



**Guidance –
Commissioning Excellent
Nutrition and Hydration
2015 – 2018**

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Guidance – Commissioning Excellent Nutrition and Hydration

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The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

“Promoting equality and addressing health inequalities are at the heart of NHS England’s values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it;
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities.”

Other formats of this document are available on request.

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Malnutrition is common in the UK, affecting more than three million people at any one time. Around 1 in 3 patients admitted to acute care will be malnourished or at risk of becoming so, and 35 percent of individuals admitted to care homes will also be affected. In addition 93 percent of those at risk of, or suffering, from malnutrition will be living in the community.

The scale of dehydration in the UK is unknown but is associated with a number of known causes of harm to people.

Executive Foreword

“The link between nutrition and hydration and a person’s health is a fundamental part of any stage of life, but all the more so for the sick or vulnerable. Person-focussed, quality compassionate care involves looking at what matters to a person as a whole, not only concentrating on their specific medical condition. This document draws together resources and research which will stimulate thinking about and approaches to the central role of nutrition and hydration in caring for people”. **Jane Cummings, Chief Nursing Officer for England**

Malnutrition and dehydration are both causes and consequences of illness, have significant impacts on health outcomes and are integral to all care pathways. Surprisingly, these problems are still poorly recognised in English community and health care settings despite numerous reports which have highlighted the fact that individuals in these settings often receive inadequate nutrition and hydration.¹

The aim of this guidance is to support commissioners to address these issues and develop strategies to improve the delivery and commissioning of excellent nutrition and hydration care in acute services and the community.

It can also support commissioners to deliver an number of commissioning priorities as outlined in The Five Year Forward View (NHS England, 2014), including continued improvements in delivering integrated commissioning; Improving the quality of care for people with cancer; transforming care for people with learning disabilities; supporting those with mental health issues; strengthening primary care services; and improving the efficiency of urgent and acute care delivery. This is due to the impact that malnutrition and dehydration has on clinical outcomes for adults, children and young people.

The cost for disease-related malnutrition for health and social care expenditure is more than £13 billion. (Elia and Russell for BAPEN, 2009).

Improving the identification and treatment of malnutrition is estimated to have the third highest potential to deliver cost savings to the NHS. (The National Institute for Health and Care Excellence (NICE, 2011)

The document outlines:

- Why commissioners should make nutrition and hydration a priority
- How to tackle the problem
- How to assess the impact of commissioned services
- How commissioners have begun to tackle the problem via commissioning
- Further resources to help commissioners address the issue.

It has been produced in collaboration with commissioners, national organisations and the feedback from the public.

Throughout this document there are a number of commissioning examples that offer approaches which could be adopted to support the realisation of this vision at a local level.

We therefore urge all commissioners to view nutrition and hydration as a priority and apply this guidance as appropriate within your commissioning responsibilities.

¹ Francis, 2013; CQC, 2011; (BAPEN and PINNT, 2014; 2014) (Vizard and Burchardt 2015).

“This is a practical guide, not only for commissioners but also for providers and other key stakeholders including service users.

It will encourage local dialogue to improve nutrition and hydration and as a consequence realise other important benefits such as reducing risk of falls and making best use of nutritional supplements.

It emphasises a person-centred approach and helpfully gathers together the evidence”.

Suzanne Rastrick, Chief Allied Health Professions Officer, NHS England

Our Vision

All people will receive safe and high quality nutrition and hydration support when required, through the commissioning of person-centred and clinically effective integrated services in the community and in health care commissioned settings.

1. Introduction

This document provides guidance for commissioners with regard to commissioning for the nutrition and hydration needs of their population in order to support the ambition stated in our vision. This work is part of the NHS England Hard Truths commitments in response to the Francis Report (Francis, 2013) and supports the Department of Health's (DH) request to develop strategies to improve the delivery of adequate nutrition and hydration services in hospital. It also will contribute to the delivery of The Five Year Forward View. (NHS England, 2014)

The significant contribution of individuals, carers, families, volunteers and the independent, community and voluntary sectors has also driven the context of this area of care.

