDA Health Education England Advanced Practice Conference - Webinar for managers: https://youtu.be/2dZ11vqW8ZM

ABOVE
Watch Advanced Practice video case studies: https://youtu.be/Hoq7yYU_ckQ

Last year we secured significant funding from Health Education England to drive forward our education and professional workforce agenda. This funding was used for our Dietetic Workforce Development Programme which saw us undertake 19 projects with the aim to improve the following areas:

Future Supply

By simulating demand for dietetics to be seen as an exciting and rewarding career option and to develop the capacity of the future supply by developing new courses and innovative Practice-based Learning (placement) opportunities.

Bridging the gap between education and employment

Working to support different entry routes into AHP roles and explore potential alternative routes such as apprenticeship and preceptorship.

Enabling the workforce to deliver and grow

Ensuring that AHPs are effectively deployed in a way that recognises the needs of the system, population and supporting staff. Guaranteeing support for the dietetic workforce throughout their career, advanced practice and new roles including medicine management, digital technology and leadership. Along with this we want to ensure the retention of the dietetic workforce making the NHS the best place to work.

What we achieved

Working to modernise and reform the education and training of dietitians in line with the NHS Long Term Plan. We reviewed out Future Dietitian report to ensure that the profession remains relevant in a rapidly changing world and that dietitians and the wider workforce remain fit for the future. To achieve this, we surveyed the workforce and produced a report with further recommendations to improve our practice and education workstreams.

We also worked to develop resources at Advanced Practice level in order to support career progression at this level. From this project, a number of resources were produced, including: sample job plans and business cases, Advanced Practice video and text case studies, updated webpages and more.

Alongside this we worked to create a Primary Care network and common data set to inform workforce planning. As part of this project, we surveyed the workforce about the First Contact Practitioner services, developed a communications plan, updated our Guide for General Practice, as well as updating our webpages and producing new case studies.

In order to build a uni-professional and multi professional narrative about the impact of the 21st century dietitian we undertook a scoping exercise on the potential use of digital innovation within dietetic practice using the steps of the Model and Process. From this we held a small survey to

ABOVE
Visit the PBL shared resources webpage:
https://www.bda.uk.com/practice-and-education/education.html

understand the current needs and knowledge of the dietetic workforce and hosted a webinar with over 300 attendees. From this work we produced a training package for pilot sites and a final report on our findings. Going forwards, we will investigate the potential for a standardised language guidance document and pilot an electronic template and digital strategy.

As part of our aim to support the future supply of the dietetic workforce, we conducted a review of opportunities for Practice-based Learning (placement) to increase capacity, in which we produced a Pre-registration Dietetic Practice-based Learning Guidance document that identifies opportunities and innovative approaches to Practice-based Learning, providing information to share good practice and maximised the potential for increasing the number of Practice-based Learning opportunities.

Alongside this project we also developed a communication campaign that promotes innovative Practice-based Learning. For this project we produced new Practice-based Learning branding, an ongoing communications campaign, as well as multiple new Practice-based Learning resources for learners (students) and educators and new website content. This project will be ongoing as we update our web content and produce new relevant resources.

ABOVE
Visit the updated Primary Care webpage:
https://www.bda.uk.com/practice-and-education/nutrition-and-dietetic-practice/dietetic-workforce/primary-care.html

To ensure we are working with the BDA membership to develop resources that support innovative thinking and support clinical educators, we produced an internal report on the feasibility of a Dietetic Common Assessment Tool as there is currently a plethora of different assessment tools being used which is inefficient and impeded Practice-based Learning expansion. This report received positive internal feedback and as a result we will be prioritising the development of a Common Assessment Tool going forwards.

We've also worked hard to ensure that we driving improvements in equality, diversity and inclusion (EDI) within pre-registration education and careers. Whilst the BDA is undertaking a bigger piece of work on EDI our focus on pre-registration education and careers saw us produce articles, an new EDI webpage and hosted a workshop with over 26 HEI leads in attendance.

"[We want to] guarantee support for the dietetic workforce throughout their career, advanced practice and new roles including medicine management, digital technology and leadership.... [and] to ensure the retention of the dietetic workforce making the NHS the best place to work."

ABOVE
Download the 2023 Multifaith Calendar:
bit.ly/bda-multifaith-calendar

ABOVE
Download the Pre-registration Dietetic PBL Guidance:
bit.ly/pre-registration-dietetic-pbl-guidance

ABOVE
Watch A Guide to Creating PASS Statements webinar:
https://youtu.be/PO89WfDLCts

ABOVE
Download our Inclusive curricula presentation:
bit.ly/bda-inclusive-curricula-presentation

ABOVE
Download our Inclusive curricula presentation:
bit.ly/setting-up-non-clinical-pbl

ABOVE
Download the Return to Practice case study: bit.ly/rtp-case-study

ABOVE
Download the International PBL Provision: bit.ly/guidance-of-international-practice

ABOVE
Download the PBL Mental Health case study: bit.ly/pbl-mental-health-case-study

ABOVE
Watch the careers video case study: https://youtu.be/pq0mKHBy4zc

ABOVE
Visit the Support Worker webpage: https://www.bda.uk.com/practice-and-education/education.html

The BDA is supporting graduates and ensuring they have access to NHS Band 5 job offers, to help support this we developed a promotional campaign in which we highlighted the dietetic roles across health and social care in the NHS across the UK. We developed new resources including written and video case studies to sit on a new webpage that hosts examples of the different dietetic roles available in the NHS to new graduates, making sure that working in the NHS is attractive and seen as a rewarding career.

To go alongside supporting early dietetic careers, we undertook a project in which we aided the development of guidance and resources to enhance early careers and support the dietetic profession. In order to achieve this, we reviewed our already existing preceptorship guidance and surveyed the BDA membership in order to understand how well these tools are being embedded into practice and reviewed its implementation. Our findings have allowed us to identify where we need to improve and provided further work initiatives.

We've also developed a number of exemplar early dietetic careers and best practice case studies as part of a suite of resources for the dietetic workforce and have ensure that we highlight the diversity of our workforce. Our case studies highlight the value of preceptorship and preceptors and what the programme brings to newly qualified dietitians.

Along with ensuring we are supporting those newly qualified within the workforce, we have worked to ensure that we are also supporting those who wish to return to practice. In order to support those interested in or in the process of returning to practice, we have updated our webpage, developed case studies and hosted webinars for those wanting to return as well as providing relevant information for managers who may be employing returnees.

As well as supporting the above areas of the dietetic workforce we also wanted to ensure that we were supporting internationally trained staff. As part of this project, we developed a new webpage for international recruits full of information about working in the UK. This new webpage also provides management with the information they need in order to support those working in the UK from overseas.

The BDA is committed to supporting the entire dietetic workforce, including our dietetic support workforce. In order to achieve this, we undertook an extensive project aimed specifically for the dietetic support workforce. We developed a new visual identity for our support workforce, as well as an online hub full of resources and information specific to our Associate Members, as well as Dietetics Today articles. We've also reviewed current job titles, produced FAQs and are currently developing a Support Workforce Professional Development Framework.

As dietetic practice continues to grow and develop, more posts evolve in mental health. As part of our programme, we worked to increase the profile of the role of dietitians in mental health services to demonstrate innovation and the impact of new ways of working. To achieve this, the BDA Mental Health Specialist Group hosted a week of webinars for Mental Health Awareness Week 2023, as well as case studies. Going forwards there will be a development of a preceptorship programme for those working in mental health.

BDA GET
General & Education Trust

Free places on leadership programme

The BDA General and Education Trust (GET) Fund is offering funding for two dietitians to develop their skills on the popular AHP Professional Leadership Programme.

The programme is for AHPs who are looking to advance their career potential and to improve service outcomes. Running since 2017, former participants surveyed noted skill development, increased knowledge and confidence, networking opportunities and improved career prospects.

The two funded places will be a great opportunity to create new future leaders within the dietetic profession, which is something that we are strongly committed to.

This is an excellent chance for BDA members who have had some management or team leader responsibilities and wish to develop their leadership skills to move towards a more senior position within the NHS, or similar organisation.

If you are interested in applying visit: bda.uk.com/leadershipprogramme

Deadline: Monday 26 June 2023.

BDA The Association of UK Dietitians

DIETITIANS JOBS

dietitiansjobs.co.uk

FIND A JOB YOU LOVE

Addressing sarcopenia

Linia Patel looks at the role of nutrition in the prevention of sarcopenia

Sarcopenia is a Greek term meaning 'poverty of the flesh'. It is the progressive loss of muscle mass that often leads to diminished strength and decreased activity levels, which can then contribute to mobility issues, osteoporosis, falls and fractures.

Sarcopenia is intricately linked with frailty, loss of physical function and the ability to do daily activities, and ultimately a poorer quality of life and even death.[1]

Between the ages of 30 and 60, the average adult loses about 250g of muscle each year. At the age of 70, muscle loss accelerates to about 15% per decade.[2] Whilst it is normal to lose some muscle as you age, sarcopenia that includes a loss of muscle mass and overall weakness which profoundly affects physical activity levels is thought to have a prevalence of 4-25 % in older, free-living adults in the UK – a number that will continue to increase as the population ages.[3]

Factors responsible for sarcopenia[2,4,5,6,7]

AGEING Age-associated muscle mass	The main cause of sarcopenia is ageing as the motor neurones in the body gradually die and no longer communicate to the brain. This causes muscle fibres to then deteriorate (atrophy). This process can then be accelerated by factors like poor diet or inactivity.
HORMONE CHANGES	Testosterone appears to be the central hormone involved in the development of sarcopenia. Growth hormone deficiency leads to loss of muscle mass but not strength. Menopause in women is a period of immense hormonal transition that is linked to a loss in muscle mass and increase in fat mass. In men, there is a reduction in testosterone by 1% each year leading to reduced muscle mass.
DISEASES	Recent evidence suggests that chronic, low-grade inflammation also contributes to the loss of muscle mass, strength and functionality.
INACTIVITY	Sedentary behaviour can further accelerate age-related decline in muscle mass, leading to a decrease in metabolic rate.
MALNUTRITION	Malnutrition (from under or over nutrition) increases the risk of developing sarcopenia by three or four times.

The importance of screening[6,7]

In some settings (i.e. acute), body composition can be assessed using CT scans, DEXA scans or even skin fold analysis. However in community settings other screening tools like the SARC-F questionnaire

Linia Patel PhD, RD is a private Nutrition Consultant and a spokesperson for the BDA

can be used. Physical performance and assessments to determine one's ability to balance can also be used to identify sarcopenia. For malnutrition, early screening to identify individuals at nutritional risk for unintended weight loss and undernutrition or malnutrition is essential. Validated screening tools like the Malnutrition Universal Screening Tool (MUST) should be used.

Optimising nutritional intake

1. **Protein**[2,5,8] – Muscle mass is maintained by a balance between protein synthesis and protein breakdown, therefore eating sufficient protein is vital. There is an increased body of research indicating that protein requirements for older adults may be higher than the current UK recommendations. Bauer et al. have suggested that, to maintain and regain lean body mass, older adults (>65 years) require 1.0-1.2g protein/kg body weight, with higher amounts for active/exercising older adults (≥ 1.2 g/kg/day) and in acute or chronic disease (1.2-1.5g/kg body weight/day).
2. **Whole diet approach**[8,9,10] – A recent UK dietary survey indicated that older adults fail to meet the recommendations for intake of fruit, vegetables, fibre, and oily fish, with evidence of low intakes of vitamin A, vitamin D, riboflavin, and folate. Intakes of intakes of saturated fat, free sugars and salt were also reported to be excessive. The Mediterranean dietary approach has the potential to be an effective strategy to improve the quality of the diet and prevent sarcopenia.
3. **Vitamin D**[11,12] – This nutrient deficiency is the most prevalent nutritional deficiency for older adults regardless of race or ethnicity. Current UK recommendations encourage all adults to take a daily supplement of vitamin D (10 micrograms µg); 400 international units (IU)/day between October and early March. Frail and housebound adults and those who always cover their skin when outdoors and people with dark skin (African, African-Caribbean or South Asian family origin) should take a daily supplement (10 µg; 400 IU/day) throughout the year.
4. **Oral nutritional supplements**[13] – Current NICE guidance advises the consideration of oral nutritional support for those at risk of malnutrition. This includes dietary advice and the use of oral nutritional supplements where appropriate.

HOW OVERWEIGHT AND OBESITY CAN MASK SARCOPENIA AND MALNUTRITION[6]

The prevalence of obesity in combination with sarcopenia – or 'sarcopenic obesity' – is on the rise. When assessing the risk of malnutrition in those with overweight or obesity the following must be taken into consideration as an increased risk of sarcopenic obesity:

- 5% unplanned weight loss over the previous six months or >10% unplanned weight loss over more than six months
- Reduced food intake of ≤50% of energy requirement for seven days, or any reduction for more than two weeks, or presence of any chronic gastrointestinal condition which adversely impacts food assimilation or absorption and/or inflammation caused by acute disease/injury or chronic disease related

The importance of movement[4]

Movement in combination with diet is important to help preserve muscle mass or help it grow. Exercise is recommended on most days of the week, but a minimum of three times per week is suggested to slow muscle loss and prevent sarcopenia. Exercise programmes including strength and balance have been shown to decrease frailty and improve strength in older adults.

REFERENCES

1 Cruz-Jentoft A, et al. 2019. Sarcopenia: revised European consensus on definition and diagnosis. Age Ageing; 48(1): 16-31.

2 Cruz-Jentoft A, Sayer A. 2019. Sarcopenia. The Lancet. 393(10191): 2636-2646.

3 Kilgour A et al.2020. Prevalence of sarcopenia in a longitudinal UK cohort study using Ewgsop2 criteria varies widely depending on which measures of muscle strength and performance are used. Age Aging. (Supplements) i222.123

4 Kumar V et al.2009. Human muscle protein synthesis and breakdown during and after exercise. J Appl Physiol; 106(6): 2026-2039.

5 Bauer J, et al.2013. Evidence-based recommendations for optimal dietary protein intake in older people: a position paper from the PROT-AGE Study Group. J Am Med Dir Assoc; 14(8): 542-559.

6 Batsis J et al.2018. Sarcopenic obesity in older adults: aetiology, epidemiology and treatment strategies. Nat Rev Endocrinol. 2018; 14(9): 513-537

7 Cederholm T, et al. 2019.GLIM criteria for the diagnosis of malnutrition – A consensus report from the global clinical nutrition community. Journal Cachexia Sarcopenia Muscle;10(1), 207-217.

8 Scientific Advisory Committee on Nutrition (SACN) 2021. SACN statement on nutrition and older adults living in the community.

9 Granic A et al. 2019. Dietary patterns, skeletal muscle health, and sarcopenia in older adults. Nutrients: 11(4): 745.

10 Knight A et al. 2016. Is the Mediterranean diet a feasible approach to preserving cognitive function and reducing risk of dementia for older adults in Western countries? New insights and future directions. Ageing Res Rev. 25: 85-101.

