DIETETICS TODAY

BE INFORMED • BE INSPIRED | BDA MEMBERSHIP MAGAZINE | NOVEMBER 2022

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MIND YOUR **LANGUAGE**

How to avoid stigma and promote inclusion in our work

CLINICAL PRACTICE

- **SERVICE EVALUATION STUDIES**
- **USING A FOOD PYRAMID IN ANOREXIA NERVOSA TREATMENT**

LEARNING DISABILITIES
Ask the right questions

DIABETES
Improving outcomes in the black community

EATWELL GUIDE
Time for a re-think?

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The importance of communication

How we say things is just as important as what we say

Communication is one of the most important skills in all of healthcare.

It is not just a straightforward exchange of information. How we say things is just as important as what we say, if we are to engage patients, colleagues and stakeholders and foster inclusivity. Equally, listening without prejudice is vital if we are to gain a clear picture of others' perspectives.

Last year, the BDA published guidelines on reducing weight stigma, particularly in written and published communications. On page 22, a group of BDA members look at how we can use this approach in our professional practice. Although the focus of the piece is on body positivity and weight, they consider the influence of conscious and unconscious biases when dealing with all patients.

Communication can be especially difficult for people with some learning disabilities and, on page 26, Briony Caffrey explains how important it is to ask the right questions to ensure you are getting accurate information from the patient, rather than interpreting what you think they mean.

Ellouise Simpson looks at how people from black African and Caribbean backgrounds are at greater risk of type 2 diabetes mellitus than white Europeans (page 20). People from black communities in the UK often feel there is a lack of cultural understanding within healthcare. Ellouise explains what we can do to better understand cultures different from our own and improve outcomes.

The BDA maintained a strong presence at the Trades Union Congress and I am pleased to say that both our motions – on the Food Emergency and Inequalities in Health – passed. We look forward to working with the TUC in lobbying for a National Food Strategy worthy of the name and challenging inequalities in health.

Strong support for NHS and other public sector workers was a theme throughout the congress. There was also a recognition that for workers to weather the current economic crisis it is vital that we support one another as we campaign, lobby, and if needs be strike.

Caroline Bovey

Caroline Bovey
Chair, BDA

MEMBERS GET MORE

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 the reader in touch with the wider membership and profession.

HAVE YOUR SAY

We like to hear from readers about the magazine or issues facing the profession. You can email us at **editor@bda.uk.com**

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

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BDA guidelines for working with commercial companies

PARTNERSHIPS

An updated set of guidelines for approaching commercial partnerships for BDA organisations has been launched.

First published as the 'BDA Guidelines for Sponsorship and Collaborative Partnerships' in 2007, a robust and transparent framework for approaching commercial partnerships is an essential part of the BDA governance toolkit.

The partnerships team, specialist groups and branch committees and others undertaking commercial partnerships on behalf of the Association use our detailed guidelines and assessment toolkit to apply our principles for working with commercial partners, and navigate decisions for evaluating an initiative using a consistent risk/opportunity-based approach.

This updated version is still published as two documents: a set of guidelines and a toolkit for their application. It aims to build on the successes of the past years and lessons learned, to support and develop the continued commercial work of the BDA and its members.

The update was approved by the BDA Board of Directors in August, and reflects the current BDA strategic plan as well as adding a new section to ensure collaborations support and promote the principles of inclusiveness and equality for all.

BDA Partnerships Manager Jo Lewis said: "We know that people are often surprised at the depth of our assessment process, which can include an interrogation of annual and corporate social responsibility reports, media and social media coverage, the role of dietitians within the business, the published evidence to support the project communications and any unrelated activities which could be harmful to the reputation of the BDA and its members."

If you would like a copy of the guidelines – of if you have any questions or other feedback, contact **partnerships@bda.uk.com**.

Read the updated guidelines here: **bda.uk.com/news-campaigns/work-with-us/our-work-with-commercial-companies.html**

Dedicated Dietitians raise almost £7,500 in memory of colleague

CHARITY

A team from NHS Greater Glasgow and Clyde's Paediatric Dietetic Service donned their running shoes to raise almost £7,500 in memory of their colleague who died from cancer.

Paediatric dietitians Rebecca Ritchie, Laura McIntyre, Carla Young, Orlaith McGuinness, Cat Campbell, Fiona Woods, Kirsty Leighton, Sarah Bremner and Lorraine Cairns, dietitian Rachel Mulcahy, dietetic support worker Peri Wallach and paediatric pharmacist Shahad Abbas all completed a half marathon at the Great Scottish Run earlier this month.