This document provides examples of commissioning approaches that can be adopted locally to improve the nutrition and hydration care of the population. A resources repository is available to support commissioners. It can be accessed at the NHS Website at <http://www.england.nhs.uk/ourwork/commissioning/nut-hyd/>

It has been developed with engagement and involvement from key stakeholders and partners including NHS clinical commissioning groups, the third sector; independent catering and wider industry; regulators including the Care Quality Commission (CQC), NHS Trust Development Authority (TDA); the Department of Health; local authority commissioners, carers and people who use health care services. (Refer to Acknowledgements)

The ongoing complex nutrition and hydration care needs associated with intestinal failure problems form part of specialised commissioning and are not covered by this document.

1.1 Scale of malnutrition and dehydration

Malnutrition is common in the UK, affecting more than three million people (AHP, 2012) at any one time. Around 1 in 3 of your patients admitted to acute care will be malnourished or at risk of becoming so (NICE, 2011), and 35 percent of individuals admitted to your care homes will be affected; for those living in the community 93 percent of those will be suffering from malnutrition. (Wise, 2015) The under nutrition of children and young people is usually associated with poverty and poor food choices. Dehydration is also common although the overall numbers affected are less clear.

The excess annual health costs associated with malnutrition alone are estimated to exceed £13 billion. (Elia & Russell for BAPEN, 2009). Therefore it is essential that malnutrition and dehydration problems are better recognised and treated. An additional benefit is the reduction of pharmaceutical waste, resulting in better use of scarce resources.

1.2 Impact on health

Both malnutrition and dehydration have substantial adverse effects on health, disease and well-being in community, residential care and hospital settings. Yet despite good evidence that specific efforts to correct the problems improve health outcomes, they often go unrecognised and untreated.

Malnutrition and dehydration also have a substantial impact on the health economy with increased demands on General Practice services, out of hours services and increased rates of transition across pathways of care.

Once in hospital patients average length of stay is three days longer (Guest et al, 2011; Stratton et al, 2003; Elia et al, 2009), mortality rates are high and failed discharges are frequent. NICE has shown that better nutritional care reduces complications and length of stay and NICE cost saving calculations show that better nutritional care is achievable with substantial savings in net NHS costs. (NICE, 2011)

Carers UK's evidence from families providing care, suggests additional benefits in terms of reduced caring activities which has an economic impact and improved quality of life.

Commissioners should therefore ensure that the health and social care organisations for which they are responsible:

- prevent malnutrition and dehydration from occurring
- identify when malnutrition has occurred through the use of active nutritional screening e.g. using the Malnutrition Universal Screening Tool ('MUST') for adults and an appropriate pediatric tool
- specifically treat those at risk from malnutrition or dehydration using documented, appropriate, NICE compliant care pathways (utilising food, drinks, oral nutritional supplements and safely administered tube or intravenous feeds/fluids as necessary) with ongoing specific care spanning organisational boundaries where needed www.malnutritionpathway.co.uk
- educate all staff, voluntary workers, patients and carers on the importance of good nutrition and hydration in maintaining better health and wellbeing, improving recovery from illness or injury and in the management of long-term conditions
- take into account the duties placed on them under the Equality Act 2010 and with regard to reducing health inequalities, duties under the Health and Social Care Act 2012. Also that service design and communications should be appropriate and accessible to meet the needs of diverse communities. (NHS England, 2014 <http://www.england.nhs.uk/ourwork/gov/equality-hub/legal-duties/>)

1.3 Definition of malnutrition and dehydration

For the purpose of this document the following definitions apply:

NICE defines **malnutrition** as:

"a state in which a deficiency of nutrients such as energy, protein, vitamins and minerals causes measurable adverse effects on body composition, function (including social and psychological) and clinical outcome." (NICE, 2012)

Dehydration can be defined as:

"a state in which a relative deficiency of fluid causes adverse effects on function and clinical outcome. In the elderly being short of fluid is far more common, results from limited fluid intake, and is reflected in raised osmolality". (This has been developed for this guidance.)