11 Scientific Advisory Committee on Nutrition (SACN). Vitamin D and health. 2016.

12 Scientific Advisory Committee on Nutrition (SACN). Update of rapid review: Vitamin D and acute respiratory infections 2020.

13 Cawood A et al. 2012. Systematic review and meta-analysis of the effects of high protein oral nutritional supplements. Ageing Res Rev;11 (2):278-296

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- Vitamin D improves skeletal muscle function[4]
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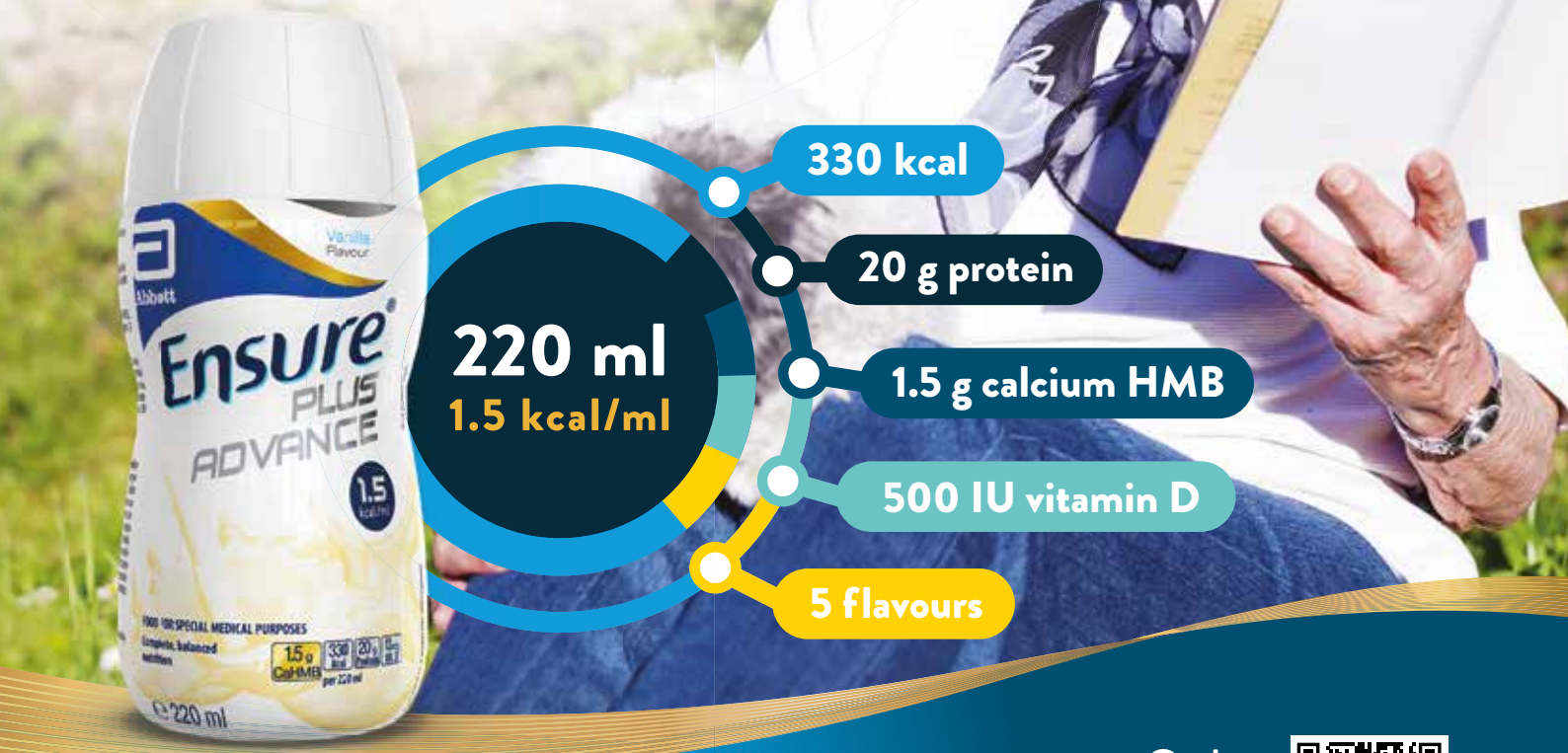

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HMB, ß-hydroxy-ß-methylbutyrate. ONS, Oral nutritional supplement. *As shown in a randomised control trial to investigate the effects of a specialised ONS on older women (≥65 years) who underwent surgery for hip fracture vs. standard post-operative nutrition. Post-operative nutrition provided 1900 kcal and 76 g protein a day. Muscle function was measured by handgrip strength. Mobilisation status was assessed on post-operative days 15 and 30. ‡In 92 patients aged 65 and over with hip fractures admitted to a rehabilitation facility, either receiving a standard diet plus 2 bottles of the study product or a standard diet only. Standard diet provided 1500 kcal, 87.4 g protein a day. §Ensure Plus Advance is an oral nutritional supplement for frail elderly people (>65 years of age, with a BMI ≤ 23kg/m²), where clinical assessment and nutritional screening show the individual to be at risk of undernutrition. †Research with 80 healthy women over 65 years of age supplemented with one serving of Ensure Plus Advance daily for 8 weeks. **References:** 1. Ekinci O *et al. Nutr Clin Pract* 2016;31(6):829-835. 2. Malafarina V *et al. Maturitas* 2017;101:42-50. 3. Deutz NE *et al. Clin Nutr* 2014;33(6):929-936. 4. European Food Safety Authority. *EFSA J* 2011;9(9):2382. 5. Berton L *et al. PloS one* 2015;10(11):e0141757.

Intended for Healthcare Professionals only.
UK-ENSPA-2300027 April 2023

Member Survey 2022/23

Your feedback and suggestions and how we're taking them forward...

Thank you to over 1,400 members who completed our Member Survey. Your feedback and suggestions help us to understand what you value the most about your membership, and what you'd like us to do in the future to support you.

Your resources

Top valued resources

1. Food Fact Sheets
2. Website
3. PENG Pocket Guide

(web tools and resources including policy and position statements, campaigning tools)

Top valued support services

1. Professional Indemnity Insurance
2. Representation at HCPC hearings
3. Trade Union & BDA office support

I value the range of available resources, the support and reassurance of the union and legal team and networking with other dietitians with the same clinical interests.

You asked us for...

- Discounted membership rates for dietitians returning to practice
- Improved food fact sheet designs to make more user friendly
- Equality, Diversity and Inclusion (EDI) resources and services to expand and diversify the BDA membership
- Additional resources around safe staffing levels
- More promotional material for the profession
- Increased public awareness of the dietetic profession
- No more plastic membership cards

How we're delivering...

- Launched a new Return to Practice membership category
- Undertaking a review and redesign of our printable food fact sheets
- Making Equality, Diversity and Inclusion (EDI) a priority across the BDA as a key focus for senior management and the BDA Board of Directors
- Producing new safe staffing guidance to complement our professional practice resources
- Providing you with a new BDA online shop where you can access member-only resources and merchandise to support you to raise the profile of dietetics
- Continuing to ensure our campaigns like New Year, New You, Dietitians Week and other political and public affairs campaigns generate widespread public and media interest and engagement
- Stopped producing membership cards and improved your 'MYBDA' online profile for easy access to your membership number, benefits and services

Key issues facing the profession

1. Workload
2. Workforce shortages
3. Below inflation NHS pay
4. Pay & working conditions

Trade Union support

Trade Union Support was a key theme this year and this is how we plan to ensure you receive the right support:

Thank you to managers who recommend their teams join us, & university tutors who encourage dietetic students to join & get involved at the start of their journeys.

- Ongoing negotiating for fair pay and better working conditions/industrial strike action
- Case work and representation on an individual basis
- Collaborations with TUC across campaigning activities
- Trade Union Rep training and support
- Promotion of the role and importance of belonging to the BDA Union

What you said about your membership...

83% said membership gives them excellent or average value for money.

88% 'satisfied' or 'very satisfied' with the resources and services we provide.

BDA membership feels like an essential element of being a member of the profession - for the networking, specialist groups, branches, CPD opportunities, resources and indemnity insurance.

Developing the profession

We are delighted that our Specialist Group networks are valued so highly by members, ranked top when it comes to best CPD offering, and a real must-have for so many of you as part of BDA membership.

More and more members are signing up to benefit from expertise, resources, events and more as part of the Specialist Group communities.

Top valued CPD

1. Access to BDA specialist groups & sub-groups
2. BDA Classroom & Learning Zone
3. CPD and networking opportunities via your BDA Branch

20% growth in specialist group memberships.

54% of members are a member of a specialist group.

THANK YOU! Thank you to our dedicated volunteers who make up the vital specialist group committees driving these networks forward.

Campaigning and influencing activities

Top valued external activities

1. Running campaigns
2. Representing the profession
3. Supporting leaders

1. (often with partners) to promote the profession or specific policy objectives.
2. Representing the dietetic profession and the science of nutrition in the press and on social media, and through consumer/ public events.
3. Supporting the profession to become leaders in nutrition & dietetic evidence-based practice at national & international level.

You asked us to be a vocal & visible voice for dietetics. What we're doing...

- Promoting the impact and value of the dietetic profession via our well visited, high performing website, and popular social media channels
- Prioritising political engagement and influence at the highest level across all four nations
- Running campaigns such as Dietitians Week, Sustainable September and our New Year, New You campaign
- Proactive press and media work to ensure the BDA and the dietetic profession is a trusted and recognised source of evidence-based information by the media
- Ensuring our Trade Union continues to work hard to negotiate fair pay, better recognition and better working conditions for the profession.
- Developing impactful external alliances and partnerships to drive the dietetic agenda forwards

How are we tackling your concerns?

- BDA/Health Education England project completion work and a variety of new resources launching to members this summer
- New dietetic apprenticeships developed, and a new membership category for apprentice members
- Prioritising work around growth of the dietetic workforce
- Safe staffing support and new resources for members

The legal and union support are good reasons alone. The education opportunities also add to the "must have" elements of membership. ALL dietitians should be members in my view.

RNG: the next 25 years

In the second part of her history of the BDA's Renal Nutrition Group, **Dr Barbara Engel** looks at the milestones in dietetic treatment over the last 25 years, starting with malnutrition

A fully referenced version of this article is available on the BDA website

The prevalence and risk of developing malnutrition is well documented in renal patients.

A meta-analysis of observational studies showed the prevalence was 11-54% in five studies of 1,776 people in stage 4-5 CKD and the 25th to 75th centile of 90 studies was 28-54% in 16,434 dialysis patients (the range was up to 98% in PD patients and 81% in HD patients). Likewise, in AKI, malnutrition prevalence of 60% and 82% was reported in two separate studies.

The causes of malnutrition are multifactorial and the term protein energy wasting (PEW) has been recommended to describe undernutrition in CKD. These many factors have been described in detail in Obi et al. (2015) in the Consensus on Protein Energy Wasting in CKD (Figure 2). In summary the causes include:

- Decreased/altered intake: due to dietary restrictions, loss of appetite, taste changes, poverty and depression
- Altered metabolism due to loss of kidney function itself, including changes in associated hormones (vit D and bone mineral disorders, EPO and anaemia), and other factors (gluconeogenesis, acidosis, inflammation)
- Comorbid conditions and drug nutrient interactions
- Dialysis factors, causing inflammation, nutrient losses, inadequate dialysis

Identification of malnutrition: screening and assessment tools

The use of the nutrition assessment tool SGA was validated in dialysis patients by Enia et al. (1993), after having previously been used to assess nutritional status in preoperative gastrointestinal surgery patients (Detsky et al. 1987). The seven-point SGA was developed for the CANUSA study. A one unit lower SGA score was associated with a 25% increase in the relative risk of death (Churchill et al. 1996) and a one unit increase in score was associated with reduction in length of stay for hospitalised patients (Kalantar Zadeh 1996). This tool was also found to positively correlate with BMI, percentage body fat and MAMC and had good repeatability in cross-sectional studies (Visser et al, 1999). Comparisons with the MUST score, which was developed in the wake of the NICE guidelines CG32 2006, showed that MUST had lower sensitivity and specificity when compared with SGA (Lawson et al 2012).

SGA, however, can take up to 20 minutes to complete and simpler screening tools incorporating BMI, albumin and unintentional weight loss (noting oedema) can identify patients in need of intervention to improve nutritional status (Engel et al., 1995). The UKKA guidelines (Wright et al. 2019) are possibly the most recent UK guidelines focusing on undernutrition in CKD, and this report highlights screening tools developed by UK dietitians for the renal patient. The Nutrition Impact Score (based on answers to PG-SGA) (MacLaughlin et al., 2018), showed correlation with length of stay and good sensitivity and specificity when compared with SGA and the Renal Inpatient Nutrition Screening Tool (iNUT) showed good agreement with SGA and was more sensitive than MUST (Jackson et al., 2018). A tool to generate referrals to dietitians for outpatient haemodialysis settings was developed by Bowra et al., (2019) and showed very good sensitivity and specificity comparing assessments carried out by healthcare assistants with a renal dietitian. The UKKA guidelines also recommend the use of SGA and bioimpedance for assessing patients.

Treatment of malnutrition

The renal dietitian's response to treating malnutrition includes the usual food first approach with the aim to encourage protein- and calorie-dense foods, little and often.

Whilst it is important to maintain an awareness of phosphorus, potassium and sodium content of foods, a pragmatic approach should be taken; when a patient has a poor appetite their intake of these potentially harmful nutrients will also be low.

There are also specific nutritional supplements which can be used (modular protein and calorie supplements), as well as complete nutritional supplements and enteral feeds, some with modified electrolytes. Two systematic reviews by Stratton et al. (2005) and Liu et al. (2018) supported the use of ONS in dialysis patients to improve serum albumin and BMI and a consensus statement was prepared by UK dietitians for use of ONS in stages 4-5 CKD (MacLaughlin et al., 2015). Enteral feeding in HD or PD patients has been successful (dry weight, MAC, albumin, increasing), although dietitians noted the importance of close monitoring of electrolytes, potassium and phosphate, which could decrease due to refeeding or to use of low electrolyte 'renal' feeds (Holley & Kirk, 2002, Patel et al., 1997). There have been other case studies of PEG feeding in adult dialysis patients in the UK (Paudet & Fan, 2014) although the technique has been more widely used in paediatric CKD patients.