Lorraine Cairns also took part in the Kiltwalk walking event in April, alongside fellow paediatric dietitians Tracey Cardigan and Rachel Mochrie. The trio completed the 22.6-mile walk, raising £2,487.

The team, who are all based at Royal Hospital for Children Glasgow, then set an initial £2,000 target for the half marathon, which has been smashed with the fundraising figure now at £4,870, meaning a total of £7,357 has been raised across the two events – with more still coming in.

They took on the challenge following the tragic loss of colleague and BDA member Morven Pollock, who died aged just 43 last December following a short battle with cancer.

Laura McIntyre said: "The loss of Morven came as a real shock to all of us and we were heartbroken to lose our dear friend and colleague. We really wanted to get together and do something, not only to honour Morven, but to support the services that helped her in her final days and weeks.

"None of the team could be properly described as a runner but Morven was passionate about fitness and we couldn't think of a better challenge to do in her honour.

"She had a huge zest for life so we've adopted the mentality of #BeMoreMorv in our department."

Laura said: "The training was tough. I was already running 5K on a regular basis but a half marathon was a huge step up.

"The day had the most amazing atmosphere and the sun even came out for us. The excitement at the start was high and the entertainment throughout the run was great. Doing it with my colleagues made it extra special."

Sarah Bremner said: "I am really glad that I took part in the half marathon and the day was full of excitement and emotion. Seeing our cheerleading colleagues towards the end helped give me the boost I needed to get across the finish line."

Carla Young added: "It was a fantastic day. I found the run really challenging – from halfway I had to dig deep, but the motivation of doing it in memory of Morv, for two great charities, really helped keep me going. I was so glad to see our colleagues near the end, cheering us on – that made me emotional but pushed me to finish. Everyone did so well."

The funds will be split between The Beatson Cancer Charity, where Morven received her treatment, and The Prince and Princess of Wales Hospice in Glasgow, who provided fantastic care of Morven and supported her family and friends in her final days.

If you'd like to donate to the fundraiser, you can do so here: **justgiving.com/crowdfunding/bemoremorvhalfmarathon**

AWARD WIN FOR FUTURE LEADERS PROGRAMME

AWARDS

The BDA's Future Leaders Programme has won a prestigious Association Excellence Award (AEA) for Best Innovation by an Association.

The Association Excellence Awards celebrate the work that membership associations, trade bodies, professional organisations and chartered institutes do for and on behalf of their members.

In a competitive category, the programme was praised for how it supports other professional associations, beyond just the BDA, as well as developing talent within the membership.

Liz Stockley, CEO of the BDA, attended the awards ceremony at the Kia Oval in London on 14 October, alongside Milly Durrant, Director of Membership, Marketing and Communications.

Liz said: "As the new CEO at the BDA, I can't tell you how proud I am to serve an award-winning association. Our Future Leaders Programme is a real jewel in our crown, supporting us and other associations to develop talent from within the membership to take on leadership roles in the future.

"This was a project that was very close to Andy Burman's heart. My predecessor drove it forward to be the successful and innovative programme it is today. I'll be doing the same too, providing opportunities and support for members of ours and other associations to lead with vision and courage."

The Future Leaders Programme was created by the BDA and is approved by the Institute of Leadership and Management. It's not designed to develop profession-specific leadership (i.e. members in their paid jobs) but is designed to support members of associations who will be better placed to lead their associations in the future, driving effective succession planning and governance excellence.

On explaining why the BDA won, the AEA stated: "The judges marked this high, as it showcases a thorough programme which is now being used by 12 other organisations, so has a lasting impact beyond the BDA. This innovation creates a culture of 'by professional associations, for professional associations', which fosters collaboration on competition.

"One member that went through the programme said, 'It's been an honour to feel valued as a member and be included in the programme, which makes me want to give back to an organisation that I value even more now I understand some of the complexities in how it's run!'"

NEW SCOTLAND BOARD CHAIR

BOARDS

Christine Brown has been appointed as the new Scotland Board Chair.

Christine comes with a wealth of experience, having a 42-year career as a dietitian working in a range of specialisms including oncology, gastroenterology and renal, undertaking research with medical colleagues in the latter area.