2. What are the outcomes needed from commissioned services?

2.1 Key outcomes

The key outcomes for commissioners to be achieved by March 2018 are to:

1. Identify a local senior/executive champion who can drive the work forward and influence key stakeholders to make improvements.
2. Understand the local burden of malnutrition and hydration and commission services as identified by this evaluation.
3. Review existing service provision and agree improvement trajectories.
4. Commission services that:
 - (a) Identify 'at risk' populations that include the needs of a diverse community and reducing health inequalities.
 - (b) Implement appropriate interventions and evaluate their effectiveness;
 - (c) Develop and implement strategies to prevent malnutrition and dehydration.
 - (d) Connect hospital and community services to deliver an integrated nutritional and hydration pathway of care across the health economy.
 - (e) Strengthen families and patients resilience by learning about prevention, maintenance and management of nutrition and hydration.
 - (f) For children and young people, incorporate the psychological, emotional and interactional aspects of feeding relationship to ensure adequate intake.
5. Commission a workforce that has the necessary skills to undertake identification, prevention and intervention to reduce burden of malnutrition and dehydration.
6. Increase public awareness of the importance of good nutrition and hydration and of the local services available to provide support if needed.
7. Maximise opportunities for working across health and social care using the Care Act (2014).
8. Define clear outcomes for 'at risk' populations to ensure any commissioned interventions are sustained.
9. Consider how data systems can be optimised to permit monitoring and evaluation.
10. Ensure patient/service user involvement in service development and quality assurance of commissioned services. Taking into account the needs of diverse communities.
11. To ensure paediatric services are delivering high quality and safe nutritional care for children and young people in a child friendly setting with appropriately trained staff.
12. To ensure that children and young people grow and develop normally and monitored according to growth centiles.



Commissioning approach: Greenwich CCG work on reviewing current practice and improving nutrition in nursing homes and GP practices work was secured via QIPP and was identified as an ideal project for the [‘Better Care Fund’](#). For more information on the commissioning needs of children and young people refer to BAPEN commissioning tool kit and appendix 1.

3. Activities that will help to achieve these outcomes

The activities below can contribute to commissioners achieving the outcomes outlined in section 3.1.

3.1 Understand your current position

- Undertake an assessment of the at risk population (as in BAPEN nutritional care tool www.data.bapen.org.uk or NICE QS 24)
- Undertake an assessment of current screening and provision of nutritional care in the community and commissioned services. (as in BAPEN nutritional care tool)
- Agree the current position with providers as a baseline for improvement
- Identify improvement plans for providers via quality schedule and governance assurance processes
- When commissioning and evaluating nutrition and hydration services take into account the duties under the Equality Act 2010 and with regard to reducing health inequalities, duties under the Health and Social Care Act 2012.

3.2 Develop commissioning improvement plans

3.2.1 Improving commissioning

- Establish a nutrition and hydration group with membership that includes representatives from health and social care and agree a work plan
- Identify systems that support the integration of nutritional and hydration care across pathways (for nutrition refer www.malnutritionpathway.co.uk)
- Identify effective communication processes between the different parts of the health economy that lead to an integrated care pathway
- Develop service specifications and management structures to ensure high standards of nutrition and hydration care are using food and drink, oral nutritional supplements, enteral tube feeding provision or intravenous support as necessary ensuring appropriateness and safe standards of practice in line with NICE Clinical Guidance CG32 and associated QS24 and CG 174
- View malnutrition and dehydration as a safeguarding issue and incorporate into local improvement plans (see Social Care Institute for Excellence resource <http://www.scie.org.uk/publications/guides/guide46/commonissues/poornutritionalcare.asp>)
- Undertake a commissioning review with regard to the appropriate use of nutritional supplements via medicines optimisation and the management of adult nutrition in the community. (refer to Greenwich CCG and Salford CCG commissioning approach for improvement in clinical outcomes and financial efficiencies) <http://www.england.nhs.uk/ourwork/commissioning/nut-hyd/>

3.2.2 Improving provider provision

- Develop quality frameworks to support provider organisations to put nutrition and hydration at the heart of care
- Consider commissioning services whereby provision is via a number of providers including the voluntary sector and health providers. This can harness the community as a resource e.g. via volunteering opportunities

- Develop screening, assessment and care pathways (refer NICE Clinical Guideline and Quality Standards for Nutrition)
- Apply appropriate sanctions and incentives within contractual arrangements that allow commissioners to reward or sanction provider's service delivery.