In addition to use of NG or PEG feeding, there are some unique methods of delivering nutrients to dialysis patients including intradialytic nutrition

Dr Barbara Engel is Programme Director Dietetics at the University of Surrey

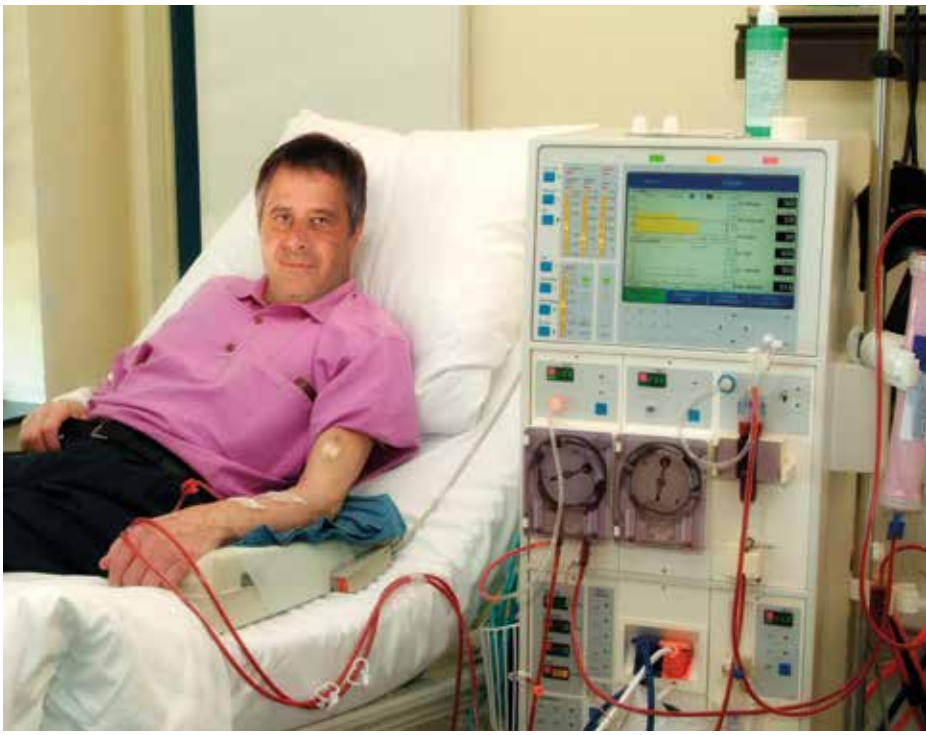
and intraperitoneal amino acids. One of the first reported studies of the use of intradialytic amino acids (provided at the end of a dialysis session) was in 1975 (Heidland & Kult, 1975). This resulted in improvements in albumin, total protein and transferrin and a reduction in phosphate levels. It is not clear when this technique was first used in UK renal units and it was not mentioned in the survey by Agusiobo-Ifenu and Judd in 1982 (although oral protein supplements Casilan and Maxipro were used at this time). By 1993, 45% of 56 renal units stated they had used IDPN (J Gordon: IDPN the national picture) and by 1997 69% of 67 renal units were using IDPN, usually in patients who had not responded to oral or enteral support.

Later RNG surveys in 2006 (A. Greenhough) and 2012 (B. Mafrici) had lower return rates of questionnaires (27 and 18 respectively) with 67% and 60% of renal units reporting use of IDPN, although this high rate may indicate reporting bias. The latest UK guidelines on undernutrition in CKD guideline section 3.4 (Wright et al. 2019) suggest that IDPN "may be considered for selected cases when oral or enteral intake is suboptimal". This mirrors the evidence brief prepared by

"The renal dietitian's response to treating malnutrition includes the usual food first approach, encouraging protein- and calorie-dense foods"

Anderson et al. (2018) and in the DOQI Guidelines for Nutrition (DOQI 2020), which stated that, whilst it is "reasonable to consider use of IDPN in the dialysis population", there was lack of evidence demonstrating superior effect of IDPN over enteral/oral interventions. It could be argued (author's opinion) that, like TPN, IDPN is most effective when other routes have failed (Engel, 1997) and for renal patients it offers a mode of feeding which does not require any additional stress for them or their family.

A dialysate fluid containing specific amino acids for use in peritoneal dialysis became available in the 1980s. Intraperitoneal amino acid (IPAA) solution contains 1.1% amino acids and provides a net gain of 18g amino acids from one 2L exchange (Lindholm et al 1993). By the mid-1990s UK renal units were publishing results from prospective studies (Misra et al., 1996) and case studies (Steele et al., 1998) showing some improvement in nutritional parameters including albumin and body composition changes. Later evidence showed increased food intake whilst there was no effect on patient survival (Li et al., 2003). The UK guidelines suggest (as with IDPN), that IPAA can be "considered for selected cases when oral or enteral intake is suboptimal". An additional use of IPAA is to optimise control of diabetes, as it replaces glucose in the dialysate and therefore reduces glucose absorption (Woodrow et al., 2017).



RNG TODAY

The current membership of the RNG stands at 420 dietitians, and we have an enthusiastic committee actively developing guidelines, information and resources for the renal community.

Some of our ongoing projects include:

1. Sustainable diets; responding to public desire for plant-based info in CKD
2. Working with other agencies to develop patient information, e.g. the Kidney Kitchen with Kidney Care UK – (kidneycareuk.org/about-kidney-health/living-kidney-disease/kidney-kitchen/kidney-kitchen-skills
3. Working with other BDA groups such as the BDA Sustainability Diets Specialist Group and international renal associations
4. In education, developing and updating courses, MSc modules, student resources, and resources for non-renal dietitians (eg AKI)
5. Enabling best practice by developing: competencies, reviewing our guidance and consensus statements eg UKKA

The third and final part of Barbara's history of the RNG, looking at developments in biochemistry and CKD bone and mineral disorder exercise therapy, will be published later in the year.

The use of blended diet with enteral feeding tubes

A Practice Toolkit is available to help dietitians who are new to blended diet

The BDA has a Practice Toolkit to provide supplementary, practical, best practice guidance for UK registered dietitians and other healthcare professionals working in the field of home enteral tube feeding (HETF), helping tube-fed individuals receive effective, equitable and quality care.

Blended diet is an umbrella term for a wide range of practices. Broadly speaking, blended diet can refer to any food or drink other than water, expressed breast milk, infant formula or commercial enteral formula being given via an enteral feeding tube.

In reality, it varies from giving a small amount of puree or juice to using blends to meet full nutritional requirements. The practice has been contentious, with some professionals expressing concerns over safety and adequacy; however, it is evident that dietitians in clinical practice have been successfully supporting patients to safely use blended diet, particularly in the speciality of home enteral tube feeding.

Considerable benefits have been noted in the literature such as reduction in reflux, retching and vomiting and improved bowel habit. Social and emotional benefits are also evident as families are able to make food choices and share the same everyday foods.

The Practice Toolkit begins with a basic background to blended diet and the reasons why it could be considered by UK registered dietitians as an option in clinical practice (Section 2). Section 3 outlines the process used to develop the recommendations for clinical practice.

It should be highlighted that, despite a marked increase in popularity, blended diet remains under-researched. Relevant literature was identified but, in the main, papers focused on either professional experience or a particular aspect of blended diet under laboratory conditions and so are limited.

For this reason, the suggested good practice provided in the Practice Toolkit draws also on the expert opinion of UK dietitians and other healthcare professionals working in the field of HETF who have experience supporting patients and families to use blended diet. The practical recommendations made in Section 4 are subdivided by topic with a view to a dietitian in clinical practice being able to quickly navigate to a particular area of interest.

Summary boxes have also been used at the end of each sub-section. Finally, in the appendices, resources have been included which can be adapted for local use and further useful sources of information have been identified.

An earlier Policy Statement had suggested dietitians should support patients who had chosen blended diet; the latest Policy Statement went a step further and suggested that blended diet may be offered as a choice to patients and carers as an option by the dietitian.

In the latest Practice Toolkit, a shared-decision approach, as recommended by NICE, rather than a risk assessment approach, is advocated.

It is envisaged that dietitians who are new to blended diet will be able to use this Practice Toolkit as a starting reference, but alongside should seek the support and supervision from an experienced colleague, as would be expected in any new specialist area.

It is hoped that this Practice Toolkit will help tube-fed individuals and their families to receive effective, equitable and quality care.

> "It is hoped that this Practice Toolkit will help tube-fed individuals and their families to receive effective, equitable and quality care"

Work on the Practice Toolkit began immediately after the publication of the BDA Policy Statement on blended diets in 2019. Both were put together following a review of an earlier Practice Toolkit and Policy Statement by a working group convened and funded by the Paediatric Specialist Group and the Parenteral and Enteral Group (PENG) of the BDA.

The group represented both specialist groups and DISC (Dietitians Interested in Special Children). Group members all had considerable clinical experience of blended diet (acute and community dietitians and specialist paediatric nurses) as well as research interests on the topic.

The authors would like to thank all the families, clinicians and academics who gave up their time and contributed by commenting on drafts and made suggestions to improve the text.

This document is an evolving work in progress, and the BDA welcomes feedback and encourages further discussion and research on the topic.

The Practice Toolkit can be downloaded from the members' area of the BDA website at **bit.ly/3BDJT3s**.

THE IMPORTANCE OF EARLY DIAGNOSIS IN INFLAMMATORY BOWEL DISEASE (IBD)

CROHN'S & COLITIS UK

INTRODUCTION

Inflammatory bowel disease (IBD) describes a group of gastrointestinal disorders, mainly Crohn's disease (CD) and Ulcerative colitis (UC), characterised by unpredictable and chronic inflammation with fluctuating periods of disease activity and remission.

During disease activity, patients often experience gastrointestinal symptoms. This significantly impedes quality of life due to the impact on daily activities, the ability to function in work and social situations, and on interpersonal relationships.

Currently in the United Kingdom, 0.81% (1 in 123) of the population are living with IBD,[1] the second highest IBD prevalence globally, after the United States.

Diagnosing IBD

Typical symptoms include:

- Gastrointestinal symptoms (GIS) including abdominal pain/ cramping, bloating, wind.
- Diarrhoea/constipation (including blood or mucus in stools), and urgency.
- Reduced appetite, malnutrition and weight loss.

Other symptoms include:

- Fatigue
- Low grade fever
- Joint pain
- Nausea and vomiting
- Mouth sores/ulcers, skin manifestations

The Crohn's & Colitis UK Symptom Checker (www.crohnsandcolitis.org.uk/symptom-checker) was specifically developed to support people with gut symptoms, to provide insight into whether symptoms may be reflective of IBD, and to encourage seeking support from their GP.

There is no single approach to diagnosing IBD. It is based on a combination of clinical, biochemical, stool, endoscopic, cross-sectional imaging, and histological investigations.[2,3]

If IBD is suspected in primary care, faecal calprotectin (FC) will be measured to assess intestinal inflammation. Given its relatively high level of specificity and sensitivity, NICE recommends measuring FC levels to distinguish IBD from irritable bowel syndrome (IBS). This can ensure appropriate referral and earlier diagnosis of IBD, while minimising unnecessary investigations in those with IBS. If FC results are <100mcg/g, then IBS is likely (100-250mcg/g is borderline, >250mcg/g is high risk of IBD). Ideally, these tests would be undertaken prior to dietetic support. However, if you see a patient referred for IBS management that you suspect could have IBD, ask if they've had a FC test. If not, it is important to challenge the diagnosis and flag to the referring GP.

DELAYS IN DIAGNOSIS

In the last few decades, there has been significant advancements in the tools available to establish a diagnosis of IBD.

Despite this, delays in diagnosis remains a fundamental challenge.[4] In fact, the time to diagnosis hasn't really improved in the last 25 years.[5] In addition, there remains the challenge of potential misdiagnosis.

A study involving 19,555 IBD cases found that 1 in 4 cases reported GIS more than six months before a diagnosis, 1 in 10 cases reported GIS five years before a diagnosis, and some patients reported GIS up to ten years before a diagnosis. Those with a previous diagnosis of IBS or depression were less likely to receive timely specialist review.[6]

Between 2019-2020, results from a UK-wide IBD Patient Survey (n=10,222 adults) found that 26% waited more than a year for a diagnosis, while 41% had visited Accident and Emergency (A&E) at least once before being diagnosed, with 12% visiting three or more times.[7]

Further studies have reflected similar findings with median diagnosis delays of 6 (2-23) months in CD and 3 (1-10) months in UC [8,9]

Reasons for delays in diagnosis

- Self-diagnosis (often IBS) and self-management (e.g. exclusion diets).
- Symptoms can be inconsistent, fluctuate over time and/or present gradually. When symptoms are less severe, it may be regarded as trivial and so appropriate tests are not performed.
- The overlap in symptoms with other common gastrointestinal disorders can result in a misdiagnosis, such as IBS.[10]
- Patients may present with non-specific symptoms such as tiredness/fatigue, weight loss, or joint pain.
- Several bottlenecks in the patient journey include lack of timely GP referrals, delays in endoscopy and specialist review.[11]

CONSEQUENCES OF DELAYS IN DIAGNOSIS

It is widely accepted that treating IBD at the earlier stages of disease and before large intestinal damage occurs is likely to lead to better clinical outcomes.[12] Pre-clinical damage is associated with immune dysregulation, gut microbiome alterations, tissue injury, which in many cases are irreversible.[12]

One recent systematic review and meta-analysis that pooled n=101 studies including 112,194 patients (59,359 with CD, 52,835 with UC) concluded that delayed diagnosis in CD was associated with an increased risk of stricturing, penetrating disease and intestinal surgery. In UC, delayed diagnosis was associated with an increased risk of colectomy.[13]

Additionally, a study of IBD patients with a delayed diagnosis found a delay as short as one week (between GP referral and specialist review) is significant in determining adverse outcomes (such as steroid and other rescue therapies, hospitalisations, surgery).[11,14]

Moreover, a systematic analysis found that adult CD patients have longer diagnostic delay compared with paediatric CD patients. Length of diagnostic delay was found to be predictive for CD-related complications in adult CD patients.[15]

Delays in IBD diagnosis highlights the need for education awareness in both primary and secondary care. The Crohn's & Colitis UK Early Diagnosis Campaign involves working with politicians and health leaders to support a national pathway across a range of health conditions for people presenting with lower gut symptoms, including Coeliac disease, IBS and IBD.

VISIT OUR CROHN'S & COLITIS UK CAMPAIGN
www.crohnsandcolitis.org.uk/our-work/campaigns/earlydiagnosis

SUPPORT FOR DIETITIANS

Newly diagnosed[16] – www.crohnsandcolitis.org.uk/newly-diagnosed

IBD Toolkit[17] – www.rcgp.org.uk/ibd

Other resources[18] – www.crohnsandcolitis.org.uk/HCP

The Dietitian Cafe podcast – www.apple.co/44VJo1W

SCAN THE QR CODE TO:

– Join our HCP community
– Access CPD questions
– Download your CPD certificate

BDA The Association of UK Dietitians
Centre for Education and Development

For the full reference list, please visit https://crohnsandcolitis.org.uk/dietitians

The Associate Principal Investigator scheme: experience of a renal dietitian

Bruno Mafrici explains how he got involved in a training programme designed to help healthcare professionals get into research


Bruno Mafrici is a Clinical Specialist Renal Dietitian and non-medical prescriber at Nottingham University Hospitals NHS Trust
@BrunoDietitian

The API scheme is run by the National Institute of Health and Care Research (NIHR) and endorsed by the British Dietetic Association through the Council for Allied Health Professional Research.