She has worked both nationally and locally and worked as a Clinical Lead for a number of years until retiring from practice earlier this year.

She worked in hospitals across Glasgow including Stobhill and Glasgow Royal Infirmary before spending the last 20 years at University Hospital Wishaw, NHS Lanarkshire.

Christine said: "I've always loved dietetics, particularly the acute setting.

"I decided to apply for the post because, although I retired, I wasn't retiring just to do nothing. I do voluntary work now, including at Pancreatic Cancer UK. I can still contribute to dietetics and the wider community for the next three years. It was my enthusiasm for dietetics that made me want to apply and make a contribution.

"During my tenure I would like to see more engagement of members, encourage more involvement with third-party organisations and work with our higher education institutions (HEIs) on student training. I also intend to visit various dietetic departments in the different health boards."

Christine will chair the first board meeting of her three-year tenure in November.

Updated Physical Health and Activity elearning programme

PUBLIC HEALTH

Health Education England elearning for healthcare (HEE elfh) has worked with the Office for Health Improvement & Disparities to refresh the content in the Physical Health and Activity programme.

Physical activity can be one of the most important tools in the healthcare professional's toolkit for condition management. It can lead to improved clinical outcomes in over 30 different chronic diseases, including type 2 diabetes, cardiovascular disease, heart disease, stroke, diabetes and several cancers, and be as effective as medication in many instances: hypertension, stroke and mild-to-moderate depression, to name just a few.

You can see more at **e-lfh.org.uk/programmes/physical-activity-and-health**.

BDA AWARDS CORNER

Dr Julie Lanigan is Honorary Associate Professor at the UCL Great Ormond Street Institute of Child Health (GOS ICH). Julie was awarded a BDA Fellowship in 2022

Name: Julie Lanigan
Job title: Honorary Associate Professor
Organisation: UCL Great Ormond Street Institute of Child Health

It is so important to thank colleagues when they make a difference. BDA Honours recognise and reward BDA members who go above and beyond, those who inspire others and are making a real difference.

If you know someone who has made a real impact on dietetics nominate them for a BDA Honour today!

The BDA Honours Committee considers nominations for the Ibex and Fellowship Honours. Honours can be considered all year round.

To nominate someone for a BDA Award, go to **bda.uk.com/about-us/honours-and-awards.html**. To see a list of past recipients, go to **bda.uk.com/about-us/honours-and-awards/past-honours-recipients.html**.

Q What does it mean to you to have been awarded with the Fellowship honour?

I feel very honoured to be awarded the Fellowship of the BDA. It has been a great pleasure to work with the BDA officers and members down the years as a volunteer, most recently as a committee member on the Paediatric Specialist Group. I am passionate about dietetics and especially paediatrics.

I see the Fellowship as recognition not just for myself but for all the hardworking dietitians who have helped raise the profile of paediatric dietetics and place dietitians in their rightful place as key players driving forward the science of nutrition and dietetics in children.

Q What drove you to become a dietitian in the first place and be where you are today?

A strong belief in the benefits of a healthy lifestyle for the prevention of disease coupled with the desire to improve health and life opportunities for children around the world first inspired me to study nutrition and dietetics.

"I have a desire to improve health and life opportunities for children around the world"

I started out in clinical practice at Northwick Park Hospital, London, and soon specialised in paediatrics. An opportunity to move to research came via Margaret Lawson, then Head of Dietetics at Great Ormond Street Hospital (GOSH) for Children. I never looked back. Working at the joint institution of UCL GOS ICH allowed me to fulfil many of my goals.

Q Who inspires you?

I have been inspired by a wide array of dedicated healthcare professionals and researchers. Our research at the UCL GOS ICH Childhood Nutrition Centre was supported by earlier work, including that of Elsie Widdowson, who provided some of the earliest evidence of nutritional programming and its role in health and disease. I was privileged to work with other pioneers investigating the impact of nutrition in early life on later health. Professors Alan Lucas, Mary Fewtrell and Atul Singhal have been my mentors and inspiration.

Clinically, my mentors included Dr Margaret Lawson and Lisa Cooke, with whom I spent many years working on the CHIVA Africa support and mentorship programme that was set up by Dr Karyn Moshal, consultant paediatrician in infectious diseases at GOSH. The programme provided training and funding for UK-based multidisciplinary teams to support the antiretroviral rollout to HIV-affected children living in South Africa. Such highly experienced, skilled colleagues were priceless in this setting.