Commissioning Approach: Staffordshire County Council has supported a partnership programme led by Age UK South Staffordshire to deliver support to those 'at risk' via trained volunteers. They work with primary and community care services. (Further information is in the repository <http://www.england.nhs.uk/ourwork/commissioning/nut-hyd/>)

3.3 Provide education and training

- Raise awareness and knowledge amongst the workforce have the skills and competencies required to meet the needs of the population. Highlight particular risk at discharge or transition
- Raise awareness amongst the public, patients, service users and their carers of the risk of malnutrition and dehydration and how to prevent or re-address. (as in to NHS England Transforming Participation in Health and Care NHS Toolkit – <http://www.england.nhs.uk/ourwork/patients/participation/>)
- Ensure that learning materials for patients and carers that are already developed are used to increase knowledge on how to manage conditions as well as awareness e.g. dementia, cancer, etc. (Carers UK resource : <http://www.carersuk.org/for-professionals/policy/policy-library/spotlight-on-caring-and-nutrition>).



Commissioning approach: County Durham and Darlington NHS Foundation Trust improvement work in nursing homes <http://www.focusonundernutrition.co.uk/home>

3.4 Develop quality indicators to support monitoring and review

- Identify and agree outcome measures with service providers.
- Ensure effective contract monitoring is ensuring standards and key performance indicators are achieved (for acute services refer to Hospital Food Standards SC19 in NHS Contract)
- Harness the use of incentives and sanctions to improve the performance and quality of services commissioned. (refer to BAPEN nutritional care tool for dashboard screening <http://www.bapen.org.uk/#>)

4. Monitoring and evaluation

Monitoring and evaluation of the commissioned services are essential to ensure the achievement of the outcomes and actions within this guidance. Quality assurance mechanisms and data sources already exist to evaluate several aspects of care described and commissioners may choose to develop further local indicators.

- **Quality schedule:** The quality schedule provides a clear primary focus for NHS England and NHS clinical commissioning groups to monitor and receive assurance from providers about the delivery of high quality care. Data can be triangulated across the quality schedule to create an early warning system
- **Contract specification:** Monitoring via the contract specification process, the key performance indicators that relate to nutrition and hydration
- **Patient reported data sources:** Information relating to nutrition and hydration is collected across a range of DH, NHS England and CQC patient and organisational surveys, including Estates Return Information Collection (ERIC) data, patient-led assessments of the care environment (PLACE) assessments, CQC in-patient survey; Accident and Emergency (A&E) patient experience survey; complaints intelligence; safeguarding (number of issues relating to malnutrition and dehydration; data on patient safety incidents.)
- **Benchmarking tools:** the in-patient experience tool kit <https://www.england.nhs.uk/2015/04/07/inpatient-toolkit/> allows benchmarking of key performance indicators for inpatient experience of care and BAPEN nutrition care toolkit can be used in hospitals and care homes to assess screening, care pathways and both patient experience and nutritional outcomes
- Ensure providers have nutrition and hydration strategy/plans and evaluate outcomes relating to delivery of strategy. (for acute services refer to Hospital Food Standards SC19 in NHS Contract)
- Use NICE QS 24 to compare against standards work with local Healthwatch and other public involvement processes to gain an independent review to feedback to CCG/local commissioners.



Commissioning Approach: A number of commissioners (Greenwich CCG; Bedford and Luton CCG; Staffordshire County Council; Salford CCG; Gateshead CCG; and others) have been working with care homes. The aim is to improve medical optimisation and primary care delivery by improving the nutrition and hydration of people in the home and increase the appropriate use of other services by the home. For details go to: <http://www.england.nhs.uk/ourwork/commissioning/nut-hyd/>

4.1 Improving experience

4.1.1 Patient/service user/carer involvement in commissioning

The participation of the public and carers within the commissioning process can also provide greater insight into the quality of the services that have been commissioned. It is also a legal requirement for health and social care commissioners (Section 13Q of the Health and Social Care Act, 2006; 14z(2) for CCGs).

The participation of the public and carers can include:

- **Strategic planning** – involve patients/service users (and carers) fully to identify and understand their needs and the gaps in the current services from the service user perspective (for example – the need for good nutritional information before, during and after treatment for cancer; support available for those needing nutritional intervention). Discuss how this relates to service provision from both primary and secondary care (help wanted at both hospital and GP stage of care and upon discharge which is an important stage of recovery).