The API scheme is a six-month in-work training opportunity programme, which provides the clinician with practical experience for healthcare professionals starting their research career.[1] At the end of six months and after submission of a summary of key learning, healthcare professionals receive formal recognition of engagement in NIHR Portfolio research studies through the certification of Associate Principal Investigator (PI) status, endorsed by the NIHR and Royal Colleges.[1]

As a dietitian I worked alongside the local PI for six months, meeting monthly to discuss study participants and the progress of the research. In addition, I was supported by a local renal research nurse, who guided me during the process.

How did I get involved?

As an experienced renal dietitian, I have a solid background in audit, service evaluation and project development, as well as quality improvement. Over the past 10 years I have led projects, developed other members of staff, and conceptualised pathways and original ideas to evaluate and audit our practice against local, national and international standards. I led by writing local[2] and

national guidelines[3-5] by critically appraising and synthesising the outcomes of relevant research, using the results to underpin my own practice and to inform the practice of others.[6]

An opportunity to increase my experience in research arose in September 2022, when our renal unit decided to take part in the pragmatic randomised trial of high or standard phosphate targets in end-stage kidney disease, known as the PHOSPHATE trial.[7]

This randomised controlled trial (RCT) is relevant to renal dietetic practice, as managing the phosphate levels of patients on dialysis is part of my current role. The primary objective is to test the hypothesis that, compared with a liberal serum phosphate concentration target of 2.0 to 2.5 mmol/L, intensive lowering of serum phosphate towards the normal level (≤1.50 mmol/l) with phosphate binders reduces the risk of fatal or non-fatal major cardiovascular events in end-stage kidney disease patients receiving dialysis.[7]

At that point, the local PI of the study made the suggestion to involve a renal dietitian as the API. This was the first time I had heard about the scheme and I was very unfamiliar with it. At first, I was sceptical and worried about the time commitments. However, the API scheme is a work-based learning opportunity, rather than a course, which makes its integration into day-to-day work much easier. It was also an opportunity for me to apply my non-medical prescribing rights further, and the API scheme allowed me to have a leading role in this pragmatic, multinational, RCT.

How did it work in practice?

The API scheme began with finding a suitable study where I could get directly involved and register to the API scheme online via the NIHR website (**nihr.ac.uk/health-and-care-professionals/career-development/associate-principal-investigator-scheme.htm**). I then completed the Good Clinical Practice (GCP) course, which includes ethics, scientific and practical standards by which all research is conducted. Compliance with GCP assures patients and the public that the rights, safety and wellbeing of people taking part in studies are protected and that research data is reliable.[8]

Ethics teaches us, as healthcare professionals, to become morally responsible, to see, to listen, to feel and to act following an ethical compass and to allow ethos to be the guide.[9] This has been a key learning practical point during the completion of the API scheme. For example, the API scheme gave me experience of how to interact with participants of the study in different situations.

Following completion of the GCP course, I became an official member of the site research team at my hospital and started to have autonomous roles within this study. For example, I presented the project to my peers, explaining what it meant to our clinical practice. As part of the API scheme, I completed the informed consent training, which allows me to act independently with participant recruitment, contributing directly to the study.

Furthermore, as 22% of the patients on dialysis[10] belong to Black, Asian and minority ethnic (BAME) communities, I wanted to ensure that the research represented these groups. I felt that I needed more training on this specific aspect and I decided to complete the Increasing Participation of Ethnic Minorities in Health and Social Care Research (IPEM) course in November 2022, offered by NIHR. The course highlighted the need to carefully consider how to approach participants from BAME communities in order to be as inclusive as possible. This is an advantage of the API scheme as it allowed me to tailor my own learning needs.

Once the participants had consented to take part in the study, I ensured that this was documented in the patient's medical record. I aimed to see patients face to face to clarify their individual dietary and pharmacological recommendations depending on their arm allocation: for the liberal arm I relaxed their low phosphate diet and stopped their phosphate binders, and for the intensive arm I intensified dietetic intervention and maximised pharmacological intervention to achieve a phosphate less than 1.5mmol/L. As part of the API scheme, I tailored the interventions independently on a monthly basis and met regularly with the research nurse and the local PI.

> "The API scheme broadly increased my research experience and my awareness of how to conduct research in clinical practice"

As part of the API NIHR scheme, I completed a checklist of mandated study activities. This is a prospective monthly diary log, which included what I did as part of the research study and what I learnt. This checklist needed to be signed off by the local PI and the National Study Coordinator at the end of the six months and uploaded onto the NIHR portal.

Conclusion

The API scheme broadly increased my research experience and my awareness of how to conduct research in clinical practice. The API scheme is a structured introduction into clinical research, which, in my opinion, will benefit dietitians starting their research career. Often, these opportunities are taken by doctors or nurses, but I would encourage dietitians with an interest in research to liaise with their research team to see if there are any studies where they could complete the API scheme.

Completing the API scheme is a great opportunity for advancing health professionals' research skills and, naturally, this has inspired me to become a principal investigator in the future.

Recommended website: **nihr.ac.uk/health-and-care-professionals/career-development/associate-principal-investigator-scheme.htm**

REFERENCES

1 NIHR (2023a). Associate Principal Investigator Scheme. [Online] available from https://www.nihr.ac.uk/health-and-care-professionals/career-development/associate-principal-investigator-scheme.htm [9 April 2023].

2 Mafrici B, Armstrong Brown V and Wilcox N (2021). Guidelines for the use and administration of intradialytic parenteral nutrition (IDPN) in adult patients on haemodialysis [Online] available from https://www.nuh.nhs.uk/download/doc/docm93jijm4n11482.pdf?ver=26753 [9 April 2023].

3 Ashby D, Borman N, Burton J, Corbett R, Davenport A, Farrington K, Flowers K, Fotheringham J, Andrea Fox RN, Franklin G, Gardiner C, Martin Gerrish RN, Greenwood S, Hothi D, Khares A, Koufaki P, Levy J, Lindley E, Macdonald J, Mafrici B, Mooney A, Tattersall J, Tyerman K, Villar E, Wilkie M. Renal Association Clinical Practice Guideline on Haemodialysis. BMC Nephrol. 2019 Oct 17;20(1):379.

4 Mafrici B (2019). Resource update: a pocket guide to clinical nutrition Journal of Kidney Care 4: 281-283

5 Mafrici, B and Armstrong Brown V (2017). Protein energy wasting and nutritional requirements in dialysis. Journal of Kidney care 2 (2): 82-90.

6 NHS England (2017). Multiprofessional framework for advanced clinical practice in England. [online] available from https://www.hee.nhs.uk/sites/default/files/documents/multi-professionalframeworkforadvancedclinicalpracticeinengland.pdf [3 April 2023].

7 Badve S, Wald R, Smith R, Palmer S, Mark P, Kishnasamy R and Walsh M (2018). Pragmatic randomised trial of high or standard phosphate targets in end stage kidney disease, PHOSPHATE trial. [online] available from https://clinicaltrials.gov/ct2/show/NCT03573089 [6th April 2023].

8 NIHR (2023b). Good Clinical Practice course. [Online] available from https://www.nihr.ac.uk/health-and-care-professionals/learning-and-support/good-clinical-practice.htm [9 April 2023].

9 Lindwall L, Lohne V. Human dignity research in clinical practice - a systematic literature review. Scand J Caring Sci. 2021 Dec;35(4):1038-1049.

10 Kidney research UK (2018). Kidney Health Inequality in the UK [online] available from: https://www.kidneyresearchuk.org/wp-content/uploads/2019/09/Health_Inequalities_lay_report_FINAL_WEB_20190311.pdf [10 April 2023].

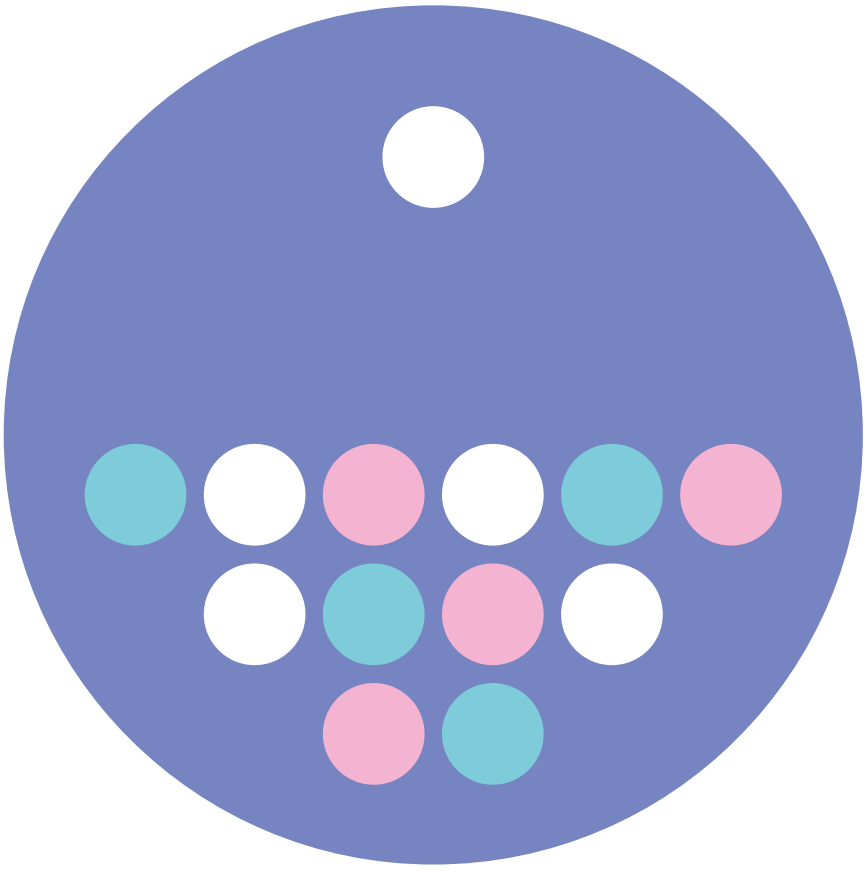
BDA AGM & Elsie Widdowson Lecture

A public health approach to dietetics

Tuesday 19 September 2023, 6pm - online

This year's lecture will be delivered alongside the AGM by Jacqueline Walker MSc BSc RD - Moray Dietetic Lead, NHS Grampian and Scottish Government, Professional Adviser.

Join us at the AGM to hear our annual highlights and accounts.



For full details and to register your place visit bda.uk.com/agm

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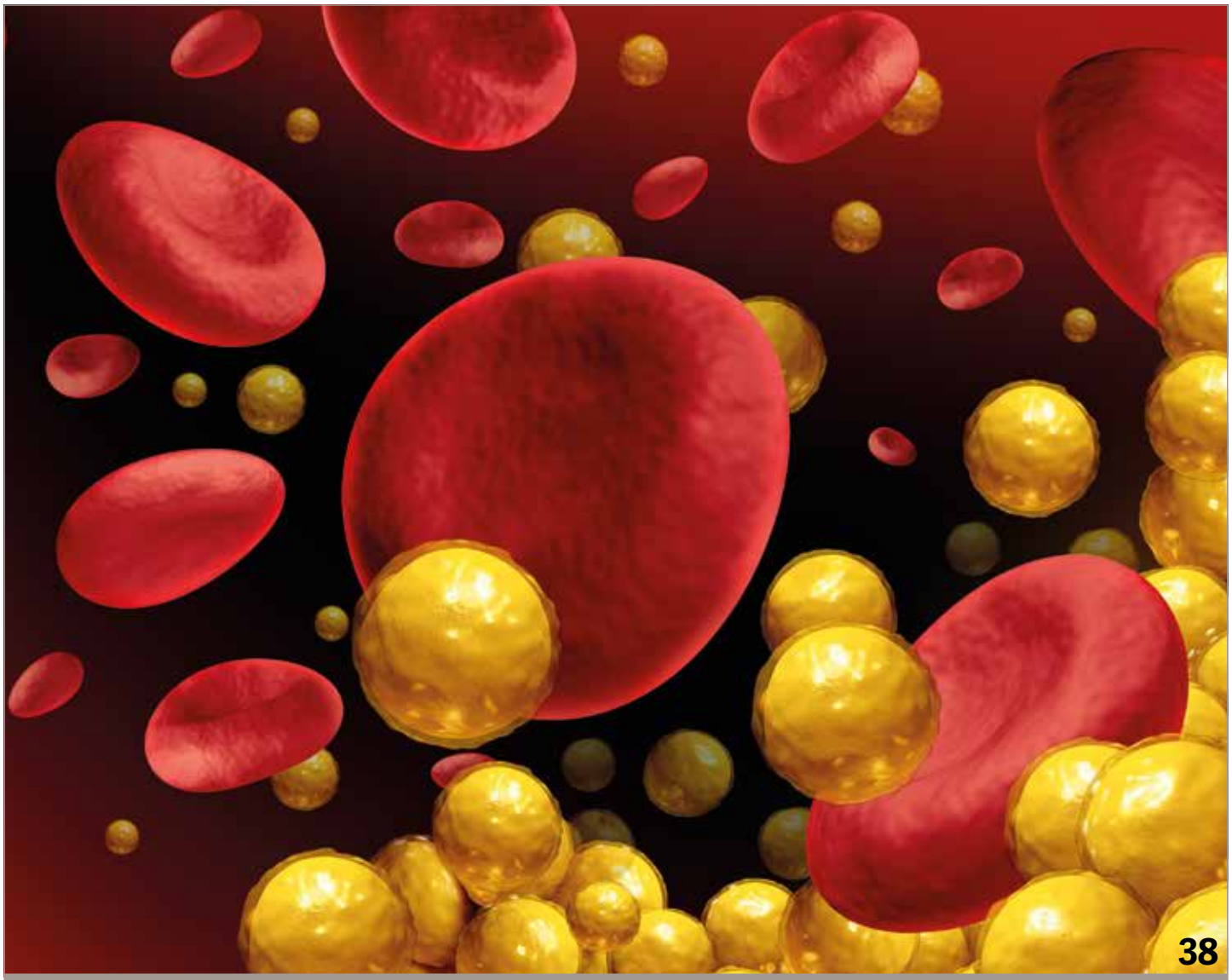

Inside this section

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"Individuals with a learning disability are more likely to have underweight or obesity than the general population"

Key points

1 Individuals with a learning disability are more likely to have an underweight or obese BMI compared with the general population.

2 Males with a learning disability die 22 years younger than males from the general population, and females 26 years younger.

3 This project aimed to examine the evidence base surrounding weight management interventions in individuals with a learning disability and to speak to individuals with a learning disability to explore their views and ideas.

Weight management in learning disabilities

Jess Lockley describes her experience of completing a Health Equity Fellowship exploring the topic of weight management in learning disabilities

Learning Disabilities Week is 19-25 June 2023

The Health Inequalities Academy of the West Yorkshire Health and Care Partnership (an integrated care service) advertised a Health Equity Fellowship. It was open to all employees in West Yorkshire health and care organisations, irrespective of their current job role/grade.