More recently Vanessa Shaw became a role model with her boundless energy and dedication to paediatric dietetics. I am privileged to have worked with them all.

Q What advice would you give to future dietitians?

Take every opportunity you reasonably can to expand your experience. Never be afraid to try something different and be confident to promote your unique skills and knowledge to develop personally and help drive the profession forward.

I would highly recommend volunteering for the BDA as a great platform to do this through. Working with highly skilled professionals at all levels who have a diverse range of knowledge and skills in clinical practice and research is invaluable.

Q What has been the highlight of your dietetic career to date?

There have been many. However, I don't think it gets much better than being able to make a difference. There are many examples but what springs to mind is an experience in South Africa when I was able to help a child recover from severe acute malnutrition.

Working in the field without a range of feeds and accessories at our fingertips can be challenging. Sometimes we must go back to basics to work out a solution. Such was the case here. Faced with a child who was unable to absorb the one available feed, dietetic knowledge and skills were essential. With the help and advice of colleagues the feed was diluted and electrolytes added. The concentration was gradually increased.

With help and support by the multidisciplinary team, mum was taught how to drip feed slowly via a syringe – a painstaking process. By the end of the week, the child had clearly rallied, and we were rewarded with a beaming smile. That's my highlight so far!

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NEWS IMPACT

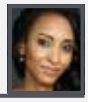
BDA MEDIA SPOKESPEOPLE MAKING THE NEWS

MAIL ONLINE

DUANE MELLOR commented on the use of offal in a footballer's diet on the Mail Online.

Read more at: dailymail.co.uk/health/article-11300029/Erling-Haaland-science-Norwegians-phenomenal-success.html

CHANNEL 5

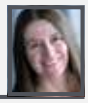


LINIA PATEL was on Channel 5's Secrets of your Supermarket Food talking about fibre.

VOICE OF ISLAM RADIO

TAHIRA BASHIR spoke live on Voice of Islam Radio about the role of diet in fitness levels.

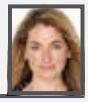
SUNDAY TELEGRAPH



FRANKIE PHILLIPS spoke to The Sunday Telegraph about the importance of breakfast.

Read more at: telegraph.co.uk/health-fitness/nutrition/diet/big-breakfast-myth-why-get-first-meal-day-wrong/

THE TELEGRAPH



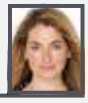
HELEN BOND was interviewed by The Telegraph about a new study that found we are only slightly healthier than we were in 1990.

Read more at: telegraph.co.uk/health-fitness/nutrition/diet/when-comes-healthy-eating-kidding/

RADIO 5 LIVE

AISLING PIGOTT was interviewed by BBC Radio 5 Live about food at the checkout.

LIVE SCIENCE



HELEN BOND spoke about vitamin D with Live Science.

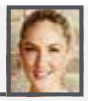
Read more at: https://bit.ly/3VPxCBG

FIT & WELL

REEMA PATEL gave Fit & Well seven dietitian-approved weight-loss hacks.

Read more at: fitandwell.com/features/dietitian-approved-weight-loss-hacks

THIS MORNING



MEGAN ROSSI talked probiotics on This Morning.

Watch again at: itv.com/hub/this-morning/2a6292a0935

PHARMACEUTICAL JOURNAL

The BDA provided a comment to The Pharmaceutical Journal about the dangers of weight-loss aids being promoted to children. The article was picked up in several national newspapers.

Read more at: dailymail.co.uk/health/article-11234637/Migraine-epilepsy-drugs-promoted-18s-weight-loss-aids-TikTok.html

independent.co.uk/life-style/health-and-families/weight-loss-pills-social-media-b2172742.html

thescottishsun.co.uk/health/9497010/warning-dangerous-pills-kids-tiktok/

theguardian.com/technology/2022/sep/22/tiktok-removes-posts-promoting-weight-loss-aids-to-children

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Check out
#BDAMedia for the latest news stories featuring BDA media spokespeople

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.

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Peptisip Energy HP had a good balance of flavour and taste with the right consistency and a pleasant aftertaste - ***Patient***

To read our patient case studies, please visit nutricia.co.uk/peptisip-energy-hp

NUTRICIA
Peptisip Energy HP

This information is intended for healthcare professionals only.
Peptisip Energy HP is a Food for Special Medical Purposes for the dietary management of disease related malnutrition in patients with malabsorption and/or maldigestion and must be used under medical supervision.
*Prior to commencing the study patients were taking a different ONS.
Reference: 1. Nutricia ACBS trial, data on file 2022.
Date of preparation: October 2022.