- **Specifying outcomes and procuring services** – discuss with people how the objectives might be delivered and what are the required outcomes (seeing a dietitian; good information on discharge; clinical outcomes – reduced exacerbation of condition in case of COPD, improved wound healing and less complications. Discuss the procurement implications (for example – more nutrition experts in local community or primary care, outcomes based commissioning and true partnership working.)
- **Managing demand and performance.** Discuss with people the way in which outcomes can be measured. For example: measure number of dietitians and waiting times; survey to check more cancer patients receive nutritional advice; use of out of hours services, number of primary care GP visits; unavoidable hospital admissions.



Useful resources: NHS England Choosing and Buying Services Together – Patient and Public Engagement in Commissioning <http://www.patientpublicinvolvement.com/news/a-practical-guide-for-patient-and-public-engagement-in-commissioning/> for people experiences: <http://nutritionandhydrationweek.co.uk/campaign-resources/patient-and-service-user-stories/>; NHS England – Transforming Participation in Health and Care guidance <http://www.england.nhs.uk/ourwork/patients/participation/>

4.1.2 Snapshot – patient and carers' views

During the production of this document The Patients Association gained a snapshot of feedback from patients/service users and carers about their experience of food and drink, via analysis of helpline calls from February – May 2015 and other sources.

The main themes from this were:

1. Ensure patients have regular and appropriate food and drink when attending hospital.

“My partner developed an abscess and was admitted to hospital. There was a long wait for the doctor... I told nurses the patient was dehydrated – one nurse said they couldn't do anything until the doctor came and that I should go home. Another nurse agreed with me that he should not have been left that long and put in a cannula (with difficulty due to dehydration) – he had been without anything to eat or drink for 11.5 hours by this time”.

“My brother has renal failure and is often in hospital. He is not encouraged to eat, meals are taken away when he has had very little and no one sees if there is something else he may eat. Staff bring in meals when he has gone off for dialysis and then take away the untouched plate before he returns. One day he had no food at all. Staff are not checking whether he has had anything to eat”.

2. Offer patients advice on nutrition and hydration and promote self-care

“The one area I would criticise about my cancer care... lack of advice about diet and nutrition. I was given no guidance even though I asked my GP... You lose a lot of weight with treatment and get very tired... Looking after your diet helps you get some power back, some control over your life”.

3. Offer carers and relatives guidance about nutrition and hydration so they help the person they care for and themselves

“My husband is a cancer/dialysis patient. On discharge he was not given any instructions related to his diet or nutrition, despite being seriously ill and loss of weight. I was appalled at the lack of any follow up regarding diet from the hospital doctors. It was my actions which ensured that my husband gradually regained his strength and appetite.... This ensured he did not have to return to hospital”.

“I think she has a reasonably balanced diet but it is difficult to know if she always eats. If I had more support I could encourage Mum to eat more.” (Carers UK, 2012)

The Care Act (2014) indicates that carers’ nutritional needs should be taken into account, particularly if ‘the carer’s physical or mental health is, or is at risk of, deteriorating’ (section 3(2)(a)). This would cover situations where the carers’ health was at risk because of a lack of ability or time to manage positive nutrition. Secondly, there is a specific criteria under section 3(2)(b)(iv) under the carers eligibility criteria: ‘Managing and maintaining nutrition’.



Useful resources: Malnutrition community pathway patient information section; BAPEN self-screening advice for patients and relatives so that patients/carers are empowered to self-manage; for carers <http://www.carersuk.org/for-professionals/policy/policy-library/spotlight-on-caring-and-nutrition> or www.malnutritionpathway.co.uk Guidance for NHS commissioners on Equality and Health Inequalities legal duties <http://www.england.nhs.uk/ourwork/gov/equality-hub/legal-duties/>

5. Guidance: Next Steps

In conclusion there are a number of first steps it is advised that commissioners undertake:

1. Ensure commissioning intentions include a focus on prevention of malnutrition and dehydration.
2. Undertake steps to understand the needs of your local population through effective engagement with the public and local providers.
3. Assess the baseline of your local providers provision against NICE guidelines and best practice.
4. Develop nutrition and hydration care pathways to meet your population's needs.
5. Ensure nutrition and hydration outcomes are in the contracting, quality assurance and performance monitoring of commissioned services.
6. Monitor and evaluate the outcomes of commissioning intentions for nutrition and hydration.
7. Deliver continuous improvements of nutrition and hydration needs of the local population through setting an improvement trajectory
8. Ensure the commissioning process is taking an integrated approach that provides the delivery of an all-encompassing approach that takes into account all aspects of nutritional care including, psychological, physical and social aspects.