By applying, you were committing to the delivery of a Health Equity Fellow Project, agreeing to undertake the formal learning as part of the fellowship programme (Foundation of Public Health) and had to be able to dedicate one day per week over a nine-month period.

Why I applied

After seeing the advert on my Trust's weekly newsletter, I immediately knew I wanted to apply! After growing up in a deprived area, I had a keen interest in health inequalities. I thoroughly enjoyed the public health lectures during my dietetic training and recall being astounded when learning about the social gradient in health.

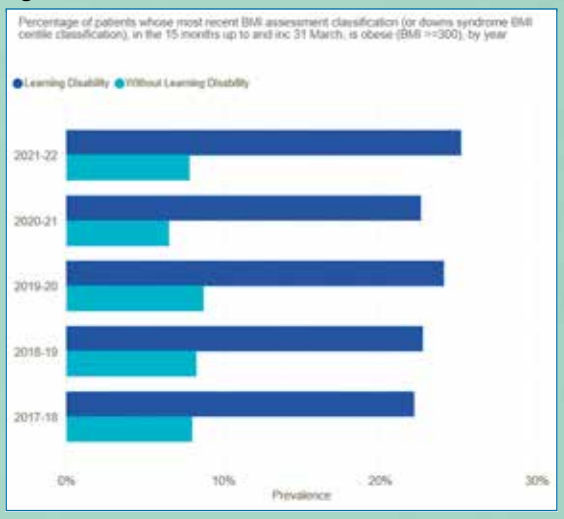
In my role as a Community Learning Disabilities (LD) Dietitian, I frequently observe the barriers people with a learning disability face with simply having a healthy diet, and I feel passionate about developing a more equitable health and care system in this area. The fellowship therefore seemed like an ideal opportunity.

After completing the application and receiving approval from my manager, I was delighted when my application was accepted.

What it involved

Fellows were assigned a mentor to support them over the nine-month period in designing and completing their project. My mentor was a research lead working in the NHS. I decided that I wanted to start with examining what the current evidence base was in the area. I also knew that I wanted to involve service users in the project to ensure the voice of the learning disability population was represented.

Figure 1



MAIN REFLECTIONS FROM THE LITERATURE SEARCH

- There was a lack of randomised controlled trials (four, including one feasibility trial) and systematic reviews (five, including one integrative review and two which included meta-analysis)
- Most of the research focuses on individuals with a mild-to-moderate learning disability, with a lack of evidence in those with more severe and profound LD
- All RCTs included incorporate physical activity and some have an inclusion criterion that states the person must be ambulatory, limiting the generalisability of the findings as many with a learning disability also have physical disabilities, which can limit their ability to engage in generic physical activity interventions
- Despite NICE[5] advising the importance of developing skills for weight maintenance in obesity management, there was a lack of weight maintenance interventions, and studies were typically short in duration
- Only six qualitative studies were found which included the views/lived experiences of those with an LD, highlighting the lack of co-production and service user involvement in the research
- Weight and BMI were often used as primary outcome measures. However, as discussed by Public Health England,[6] it can be difficult for all of the LD population to accurately have this measured due to wheelchair use and atypical body shapes
- The Mental Capacity Act (2005) and individuals' capacity around dietary choices is rarely mentioned in the literature, despite this being regularly considered in weight management interventions in clinical practice

The fellowship presented the unique opportunity to meet and learn from other fellows who were working in a wide variety of settings across healthcare and private organisations such as charities. The diverse range of project topics helped me to fully appreciate the work that needs to be done in the area of health inequalities.

The project

Individuals with a learning disability are more likely to have an underweight or obese BMI compared with the general population.[1] Data taken from NHS Digital suggests that levels of obesity are much higher in the LD population than in those without an LD[2] (Figure 1).

The 2021 Learning from Lives and Deaths of People with a Learning Disability and Autistic People (LeDeR) report[3] found that, on average, males with a learning disability die 22 years younger than males from the general population, and females 26 years younger – highlighting the stark inequalities experienced by this population group and the importance of reducing inequalities relating to overweight/obesity and its associated comorbidities.

The aims of my project were: 1) to examine the evidence base surrounding weight management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interventions in individuals with a learning disability; 2) to speak to individuals with a learning disability to explore their views and ideas on this topic.

Given the short timeframe of the fellowship, it was not possible to complete a systematic review of the literature, so a rapid review was completed.[4] I utilised the library resource at my Trust, which completed a literature search around weight management interventions in those with a learning disability. A total of 90 articles were identified by the library and, through a process of removing duplicates, screening the abstracts and then assessing the relevance of the remaining full texts, 35 relevant articles were identified.

I then began the process of extracting data from the 35 articles, with the focus in my final report being on systematic reviews and randomised controlled trials (RCTs), due to these being higher-quality levels of evidence.

It must be acknowledged that, as this was a rapid review, the search strategy and lack of time to read other studies identified in reference lists may have limited the findings.

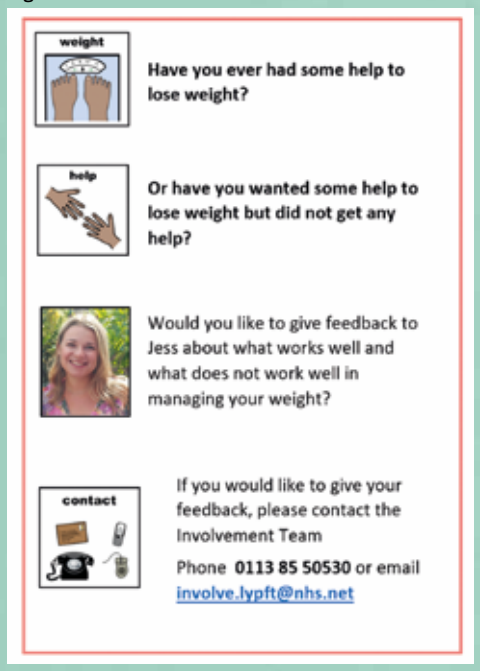
Service user feedback sessions

The service user involvement element of this project was completed in collaboration with the Involvement Team at LYPFT. Figure 2 shows the project flyer and project information leaflet which were designed with the Involvement Team and distributed across their networks and within the CLDT to help recruit participants. The main target audience was individuals with a learning disability who have tried to manage their weight – either with help from mainstream, commercial or specialist services, or those who had not had any help to lose weight.

A 'weight management conversation tool' (Figure 3) was developed with the Involvement Team which was to be completed during the feedback sessions.

Three participants took part in the feedback sessions. The project information and a consent form were discussed at the start of the sessions. One of the

Figure 2



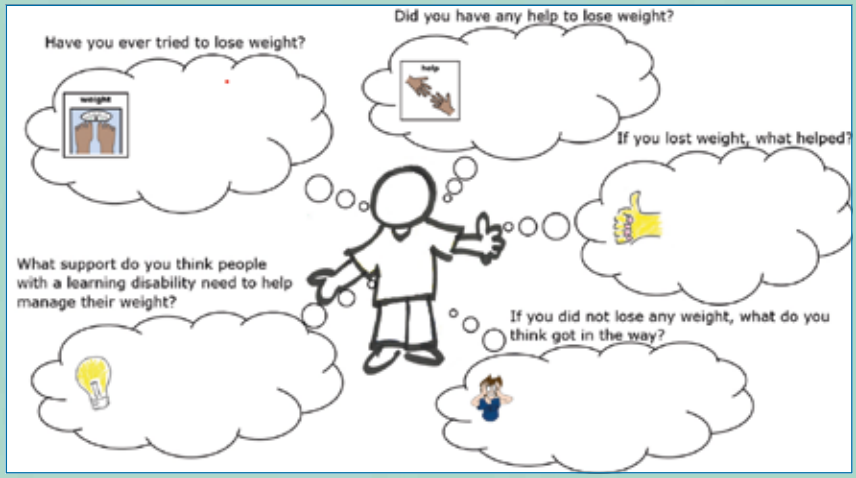


Figure 3

participants hadn't received any help from services to manage their weight and the two other participants were both currently accessing a commercial weight management service.

Due to the small number of participants and the fact that this was not a qualitative research study, there are limitations on what conclusions can be drawn from the information gathered. However, the main themes are summarised below.

- All participants indicated that they had tried to lose weight before as well as trying currently
- When discussing what helped them to lose weight:
  - Two participants referenced increased physical activity, e.g. "going to the gym" and "more walking"
  - Two participants referenced changing their eating, e.g. "learning about portion sizes", "not eating so much", "eating more fruit"
- When discussing what got in the way of losing weight:
  - All three participants referenced lack of accessible information, e.g. "information being long-winded with jargon" and "not being able to take it all in"
  - All three mentioned food, e.g. advertising of McDonalds (in the media), "buying wrong foods such as cream cakes", "I've got a very sweet tooth and like crisps"
- When discussing what support they think people with a learning disability need to help manage their weight:
  - All three participants referenced help from professionals, e.g. "think people need to be referred for help", "going to their doctor or hospital", "healthcare professionals to provide more information"
  - two participants referenced peer-to-peer support e.g. "getting help from a friend", "peer-to-peer support from somebody who has lost weight before"

Reflection on service user feedback

It would have been beneficial to interview a larger number of participants with a wider variety of experiences, e.g. experience of input from specialist services to provide insight in to ways we can improve practice. Additionally, the project has provided further evidence of how it is possible to involve service users in projects – the research community and those working with service users with a learning disability around managing their weight should aim to involve the views of individuals with an LD.

RESPONSES TO THE QUESTION: 'WHAT SUPPORT DO YOU THINK PEOPLE WITH A LEARNING DISABILITY NEED TO MANAGE THEIR WEIGHT?'

Information is presented as close as possible to words used by the participants.

- Support workers or family to encourage, support, help with reading food labels and cooking
- Easy-to-read accessible information on losing weight, such as a book with pictures and writing
- Healthcare professionals to provide more information and to work with the person to come up with an action plan and set goals, working together and checking how they are getting on with the plan
- Mental health support, as losing weight can be a lot of pressure; someone to talk to if finding it hard e.g. family/healthcare/friends
- Someone to talk to when the willpower is going away as this can make you feel stressed out
- Role models – more public speaking from people with a learning disability who have lost weight to change people's attitude about how to lose weight, and to reduce bullying of people who are overweight, e.g. in schools
- Peer-to-peer support from somebody who has lost weight
- Eating healthy
- Getting weighed
- Going to their doctor or hospital
- More accessible information
- Getting help from a friend such as going to Slimming World together so you can help each other and chat on the way there
- Think people need to be referred for help such as to a dietitian or Slimming World
- Need help to do more exercise such as swimming, e.g. a physiotherapist to show what to do in the pool

What next?

The work completed through the fellowship has been shared at various forums such as: our CLDT team meeting, Allied Health Professional Forum and Local Governance meeting. A desired outcome of the fellowship is to employ a co-production approach in future dietetic clinical pathway and resource development including the development of weight management easy-read resources for service user education sessions. The weight management provision in Leeds is being reviewed and this report has been shared with colleagues working in Leeds City Council to ensure learning disabilities are being fully considered in service design. Finally, my hope is that professionals such as dietitians working with services users with learning disabilities consider contributing to the evidence base in this area as part of the the larger aim of reducing inequalities in this population.

*If you would like to read Jess' full report on this topic as well as other projects that were completed as part of the fellowship, these are available on the West Yorkshire Health and Care partnership website at: **wypartnership.co.uk/our-priorities/population-health-management/health-inequalities/health-equity-fellowship/health-equity-fellows***

REFERENCES

1 Health inequalities: Overweight, obesity and underweight [Internet]. Available from: https://fingertips.phe.org.uk/documents/Health_inequalities_Overweight_obesity_underweight.pdf

2 Health and Care of People with Learning Disabilities [Internet]. NHS Digital. Available from: https://digital.nhs.uk/data-and-information/publications/statistical/health-and-care-of-people-with-learning-disabilities

3 LeDeR Learning from lives and deaths -People with a learning disability and autistic people Annual Report [Internet]. 2021. Available from: https://www.kcl.ac.uk/ioppn/assets/fans-dept/leder-main-report-hyperlinked.pdf

4 Dobbins M. Steps for conducting a rapid review Rapid Review Guidebook [Internet]. Available from: https://www.nccmt.ca/uploads/media/media/0001/02/800fe34eaedbad09edf80ad5081b9291acf1c0c2.pdf

5 NICE. Overview | Obesity: identification, assessment and management | Guidance | NICE [Internet]. Nice.org.uk. NICE; 2014. Available from: https://www.nice.org.uk/guidance/cg189

6 Public Health England. Obesity and weight management for people with learning disabilities: guidance [Internet]. GOV.UK. 2018. Available from: https://www.gov.uk/government/publications/obesity-weight-management-and-people-with-learning-disabilities/obesity-and-weight-management-for-people-with-learning-disabilities-guidance

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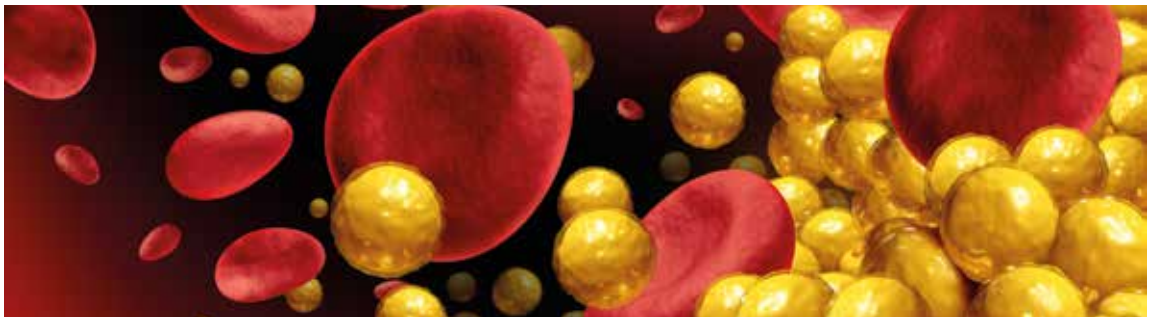
Key points

1 NICE has guidelines considering statin treatment for adults with type 1 diabetes but there does not appear to be a recommendation or pathway for children and young people.

2 In the clinical setting, healthcare professionals often focus on the microvascular complications of diabetes, with less consideration given to this patient group's macrovascular complications affecting health in later life.

3 For many people, raised cholesterol can be improved with lifestyle changes. The degree of reduction in cholesterol by diet alone, however, is often insufficient to negate the risk.



Is cholesterol the forgotten biomarker in managing cardiovascular risk in children with type 1 diabetes?

Wendy Frost reports on an audit amongst children with type 1 diabetes carried out with the aim of identifying those who are potentially more at risk of cardiovascular disease

Children and young people with type 1 diabetes (T1D) are faced with an increased risk of developing cardiovascular disease (CVD). There is currently no consensus on managing the risk of raised cholesterol levels for this patient group.