PUBLIC HEALTH MATTERS

Scottish AHP Public Health Strategic Framework Implementation Plan

Dr Ruth Campbell gives an update on the implementation of the UK AHP Public Health Strategic Framework in Scotland

Writer info

Dr Ruth Campbell is Consultant Dietitian in Public Health Nutrition at NHS Ayrshire & Arran

In the May 2021 issue of *Dietetics Today*, I wrote about an invitation from the Chief AHP Officer to chair a stakeholder reference group to develop an implementation plan for the UK AHP Public Health Strategic Framework[1] in Scotland. The Scottish AHP Public Health Strategic Framework Implementation Plan 2022-2027[2] was launched at an NHS Education Scotland webinar on 2 August 2022.

As a reminder, the five goals set out in the UK Framework are:

- Developing the AHP workforce: the AHP workforce will have the skills, knowledge and behaviours to promote, improve and protect the health and wellbeing of individuals, communities and populations
- Demonstrating impact: AHPs will be able to demonstrate their contribution to improved population-level health outcomes through robust evaluation and research
- Increasing the profile of the AHP public health role: AHPs will be recognised as valuable public health experts through ongoing profile raising of the AHP contribution to public health
- Strategic connections and leadership: Effective relationships will exist between AHPs and system leaders at local and national levels to make best use of AHPs to improve public health and reduce inequalities
- Health and wellbeing of the workforce: the expertise of AHPs will be used to protect and improve the health and wellbeing of health and care workers

The stakeholder reference group felt that each of the "we will" commitments in the UK Framework are quite high level so we wanted to create actions that are applicable in a Scottish context but also are more tangible. Over the course of 12 months, we worked our way through a systematic process where we posed four questions across each of the "we will" statements. These were:

- What's happening already in Scotland – where are we now?
- What do we want to achieve – where do we want to be?
- How will we reach that outcome – what action do we need to take to get there?
- Who do we need to influence or connect with?

This discussion happened within the reference group but, in addition, group members were responsible for taking these questions back to their own respective health board or organisation to have that local discussion and feed back to the national group. This led to an inclusive and collaborative approach to the development of the actions in the plan.

For each goal, key outcomes are set out as well as the actions required to achieve them. It is anticipated further actions will be identified as implementation progresses.

Some of the actions include:

Developing the AHP workforce

- Collaborate with HEIs on public health content of pre-registration curricula
- Explore opportunities to expand student placements in public health settings
- Promote opportunities for work-based learning
- Scope learning needs to fulfil public health role
- Link with Transforming Roles programme and AHP Education Review

Demonstrating impact

- Promote use of AHP Hub hosted on Royal Society for Public Health website
- Support AHP Careers Fellowship Scheme projects aimed at improving public health
- Promote use of the King's Fund toolkit and other resources
- Commission a mapping of tools available to measure impact of work on population health and identify gaps

Increasing the profile of AHP public health role

- Public health skills of AHPs recognised and reflected in Scottish Government policy
- Build on AHP Compendium 2020 and develop a Public Health Compendium
- Support AHPs to showcase their work

Strategic connections and leadership

- Strengthen relationships locally between AHPs and public health/health improvement staff
- Connect AHPs to the ambition for public health in Scotland to be a world-class system
- Integrate public health priorities into AHP service transformation, workforce planning and workforce development

Health and wellbeing of the workforce

- Continue to encourage AHP leadership and engagement in local workplace initiatives
- Continue to support AHPs in their role in enabling people into work and returning to work
- Support delivery of initiatives to promote health and wellbeing of students

Next steps

The Scottish Government will set up a national oversight group, which will be chaired by the Chief AHP Officer. This group will be responsible for leadership and governance of the plan to ensure it is implemented over the next five years. There is an expectation that each local NHS Board or organisation will develop its own implementation plan through appropriate local mechanisms.