6. Examples of Commissioning approaches and resources repository

A resources repository has been developed on the NHS England website. This contains further details of the commissioning approaches in this guidance including contact details of the commissioners and further resources. The repository can be accessed at this link: <http://www.england.nhs.uk/ourwork/commissioning/nut-hyd/>

7. Acknowledgments

7.1 Commissioners

Thank you to all of the commissioners below who have been involved in the development of this document.

Rena Amin	Joint Associate Director Medicine Management	NHS Greenwich CCG
Jayne Louise Sivakumar	Head of Service Development	NHS Barnsley CCG
Catherine Whitehouse	Deputy Executive Nurse	NHS Redditch and Bromsgrove CCG
Jo Galloway	Executive Nurse, Quality and Patient Safety	NHS Redditch and Bromsgrove CCG
Nicola Day	Public Health Commissioning Lead	Staffordshire County Council
Lucy Gratton	Public Health Commissioning	Staffordshire County Council
Susan Little	Quality Assurance Lead	Herefordshire CCG
Deborah Turner	Head of Quality and Patient Safety (Chief Nurse)	NHS North Kirklees CCG
Marianne Smith	Nursing and Patient Safety Advisor	NHS South Warwickshire CCG
Philippa Potter	Regional Associate Director of Nursing	NHS England (South)
Paula Wilkins	Assistant Director Quality Assurance	Kent and Medway Area Team
Alison Smith RD	Prescribing Support Dietician	Aylesbury Vale CCG and Chiltern CCG
Wendy Hope	Lead Nurse Clinical Governance	Leicester City CCG
Debbie Parker	Clinical Programme Manager for Compassion in Practice (London)	NHS England (London)
Charlotte Brown	Funded Nursing Care Co-ordinator	South West CSU
Alison Kyle	Head of Dietetics	Yeovil District Hospital
Rachel Oostr	Dietetic Advisor	NHS Greenwich CCG
Elizabeth Beech	Healthcare Acquired Infection and Antimicrobial Resistance Project Lead & Prescribing Advisor	NHS Bath and North East Somerset CCG & NHS England Patient Safety Team
Jennifer Owen	Deputy Chief Nurse	Halton CCG

Finola Syron	Vulnerable Adults Project Manager	NHS England (London Region)
Fiona Fretter	Quality Lead	East Leicestershire and Rutland CCG
Sarah Timms	Registered Nurse Member	Haringey CCG
Mary Hopper	Director of Quality	NHS Sutton CCG
Sian Huszak	Patient Experience Manager	NHS England – North Midlands
Jackie Williams	Head of Quality	Herts Valleys CCG
Joan Plant		Herts Valleys CCG
Karen Sobey Hudson	Clinical Quality Manager [Patient Safety]	NHS England, London
Phil Willan	Patient Representative	
Marion Shipman	Assistant Director Governance and Quality	Lambeth Clinical Commissioning Group
Liz Slater	Nurse Manager – Patient Experience	NHS England North Region
Dr Katrina Lake	Deputy Director of Quality – Patient Experience and Safeguarding	NHS England South (South East)
Cathy Forbes	Food First Dietitian	South Essex Partnership Trust commissioned by Luton CCG and Bedfordshire CCG
Vittoria Romano	Food First Dietitian	South Essex partnership FT
Emma Stratton	Public Health	Leeds City Council
Derek Johnson	Principal Catering Manager	Leeds City Council
Richard Porter	Health Improvement Specialist (Older People) Public Health	Leeds City Council

7.2 National Strategic Advisory Group members

Thank you to all the people below who have been involved in the development of this document via the National Strategic Advisory Group.

Andy Burman	Chief Executive	The British Dietetic Association
Kate Hall	External Affairs Manager	Nutricia Ltd/Malnutrition Task Force
Ruthe Isden		Age UK/Malnutrition Task Force
Andy Jones	Immediate Past Chair	Hospital Caterers Association
Dr Liz Jones	Head of Patient Environment Commercial Division	Department of Health
Lee Sheppard	Director of Public Policy & External Affairs	Apetito Ltd/Malnutrition Task Force
Mike Stroud	Chair	British Association for Parenteral and Enteral Nutrition (BAPEN)
Ailsa Brotherton	Clinical Quality Director (North)	NHS Trust Development Authority/BAPEN
Liz Evans	Chair	National Nurses Nutrition group
Heather Eardley	Development Director	Patients Association
Phil Willan		Patient Representative
Adam Michallat-Cox	Deputy Chair	National Association of Care Catering
Mike Durkin	Director of Safety	NHS England

7.3 Other Acknowledgments

Thank you to all the people below who have provided advice in the development of this document.