The National Institute of Clinical Excellence (NICE) guidelines[1] recommend considering statin treatment for the primary prevention of cardiovascular disease in all adults with type 1 diabetes, and offering statin treatment to adults with type 1 diabetes who are older than 40 years of age or who have had diabetes for more than 10 years. This includes those who have established nephropathy, or other cardiovascular risk factors. These guidelines are clear for the adult population with T1D; however, there currently does not appear to be a recommendation or pathway for children and young people.

The NICE guidelines for Management of Children and Young People with Diabetes 2015 do not include cholesterol screening for children with type 1 diabetes.[2] The National Paediatric Diabetes Audit (NPDA, 2020-2021), however, lists annual cholesterol measurement in children over 12 as one of the seven core care processes.[3]

In 2017, a study by Candler et al.[4] assessed the cholesterol screening of children with type 1 diabetes by sending an online survey to 280 children's diabetes professionals. From the 87 (31%) who responded, they discovered a considerable variability in testing across centres and actions taken if levels were abnormal. The data in this study could have been weighted to extremes, and respondents may have had strong opinions about the quality of their processes, either positive or negative. The non-respondents may have been those with no concerns regarding their practice. The views and practices of these professionals are still a helpful indicator, despite information from all those surveyed not being reported.

Dyslipidaemia is often overlooked and inadequately treated in young people with diabetes, even though CVD remains a significant cause of mortality in adults with diabetes.[5] The aetiological risk factors leading to the onset of CVD are well recognised and include hyperlipidaemia, hypertension, diabetes, obesity, smoking and lack of physical activity. They collectively represent over 90% of the CVD risks in all epidemiological studies.[6]

In the clinical setting, healthcare professionals may often focus on the microvascular complications of diabetes, aiming for good glycated haemoglobin (HbA1c) results and optimal 'time in range'. Should better consideration be given to this patient group's macrovascular complications affecting health in later life?

An audit amongst children with T1D in our district general hospital was carried out with the aim of identifying those who are potentially more at risk of CVD. This was also an opportunity to explore treatments and the advice given to these individuals. Data was collected from hospital records and analysed for HbA1c, BMI percentile and lipids for children over 12 years of age in our paediatric diabetes clinic.

Audit

The study group consisted of all the over-12-year-old patients in the local hospital children and young people's diabetes clinic. This is the starting age at which the NPDA begins to collect data, and the age that the test is first performed in the chosen clinic. This group consisted of 82 children. Of this group, there was data for cholesterol results available for 65 children. The remaining children had not yet had their test performed. The latest recommendations suggest that screening for dyslipidaemia is recommended soon after diagnosis (when glycaemia is stabilised) in all young people with T1D from age 11 years.[7]

All these tests were non-fasting and formed part of the annual review process. In this trust, it is not current practice to repeat fasting lipids if they are abnormal. Studies have shown that fasting may not influence total cholesterol, LDL-C and HDL-C.[8] Recent recommendations advocate re-testing if LDL-C or triglycerides (TGs) are raised.[7]

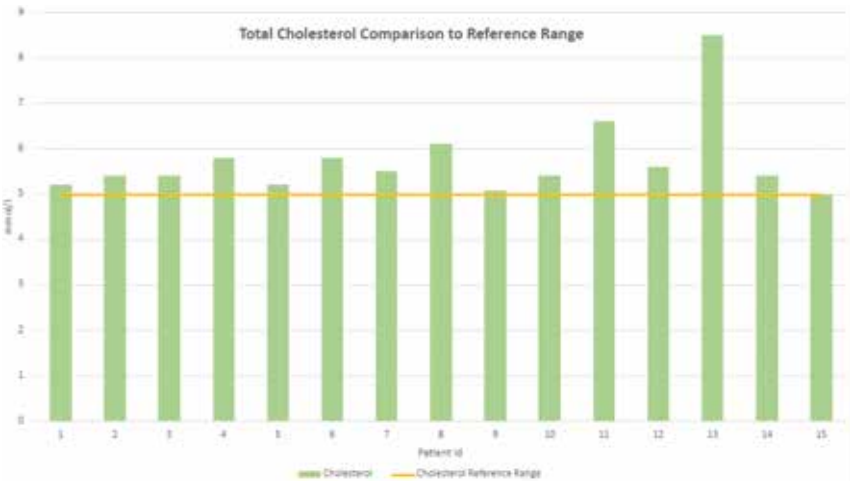
Smoking status and alcohol intake was discussed routinely at annual review appointments for this group. All patients in the group denied smoking or drinking alcohol regularly, and all had blood pressure readings in the ideal range.

Wendy Frost is an Advanced Dietitian in Paediatrics at Worthing Hospital. Wendy lives with type 1 diabetes herself.

Results

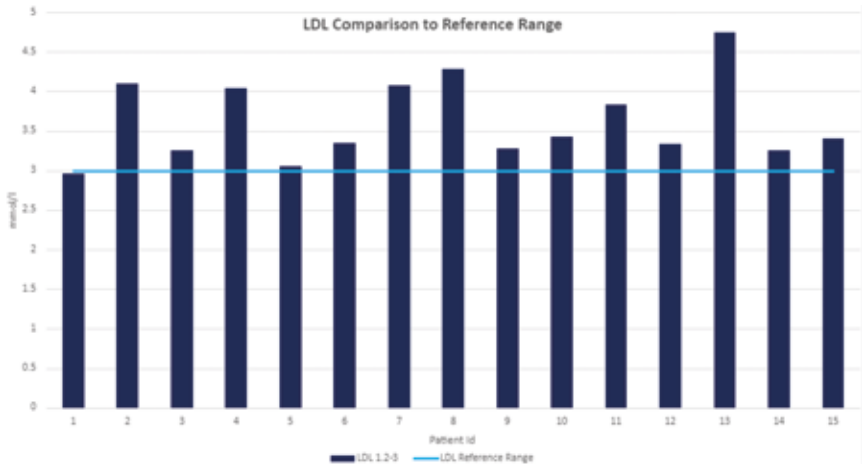
Total cholesterol

Fifteen children (23%) had cholesterol levels equal to or above the hospital reference range of 5mmol/l. None of them were known to have familial hypercholesterolaemia, although with a result over 7.5mmol/l, child number 13 has a greater risk of having this genetic disorder.[9]



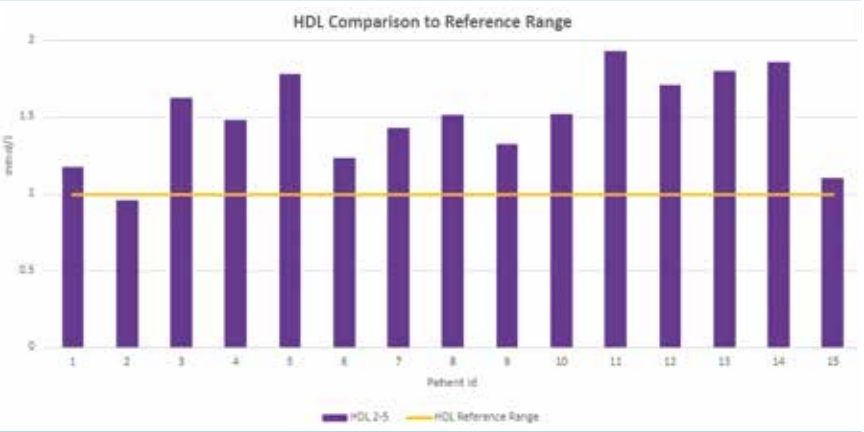
LDL-C

All those with raised total cholesterol levels were seen to have raised low-density lipoprotein cholesterol (LDL-C) levels, which is usual with an overall raised cholesterol.



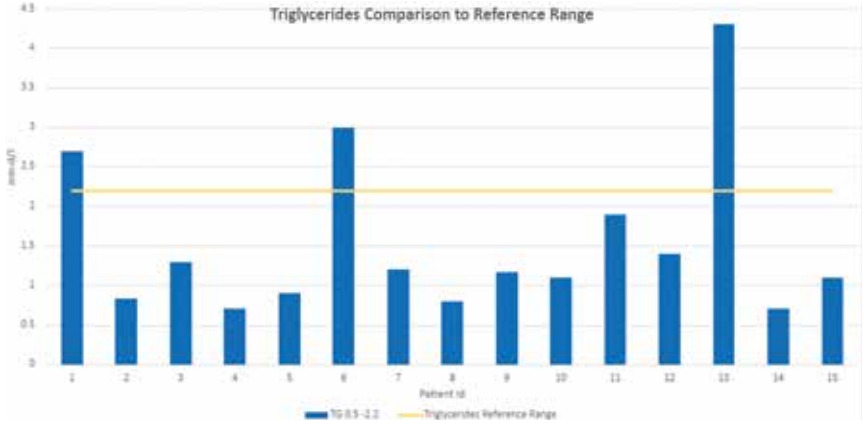
HDL-C

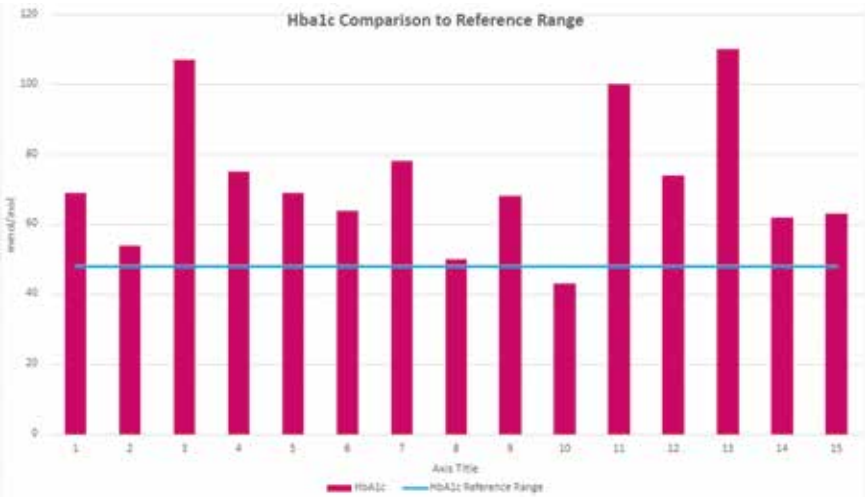
The reference range for high-density lipoprotein cholesterol (HDL-C) is 2-5mmol/l. Child number 2 was shown to have a level under 1mmol/l, a risk factor of concern. Lower values are associated with increased cardiovascular risk in T1D, which indicates less cholesterol is being transported to the liver for removal from the bloodstream.[10] HDL has also been shown to have an antiatherogenic role.[11]



Triglycerides

Children 1, 6 and 13 had significantly raised triglycerides (TGs). A raised TG level is a risk factor for CVD and is independent of total cholesterol.[12] When TGs are elevated, lipoprotein metabolism is altered, which increases CVD risk.[13]

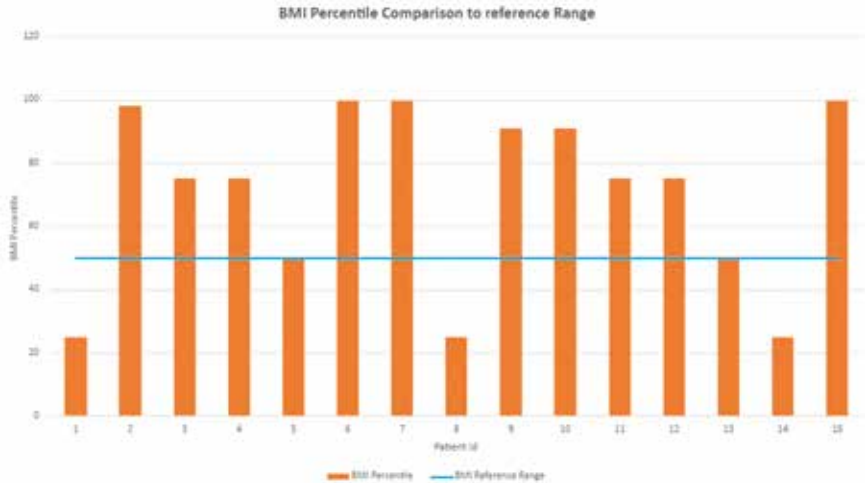




HbA1c

Child number 10 was the only one in the audit group who had an HbA1c below the current national recommendation of 48mmol/mol. Based on the evidence in adults with T1D, NICE recommends an overall target of 48mmol/mol, where possible, for children and young people with T1D to reduce long-term complications.[2]

The risk factors of high HbA1c and BMI percentiles for these 15 children were then identified.

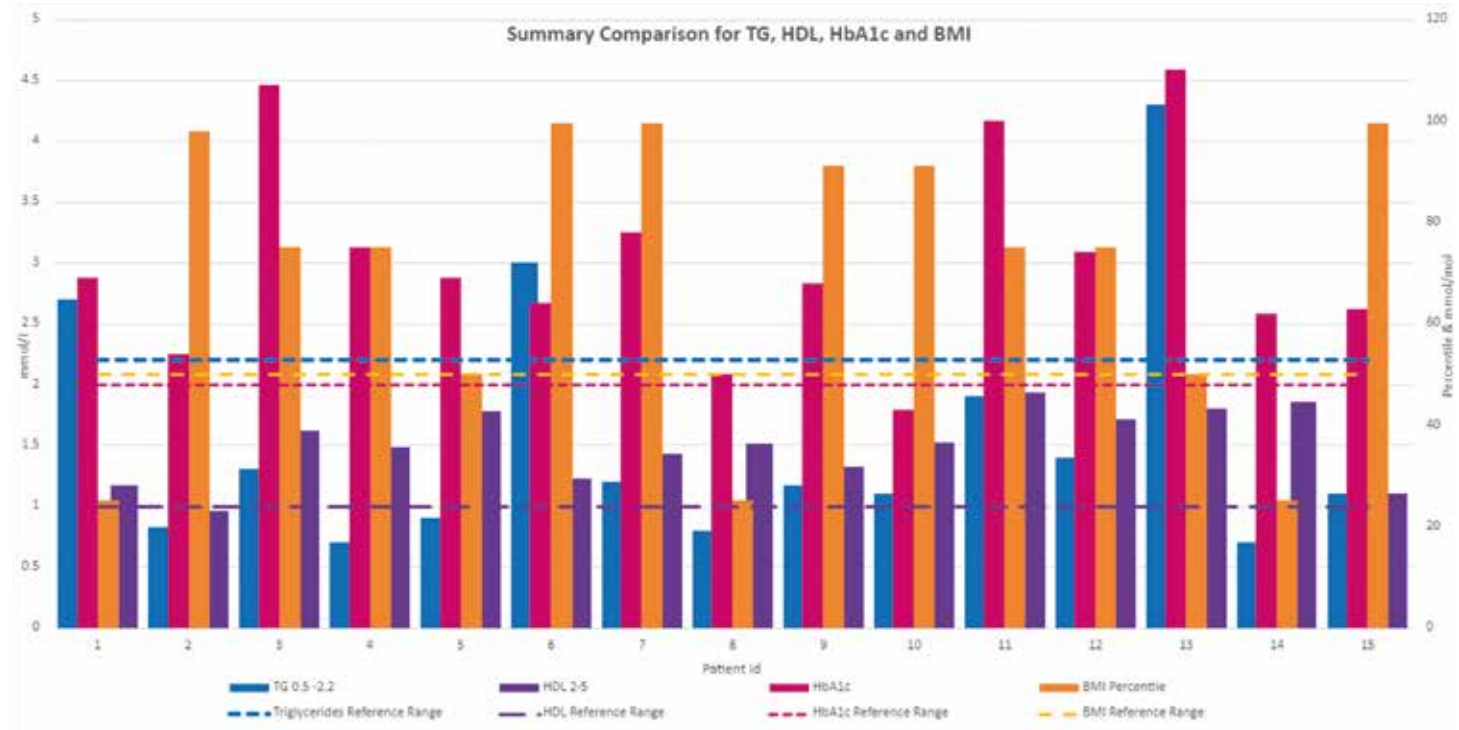


BMI

Ten of the children had BMIs over the 50th percentile. This, therefore, leaves five children who were of an ideal weight and had raised lipids. These children potentially could be consuming their recommended calorie intakes; however, they may benefit from more specific dietary interventions to improve their lipid status, for example, advice on exercise and consideration of medication.