REFERENCE

1 UK AHP Public Health Strategic Framework 2019-2024 – ahpf.org.uk/files/UK%20AHP%20Public%20Health%20Strategic%20Framework%202019-2024.pdf2 gov.scot/publications/scottish-allied-health-professions-public-health-strategic-framework-implementation-plan-2022-2027/

SMOOTHIE *Vibes*

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287 kcal	10g	27

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❤️ Red Berry 💛 Tropical 🤍 Peach 🧡 Orange & Mango.

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nualtra.com/get-samples

The Eatwell Guide: an urgent call for government action

A recent survey and research project, funded by an educational grant from Danone, has explored Eatwell Guide communications, with some stark findings which raise some challenging questions

Writer info

Juliette Kellow is a registered dietitian, nutrition consultant and writer

Research shows for every million people in the UK, only 780 meet all the recommendations set out in the Eatwell Guide. It's a staggering statistic. But recent work to understand the views of health professionals shows it's unsurprising given limited resources and campaigns to support the government-created national food model. With the health of the public and planet under serious threat, health professionals are clear about the need to ask for a government-created and funded comprehensive communications strategy and expanded resource hub to support them in their work.

In September 2022, MyNutriWeb hosted *The Eatwell Guide: Time for a Shake Up?*,[1] a roundtable webinar with presentations covering current adherence to the guide, materials available to support the recommendations, a look at food-based dietary guidelines in other countries and UK health professional views on the national food model. A discussion then took place with input from a variety of experts and questions from attendees on what needs to be done to ensure the Eatwell Guide is fit for purpose and brings about the much-needed dietary change required to improve the health of the people and the planet.

The background…A brief history of the Eatwell Guide

The Eatwell Guide[2] translates UK dietary reference values and food-based recommendations into a visual model. The current version was launched in March 2016, updating and replacing its predecessor, the Eatwell Plate. It consists of five food groups in the proportions they should be consumed to achieve a healthy balanced diet, together with additional guidance in areas such as hydration, energy requirements and front-of-pack nutrition labelling. Whilst developed with the health of the nation in mind, the Carbon Trust[3] also conducted a post hoc sustainability assessment of the Eatwell Guide and concluded it showed a much lower environmental impact than the current UK diet.

The problem…

Current adherence to the Eatwell Guide is extremely low. A study published in the BMJ Open in 2020 confirmed just 0.078% of the UK population (aged five and above, based on data from wave 5-9 of the National Diet and Nutrition Survey) met all nine of the recommendations, which focus on total fat, saturated fat, salt, sugar, fibre, oil-rich fish, non-oil-rich fish, fruit and veg, and red and processed meat. This means just 780 people in a million meet all the recommendations. With a projected UK population of around 64 million people over the age of five in 2022, that's fewer than 50,000 people meeting all the Eatwell Guide recommendations in the entire UK!

But that's not all. Only 30% of people in the study met five or more of the recommendations. The majority – 44% – achieved just three or four, while a quarter managed no more than two. Low adherence was found to have a significant negative impact on both health and the climate. Those who met two or fewer of the recommendations had a 7% increased risk of mortality and a 30% increase in dietary greenhouse gas emissions compared with those who met five or more. The researchers concluded: "A fast-tracked nationwide shift towards adherence to the Eatwell Guide will provide an essential step towards sustainable and healthy diets in the UK."

Why the low adherence?

Amy Culliford, a freelance Public Health Nutrition Consultant who specialises in sustainable diets and food systems, says her research suggests it's unsurprising that adherence is low. Amy and her team have reviewed the current literature on communicating dietary guidelines and looked at other countries' communication strategies. The conclusion? Amy says: "The Eatwell Guide communications need to be improved to bring them in line with international best practice with various lessons to be learnt from countries such as the USA, Canada, Australia, Ireland and Brazil.

"Messaging needs to be tailored to specific groups, motivating factors and barriers to dietary behaviour change should be addressed and more consistent, accessible educational resources and practical tools must be provided. Collaboration across the board, including government, the food industry and healthcare – is also essential." This research will be submitted for publication later this year.