Emily Holzhausen	Director of Policy and Public Affairs	Carers UK
Angela Horsley	Senior Nurse Children and Young People National	NHS England
Sue Hill	Chairperson	British Society of Paediatric Gastroenterology, hepatology and nutrition
Stacey McCann	Commissioning Nurses Lead	NHS England

8. Involvement of patients, carers and public

Patients, carers and public were involved in all aspects of the development of this guidance via direct contact (Patient representative on strategic group; public feedback via patients association telephone line) and through public representative national groups – Age UK; Patient Association; Carers UK.

9. References

Allied Health Professionals. (2012) QIPP and ONS toolkit – a guide for healthcare commissioners.’ Endorsed by all AHP colleges including the BDA and the RCSLT.

<https://www.networks.nhs.uk/nhs-networks/ahp-networks/ahp-qipp-toolkits>

British Association of Parenteral and Enteral Nutrition, BAPEN. (2015) Nutritional Care Tool

<http://www.bapen.org.uk/news-and-media/news/bapen-nutritional-care-tool>

BAPEN and PINNT. (2014)

Improving Patient/Public Experiences: Nutritional Care and the Patient Voice: Are we being listened to?

<https://www.networks.nhs.uk/nhs-networks/ahp-networks/ahp-qipp-toolkits>

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Meeting Quality Standards in Nutritional Care: A Toolkit for Commissioners and Providers in England

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10. Appendix 1: Nutritional matters of particular relevance to paediatrics

This Appendix is reproduced with the permission of BAPEN (2015) and is taken from the commissioning toolkit. It highlights some of the additional issues which should be considered when commissioning paediatric services.

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

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

10.1 Key steps in commissioning nutritional support services

1. Define high risk groups for example:
 - children with neurodisabilities
 - children born prematurely
 - children living in deprived circumstances
 - children with black and ethnic or cultural minority backgrounds
 - children with chronic intestinal disorders (gluten intolerance, inflammatory bowel disease, cholestatic liver disease, cystic fibrosis, intestinal failure)
 - children with chronic illness impacting on nutrition (congenital heart disease, cerebral palsy, juvenile onset diabetes, chronic renal failure)
 - young people in transition from paediatric to adult services
2. Benchmark local services against those provided in centres of excellence, using evidence acquired from registries and outcome audits
3. Train health visitors, paediatric nurses, social workers, dietitians and paediatricians in nutritional screening and the indications for onward referral for nutritional assessment and support
4. All children admitted to hospital to have height and weight measured, recorded and plotted on UK-WHO growth chart

5. Clear referral guidelines for nutritional assessments of children considered potentially to be suffering from malnutrition i.e. weight for height $<-2SDS$ or height for age $<-2sds$
6. Staff working with children will need to have gained specifically appropriate knowledge, skills and competencies.
7. Multi-disciplinary teams (MDT) are needed to ensure that care pathways are followed and parents are supported in delivering the treatment for their child. In some situations this will require specific nutritional MDT's (e.g. nutrition steering committees and nutrition support teams in acute hospital trusts), whilst in other long-term conditions such as inflammatory bowel disease (IBD) cooperation between local paediatric services (e.g. local paediatrician and paediatric dietitian) and tertiary hospital IBD specialists (e.g. paediatric gastroenterologist and paediatric IBD specialist dietitian) will be commissioned.
8. Availability of protocols and care plans for children with or at risk of malnutrition.
9. Patient surveys including Quality of Life questionnaires for child and parents/carers.
10. Appropriate information for children and their families using multi-media
11. Documentation of use of nutritional screening tool (STAMP, PYMS or STRONGkids) and results recorded in clinical record and in letters communicated with GP and other members of the multi-disciplinary team.
12. Patients have access to multi-disciplinary teams and support provided according to agreed care plans.