Summary

Additional risk factors for children with raised cholesterols and LDL-C.



CHILD NUMBER	HDL - C	TRIGLYCERIDES	HBA1C	BMI	ADDITIONAL RISKS
1	→	↑	↑	→	2
2	↓	→	↑	↑	3
3	→	→	↑	↑	2
4	→	→	↑	↑	2
5	→	→	↑	→	1
6	→	↑	↑	↑	3
7	→	→	↑	↑	2
8	→	→	↑	→	1
9	→	→	↑	↑	2
10	→	→	→	↑	1
11	→	→	↑	↑	2
12	→	→	↑	↑	2
13	→	↑	↑	→	2
14	→	→	↑	→	1
15	→	→	↑	↑	2

KEY

In range	→	Below range	↓	Above range	↑

What do these results indicate?

The summary chart shows that there are other risk factors to consider in this group of children with raised cholesterol levels. It could be easy to assume that high cholesterol is merely a secondary effect of high glucose and its associated metabolic effects.[14] This is not true in the findings. A commonly held belief might be that those with overweight are also those who are more likely to have raised lipids.[15] However, this is not the case in this audit group. There are five children in this group with additional risk factors, including raised TGs and HbA1c levels whose BMI is considered in the ideal range. The one child with an HbA1c below the desirable range had a raised BMI. Alongside their raised lipids, this child could miss additional treatment, with good glycaemic control being the primary focus at a consultation.

Discussion

Cholesterol is a lipophilic molecule that is essential for human life. It has many roles that contribute to normally functioning cells. For example, cholesterol is a vital component of cell membranes. Cholesterol functions as a precursor molecule in the synthesis of vitamin D and steroid hormones. Cholesterol is also a constituent of bile salts used in digestion to facilitate the absorption of fat-soluble vitamins A, D, E and K. It is transported through the blood, along with triglycerides, inside lipoprotein particles. These lipoproteins can be detected in the clinical setting to estimate the amount of cholesterol in the blood.[10]

While cholesterol is central to many healthy cell functions, it can also harm the body if it is allowed to reach abnormal blood concentrations.[10] LDL is the particle that transports cholesterol around the body and collects in the walls of blood vessels. HDL is the particle that transports cholesterol to the liver to be broken down. It is, therefore, a concern when this is too low, indicating that less cholesterol is being transported from the blood vessels to the liver for removal. Triglycerides are the fats carried in the blood which the body uses for fuel or in excess stores as body fat. An excess in the bloodstream can occur with high blood glucose levels.

High triglycerides and LDL cholesterol levels, combined with low levels of HDL cholesterol, are associated with the build-up of plaque in the arteries and a higher risk of CVD. "Consistent evidence from numerous and multiple types of clinical and genetic studies unequivocally establishes that LDL causes atherosclerotic cardiovascular disease."[16, p2460]

Children with type 1 diabetes and elevated LDL cholesterol have an increased risk for cardiovascular disease, a process that can begin in childhood.[17] Atherosclerosis starting in childhood and its progression is influenced by lifelong low-density lipoprotein cholesterol (LDL-C) exposure. Cardiovascular disease (CVD) represents a leading cause of death globally.[18] It is a fact that many of the cardiovascular risk factors are linked, and strategies to improve glycaemia will also help with weight management and can improve lipids in many cases. Annan et al. highlighted in 2022 that hyperglycaemia, insulin deficiency and insulin resistance are associated with dyslipidaemia. Accordingly, the initial therapy should be to optimise glucose management.[5]

The NPDA audit 2020-21 found that 19.8% of children aged 12 years and older with T1D had a total blood cholesterol level exceeding the target of 5 mmol/l.[3] This figure was 23% in the patient group studied. Most recent recommendations have suggested that a level of 4.5mmol/l would be ideal, making this risk factor of greater concern.[7]

The adult recommendation is to aim for a total cholesterol level under 4mmol/l.[1] This would have significant implications if lower levels were targeted in the paediatric population. More intensive first-line management with diet and lifestyle modifications would require more input from healthcare professionals. An increased number of patients may feel additionally burdened by having another treatment to comply with alongside their insulin therapy. They could also

potentially experience undesirable side effects from their medication. Increased usage of statins would also have huge financial ramifications for the NHS.

Current approaches

The focus of education at diagnosis is usually on glycaemic control and dose adjustment for 'normal eating'. There are huge variations in the understanding of what a normal diet should look like and how much change is required when the diagnosis presents. To soften the blow of the diagnosis, healthcare professionals may tell families that their newly diagnosed child can continue eating their 'normal' diet before exploring their usual intake.

Dietary recommendations should be based on healthy eating principles suitable for all young people and families to improve diabetes outcomes and reduce cardiovascular risk.[5] Consideration needs to be given when adjustments to carbohydrates are made so as not to increase dietary fats unfavourably. The Mediterranean diet of monounsaturated fats, wholegrain carbohydrates and reduced intake of red and processed meats is likely to be beneficial. Dietitians play an essential part in educating patients, their families and other health professionals.

A study by Magriplis et al.[19] demonstrated that in the group of adults studied, diet and lifestyle changes related to dyslipidaemia could be achieved with continuous education, monitoring and follow-up. The key to this was the engagement of individuals. This can be a huge challenge in paediatrics, where the possible consequences of the risks are a long way off, and no immediate effects are seen. Children and young people often appear to engage better when discussing blood glucose trends, looking at continuous glucose monitor (CGM) data and achieving quick improvements that can be seen with recommended changes.

Living with type 1 diabetes carries a significant burden for the individual and family. In recent times we have had to consider the cost-of-living crisis and food insecurity more than ever before. Limited budgets can result in families buying cheaper, less nutrient-dense, high-fat, and high-sugar foods, unable to afford foods rich in unrefined grains, fresh fruit and vegetables. This can have a detrimental effect on both overall glycaemia and lipid levels. Day-to-day management of T1D involves decision-making with every mouthful of food and every activity, which poses a substantial challenge for the individual. An understanding that all children with T1D have an increased risk of CVD and identifying those who would benefit from statin treatment seems a sensible suggestion considering the lifetime of increased risk and the opportunity to improve outcomes in later life.

For many people, raised cholesterol can be improved with lifestyle changes, including increased activity, optimising BMI and following national recommendations for a healthy diet. The degree of reduction in cholesterol by diet alone, however, is often insufficient to negate the risk.[20]

What about drug treatment?

If the implementation of lifestyle interventions for six months does not lower cholesterol to 3.4mmol/l, with an ideal target LDL-C of 2.6mmol/l, then statins should be considered.[7] When questioning colleagues across the local network, both the repeating of tests and the use of statins are not commonplace.

A study conducted by Schwab et al.[21] looked at cardiovascular risk factors in patients with diabetes up to 26 years of age. They established that "despite the high prevalence of risk factors, only a small minority of patients received lipid-lowering treatment. A combination of early identification, prevention and treatment of risk factors is necessary, considering the high incidence of future cardiovascular disease".[21, P218]

Raffles et al.[22] asked: "What do we do with lipid levels measured as part of the NPDA?" They concluded that pharmacological management in childhood is controversial, and the data is lacking on the benefits of lifestyle modification in this group.

Studies by Canas et al.[17] concluded that atorvastatin (a commonly used lipid-lowering agent) reduced atherogenic lipoprotein sub-particles in children without worsening insulin resistance. The drug was safe and well tolerated. They recommended that long-term studies would provide better insight into the impact of these interventions in the development of CVD in children with diabetes.

A significant consideration in prescribing statins in young females is that it is contraindicated in pregnancy. Statins have a potential teratogenic risk[23] as cholesterol is an integral part of cell membranes, and an agent given to reduce cholesterol could result in congenital abnormalities. Those planning a pregnancy or who cannot reliably avoid getting pregnant should not be treated with statin therapy. Oral contraceptive agents might be considered alongside starting statins.[24]

If prescribed appropriately and consideration is given to the individual, would statin therapy take care of one of the numerous risk factors and play a valuable part in reducing overall CVD risk? Would these children and young people benefit from the early use of statins? Could a scoring system help to highlight those most in need of intensive advice and treatment? A pathway to follow for a consistent approach would make sense.

While a national approach would be invaluable, steps have been taken at this hospital trust to address the findings from this audit to support patients most at risk.

Problems identified locally

1. Family history of CVD and hyperlipidaemia is not routinely discussed at diagnosis
2. The system for keeping track of annual review blood tests and reviewing results is flawed, and a robust system for flagging raised cholesterol is not in place
3. Annual review appointments require more time for all the necessary discussions
4. No process exists for children with raised cholesterol who have not responded to diet alone after six months of receiving dietary advice

Suggested actions

1. Detailed family history to be taken at the three-month clinic review when the first HbA1c test is measured. Discussions around why this longer-term glucose level is done would tie in with those around CVD risk and avoid more overwhelming conversations at the time of diagnosis

REFERENCES

1 National Institute for Health and Care Excellence. Cardiovascular disease: risk assessment and reduction, including lipid modification. Clinical guideline [CG181] Published: 18 July 2014 Last updated: 10 February 2023

2 National Institute for Health and Care Excellence. NG18: Diabetes (type 1 and type 2) in children and young people: diagnosis and management. 2015. Last updated: 29 June 2022.

3 Care processes and outcomes 2020-21, RCPCH Audits National Paediatric Diabetes Audit NPDA Appendix 1 - full audit analysis.

4 Candler T, Mahmoud O, Edge J, Hamilton-Shield J. Hypercholesterolaemia screening in Type 1 diabetes: a difference of opinion. Diabetic Medicine. 2017 Jul;34(7):983-6.

5 Annan SF, Higgins LA, Jelleryd E, Hannon T, Rose S, Salis S, Baptista J, Chinchilla P, Marcovecchio ML. ISPAD Clinical Practice Consensus Guidelines 2022: Nutritional management in children and adolescents with diabetes. Pediatric diabetes. 2022 Dec;23(8):1297-321.

6 Flora GD, Nayak MK. A brief review of cardiovascular diseases associated risk factors and current treatment regimes. Current pharmaceutical design. 2019 Oct 1;25(38):4063-84

7 Bjornstad P, Dart A, Donaghue KC, Dost A, Feldman EL, Tan GS, Wadwa RP, Zabeen B, Marcovecchio ML. ISPAD Clinical Practice Consensus Guidelines 2022: Microvascular and macrovascular complications in children and adolescents with diabetes. Pediatric diabetes. 2022 Dec;23(8):1432-50.

8 Schwab KO, Doerfer J, Naeke A, Rohrer T, Wiemann D, Marg W, Hofer SE, Holl RW, German/Austrian Pediatric DPV Initiative. Influence of food intake, age, gender, HbA1c, and BMI levels on plasma cholesterol in 29 979 children and adolescents with type 1 diabetes–reference data from the German diabetes documentation and quality management system (DPV). Pediatric diabetes. 2009 May;10(3):184-92.

9 National Institute for Health and Care Excellence 2017a: Identification and management of familial hypercholesterolaemia (Full guideline) [National Collaborating Centre for Primary Care, 2017] and Familial hypercholesterolaemia: identification and management.

10 Huff T, Boyd B, Jialal I. Physiology, cholesterol. InStatPearls [Internet] 2022 Mar 9. StatPearls Publishing.

2 The team administrator will inform the dietitian of all raised cholesterol test results so that a dietetic review can be booked, and six-monthly review blood test appointments arranged
3 A more extended appointment slot is offered for the annual review
4 Explore the possibility of using fingerpick cholesterol testing alongside HbA1c in the clinic to allow prompt and timely discussion and support engagement
5 Consider referral to a lipid specialist for advice on individual cases
6 Liaison with network lead clinicians to take this issue forward for further discussion

An understanding and awareness from health professionals that all children with T1D have an increased risk of CVD is fundamental. Standardising the treatment pathway seems a sensible suggestion to ensure that everybody is offered optimum treatment considering the lifetime of increased risk, enabling improved outcomes in later life.

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Children and Young People's Diabetes Module

11 Kwiterovich PO Jr. The antiatherogenic role of high-density lipoprotein cholesterol. Am J Cardiol. 1998 Nov 5;82(9A):13Q-21Q. doi: 10.1016/s0002-9149(98)00808-x. PMID: 9819099.

12 Cullen P. Evidence that triglycerides are an independent coronary heart disease risk factor. The American journal of cardiology. 2000 Nov 1;86(9):943-9.

13 McBride P. Triglycerides and risk for coronary artery disease. Current atherosclerosis reports. 2008 Oct;10(5):386-90.

14 Parhofer KG. Interaction between glucose and lipid metabolism: more than diabetic dyslipidemia. Diabetes & metabolism journal. 2015 Oct 22;39(5):353-62.

15 Feingold KR. Obesity and dyslipidemia. Endotext [Internet]. 2020 Nov 2.

16 Ference, B.A., Ginsberg, H.N., Graham, I., Ray, K.K., Packard, C.J., Bruckert, E., Hegele, R.A., Krauss, R.M., Raal, F.J., Schunkert, H. and Watts, G.F., 2017. Low-density lipoproteins cause atherosclerotic cardiovascular disease. 1. Evidence from genetic, epidemiologic, and clinical studies. A consensus statement from the European Atherosclerosis Society Consensus Panel. European heart journal, 38(32), pp.2459-2472.

17 Canas JA, Ross JL, Taboada MV, Sikes KM, Damaso LC, Hossain J, Caulfield MP, Gidding SS, Mauras N. A randomized, double blind, placebo-controlled pilot trial of the safety and efficacy of atorvastatin in children with elevated low-density lipoprotein cholesterol (LDL-C) and type 1 diabetes. Pediatric diabetes. 2015 Mar;16(2):79-89.

18 Balder JW, Lansberg PJ, Hof MH, Wiegman A, Hutten BA, Kuivenhoven JA. Pediatric lipid reference values in the general population: the Dutch lifelines cohort study. Journal of Clinical Lipidology. 2018 Sep 1;12(5):1208-16.

19 Magriplis E, Sialvera TE, Papadopoulou A, Efstathiou SP, Trautwein EA, Goumas G, Dimakopoulos I, Papavasiliou K, Koutsouri A, Zampelas A. Effectiveness and easiness of adherence to behavioural guidelines for diet and lifestyle changes for cholesterol-lowering: the Increasing Adherence of Consumers to Diet & Lifestyle Changes to Lower (LDL) Cholesterol (ACT) randomised controlled trial. Journal of Human Nutrition and Dietetics. 2019 Oct;32(5):607-18.

20 Maahs DM, Dabelea D, D'Agostino Jr RB, Andrews JS, Shah AS, Crimmins N, Mayer-Davis EJ, Marcovina S, Imperatore G, Wadwa RP, Daniels SR. Glucose control predicts 2-year change in lipid profile in youth with type 1 diabetes. The Journal of pediatrics. 2013 Jan 1;162(1):101-7.

21 Schwab KO, Doerfer J, Hecker W, Grulich-Henn J, Wiemann D, Kordonouri O, Beyer P, Holl RW, DPV Initiative of the German Working Group for Pediatric Diabetology. Spectrum and prevalence of atherogenic risk factors in 27,358 children, adolescents, and young adults with type 1 diabetes: cross-sectional data from the German diabetes documentation and quality management system (DPV). Diabetes care. 2006 Feb 1;29(2):218-25.

22 Raffles A, Kyriakos E, Jain G, Winocour P. G572 (P) What do we do with lipid levels measured as part of the national paediatric diabetes audit?

23 Karalis DG, Hill AN, Clifton S, Wild RA. The risks of statin use in pregnancy: a systematic review. Journal of clinical lipidology. 2016 Sep 1;10(5):1081-90.

24 O'Gorman CS, O'Neill MB, Conwell LS. Considering statins for cholesterol-reduction in children if lifestyle and diet changes do not improve their health: a review of the risks and benefits. Vascular health and risk management. 2010 Dec 20:1-4.

Key

- BDA endorsed courses
- CED courses
- Diary dates
- BDA Events

Notes: The courses and events featured on these pages are for dietitians and dietetic support workers (unless otherwise stated). The course or event may be run by BDA Centre for Education and Development (CPD), Specialist Groups and Branches or external providers. All training activity can be used as evidence to support your continuing professional development (CPD). To include a listing on these pages, please email: **publications@bda.uk.com**.

Online

Let's Get Cooking – How to Run Practical Cooking Clubs

Provider: British Dietetic Association
Venue: Online
Cost: BDA members £80, non-members £115
Details: This six-module course is aimed at anyone who wants to lead or support cooking activities in the community, schools, prisons or care settings.

Running cooking sessions is very rewarding, and this course will help build the skills you need to run them smoothly and safely.
How to book: bda.uk.com/events/calendar/let-s-get-cooking-how-to-run-practical-cooking-clubs.html

Using Behavioural Change Tools in Childhood Obesity

Provider: Dr Laura Stewart T/A AppleTree
Dates: Various dates in 2023
Venue: Online
Cost: £295
Details: Practical virtual training on using behavioural change tools in childhood obesity from a leading expert.

June

Starting Out in Paediatric Dietetics

Provider: British Dietetic Association
Date: 15 June
Venue: Virtual classroom
Facilitators: Katie Elwig and Sue Meredith
Details: This online course aims to introduce the key aspects of paediatric dietetics for dietitians starting out on their paediatric dietetic careers.

Healthcare Professionals and the Media: Practical Workshop

Provider: British Dietetic Association
Date: 15 June
Venue: BDA office, Birmingham
Facilitator: Aimee Postle
Details: This one-day course builds upon the self-study you have already completed during the online module. Having reviewed the changing media context, relationships with journalists, and compelling content, you will now have a go at pitching your stories and completing practice interviews. This course is suitable for those relatively new to engaging with the media and will also provide practice and feedback opportunities for those with existing media engagement experience.

Starting Out as a Freelance Dietitian

Provider: British Dietetic Association
Date: 22 June
Venue: BDA office, Birmingham
Facilitators: Jill Scott and Fiona Hinton
Details: This online course aims to equip participants with the key elements required when starting out as a freelance dietitian, offering the practical support, knowledge and tools needed to embark on a career in freelance dietetics.

Introduction to Nutrition in Cancer

Provider: British Dietetic Association
Date: 28 June
Venue: Virtual classroom
Facilitators: Lucy Eldridge and Vicky Nelson
Details: This blended learning course, on MS Teams, is an interactive day that has links with the Macmillan Allied Health Professions Competence Framework for those working with people affected by cancer (Macmillan, 2017) and will increase the knowledge and skills in the nutritional care of adults living with and beyond cancer.

Future Leaders Programme

Provider: British Dietetic Association
Date: 30 June
Details: Leadership development for professional association leaders is rare. The BDA is at the forefront of developing its own members with a unique, award-winning programme, developed by us and approved by the Institute for Leadership and Management. The programme aims to ensure that future association leaders have an opportunity to learn in a multi-professional environment and are supported to govern and lead their association with vision and courage.

The second intake of 2023 can apply between 1 March and 30 June 2023.

For more information, please visit bda.uk.com/about-us/how-we-work/future-leaders-programme.html.

July

Advancing Dietetics in Mental Health (two days)

Provider: British Dietetic Association
Date: 3 & 4 July
Venue: BDA office, Birmingham
Facilitators: Caroline Frascina and Lisa Waldron
Details: This two-day course is aimed: at dietitians new to mental health who need more depth than the BDA Introduction to Mental Health, Learning Disabilities and Eating Disorders course; dietitians who want to specialise in or who have an interest in mental health; dietitians wanting an update in mental health.

This course will provide dietitians specialising in mental health with the essential knowledge and skills required to work in this area.

Advancing Dietetics in Eating Disorders (two days)

Provider: British Dietetic Association
Date: 4 & 11 July
Venue: Virtual classroom
Facilitators: Sarah Morton and Laura Passman
Details: This course has been developed to provide dietitians specialising in eating disorders with the essential knowledge and skills required to work in this area. It is aimed at dietitians new to eating disorders who need more depth than the BDA Introduction to Mental Health, Learning Disabilities and

Eating Disorders (ED) course or dietitians wanting to specialise in or who have an interest in ED

HEART UK 36th Annual Medical & Scientific Conference: Lipids – the best yet
Provider: HEART UK – The Cholesterol Charity
Dates: 5-7 July
Venue: The Oculus, University of Warwick, Coventry
Cost: Qualified doctor £310, other HCPs £240, students - £90, industry professionals £400
Details: This conference will offer more than 11 hours of stimulating live educational content. heartuk.org.uk/conference

Consolidating Dietetic Practice in Diabetes
Provider: British Dietetic Association
Date: 11 July
Venue: BDA office, Birmingham
Facilitator: Diana Markham
Details: This course will build on existing skills and knowledge in relation to nutritional recommendations for diabetes and explores the application of theory to practice. It discusses current Diabetes UK and the American Diabetes Association evidence-based nutritional guidelines for diabetes. It discusses all current oral and injectable anti-hyperglycaemic medications and their dietary implications. This course includes an introduction to carbohydrate counting, but this subject is covered in much greater depth in the Advancing Dietetic Practice in Diabetes course.

Management of Chronic Kidney Disease Stages 3-5
Provider: British Dietetic Association
Date: 17 July
Venue: BDA office, Birmingham
Facilitator: Fiona Willingham
Details: This course has been developed to help dietitians obtain the necessary knowledge and skills to undertake the appropriate dietetic assessment, management and monitoring of patients who have chronic kidney disease (CKD) stages 3-5 and are on the CKD patient care pathway.

August

Nutritional Management of the Adult Liver Disease Patient – a Holistic Approach
Provider: The Nutrition Trainer
Dates: 10 August 9.30am-4.15pm & 11 August 10am-3.30pm
Venue: Virtual, via Zoom
Cost: £300
Details: Exploring the nutritional treatments within a variety of liver conditions. Specifically designed for dietitians who are not specialists.

September

Basic Nutrition Principles & Advancing Dietetic Support Worker Practice in Paediatrics
Provider: British Dietetic Association
Date: 8 September
Venue: Virtual classroom
Facilitator: Dr Fiona McCullough
Details: This course is designed to help lay the foundations of childhood nutrition (in healthy and sick children), and discusses the importance of growth, breast feeding and early dietary practices; basic nutritional requirements and recommendations for all children; common nutritional issues; detecting nutritional risk and faltering growth; an overview of dietetic management in some common conditions.

DSW – Nutrition and Nutritional Support Update
Provider: British Dietetic Association
Date: 14 September
Venue: BDA office, Birmingham
Facilitator: Dr Fiona McCullough
Details: This one-day course is aimed at dietetic support workers working in both acute and community settings. It will be suitable for those relatively new in post and as a useful update for those with some previous knowledge and experience.

Introduction to Dietary Management of Adults with Inflammatory Bowel Disease
Provider: British Dietetic Association
Date: 22 September
Venue: BDA office, Birmingham
Facilitator: Dr Kirsty Porter
Details: This one-day blended learning course will increase knowledge and skills in the nutritional care of adults living with inflammatory bowel disease (IBD). By the end of the course, delegates will be able to understand what IBD is, including the prevalence, diagnosis and symptoms and the associated complications with the main focus on Crohn's disease and ulcerative colitis and be able to refer to current national and international guidelines/standards for the management of IBD.

October

Irritable Bowel Syndrome – Dietetic Management and Symptom Control
Provider: British Dietetic Association
Date: 5 October
Venue: BDA office, Birmingham
Facilitator: Dr Amanda Avery
Details: This course aims to present the latest research and clinical practice guidelines to facilitate evidence-based management of irritable bowel syndrome (IBS). It is for dietitians who currently manage, or are keen to develop knowledge in managing, adults with IBS. The course is taught through self-directed learning and an interactive workshop.

Management of IBS using the Low FODMAP Diet
Provider: British Dietetic Association
Date: 6 October
Venue: BDA office, Birmingham
Facilitator: Julie Thompson
Details: This course aims to present the latest research and clinical practice guidelines to facilitate the delivery of the Low FODMAP Diet to support the management of irritable bowel syndrome (IBS). It is for dietitians who currently

Get listed

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Course in focus

Introducing Behavioural Science to Understand and Change the Dietary Behaviours of Athletes
Provider: British Dietetic Association
Date: 16 June
Venue: BDA Office, Birmingham
Facilitators: Louise Sutton, Dr Meghan Bentley and Professor Susan Backhouse
Details: This one-day course is designed for sports nutritionists at all levels wanting to inform, develop or review their service to promote nutritional adherence in athletes. The purpose of this course is to enable sport nutritionists to develop their understanding of the barriers and enablers of human behaviour as well as the contexts shaping our decision-making.

BDA Classroom prices

BDA members	£165
Non-members	£230
Support workers (BDA members)	£150
Support workers (non-members)	£180

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manage, or are keen to develop knowledge in managing, adults with IBS. The course is taught through self-directed learning and an interactive workshop.

Building on the Skills and Knowledge of Enteral Nutrition

Provider: British Dietetic Association
Date: 12 October
Venue: BDA office, Birmingham
Facilitators: Rhiannon Robinson and Mel Gollaglee
Details: This basic-to-intermediate course will build on existing knowledge and skills in the management of enteral tube feeding. The course aims to enable confidence in everyday practice in adult enteral nutrition. The course is designed for participants who are newly qualified band 5 dietitians with less than two years of experience or for those to whom enteral feeding is a new specialism.

Advancing Dietetics in Learning Disabilities (two-day online course)

Provider: British Dietetic Association
Date: 16 & 17 October
Venue: Virtual classroom
Facilitator: Briony Caffrey and Angela Norris
Details: This two-day online course looks in depth into topics such as the role of the dietitian when working with people with learning disabilities as well as the role of the MDT in learning disabilities; nutritional challenges and vulnerabilities; mental and physical health co-morbidities; mortality reviews; abuse in care; safeguarding; and enteral feeding.

Introduction to and Principles of Behaviour Change

Provider: British Dietetic Association
Date: 19 October
Venue: Virtual classroom
Facilitator: Dr Kirsten Whitehead
Details: This one-day course is a mix of theory and practice. It will introduce the subject of behaviour change and the person-centred approach, including some of the evidence base and policy. There will also be some practical activities to help develop your communication skills for working in a person-centred way.

November

Advancing Dietetics in Eating Disorders (two days)

Provider: British Dietetic Association
Date: 2 & 3 November
Venue: BDA office, Birmingham
Facilitators: Christian Lee and Stephanie Sloan
Details: This course has been developed to provide dietitians specialising in eating disorders with the essential knowledge and skills required to work in this area. It is aimed at dietitians new to eating disorders who need more depth than the BDA Introduction to Mental Health, Learning Disabilities and Eating Disorders (ED) course or dietitians wanting to specialise in or who have an interest in ED.

Advancing Skills for Independent Delivery of the BDA Work Ready Programme

Provider: British Dietetic Association
Date: 6-7 November
Venue: Virtual classroom
Facilitator: Sue Baic
Details: This course is intended for dietitians who have some experience in health promotion/workplace health interventions and is being run to accredit BDA members as BDA Work Ready dietitians which will allow access to the full range of resources and use of a logo on publicity materials.

DSW – Competency and Professional Practice Training

Provider: British Dietetic Association
Date: 8 November
Venue: Virtual classroom
Facilitator: Dr Fiona McCullough
Details: This one-day online course is aimed at dietetic support workers working in both acute and community settings. It will be suitable for those relatively new in post and as a useful update for those with some previous knowledge and experience.

Starting out in Paediatric Dietetics

Provider: British Dietetic Association
Date: 15 November
Venue: BDA office, Birmingham
Facilitators: Sue Meredith and Angharad Banner
Details: This online course aims to introduce the key aspects of paediatric dietetics for dietitians starting out on their paediatric dietetic careers.

Advancing Dietetics in Mental Health (two days)

Provider: British Dietetic Association
Date: 21 & 28 November
Venue: Virtual classroom
Facilitators: Caroline Frascina and Rebecca Halsey
Details: This two-day course is aimed at: dietitians new to mental health who need more depth than the BDA Introduction to Mental Health, Learning Disabilities and Eating Disorders course; dietitians who want to specialise in or who have an interest in mental health; dietitians wanting an update in mental health.

This course will provide dietitians specialising in mental health with the essential knowledge and skills required to work in this area.

February 2024

Enhancing Communication Skills in Practice for Dietetic Support Workers

Provider: British Dietetic Association
Date: 7 February
Venue: BDA office, Birmingham
Facilitator: Dr Fiona McCullough
Details: This one-day course is aimed at dietetic support workers working in both acute and community settings.

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