The nutrition expert view

"The lack of practical resources and disjointed communication strategies to support the Eatwell Guide are issues that certainly resonate with health professionals including dietitians and nutritionists (see Figure 1). A recent survey of the British Dietetic Association and MyNutriWeb community of professionals collated the views of almost 2,400 health professionals to gain insight into how the Eatwell Guide is currently used and to identify what needs to be done to improve communication. Key findings included:

- The Eatwell Guide provides a good overview – dietitians and nutritionists like the pictorial approach, the simplicity and colour coding and that it clearly demonstrates the five food groups
- But there are some major issues – health professionals say there is a lack of resources to help translate Eatwell Guide recommendations into tailored and personalised information for a diverse population

Figure 1: Percentage of respondents who consider the EWG communications fit for purpose

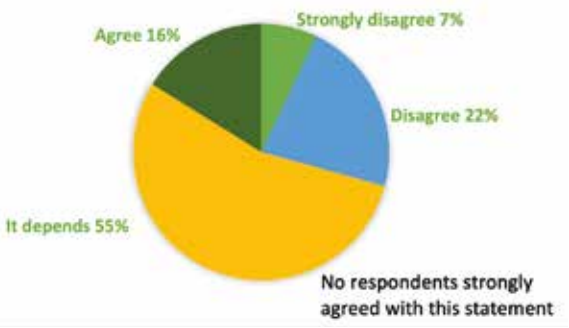


Figure 2: Communication tools health professionals would find 'helpful' or 'very helpful' for consumers to put Eatwell Guide recommendations into action

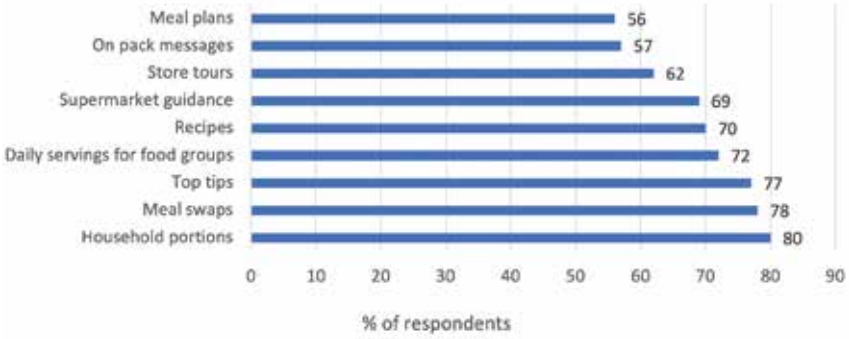
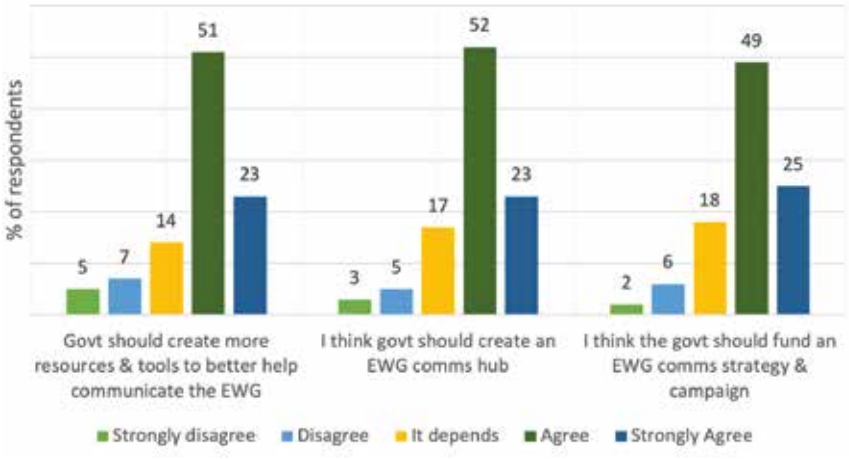


Figure 3: Views respondents on how Government should support the EWG



with different needs, whether that's taking cultural considerations into account, providing information for those on a budget or working with people with different dietary needs. Table 2 shows the resources health professionals would like to help them better communicate the Eatwell Guide

- The lack of portion size guidance is a major drawback – health professionals are currently using a variety of other resources such as materials from the British Nutrition Foundation, the British Dietetic Association and Love Food Hate Waste, resulting in a lack of consistency and often confusion
- Resources need to get to the masses – the Eatwell Guide needs to modernise and use popular technology, including apps, videos and social media

Time for a shake-up

It's clear that whilst government has provided the Eatwell Guide to encourage dietary change, and has supported this with various communication activities and development of practical apps via 'Better Health: Healthier Families' (nee Change4Life), it is clear that more joined-up support and funding is needed to effectively translate the recommendations into dietary practice. This is made clear by the inconsistent usage and low adherence. In short, it is failing both public health and the crucial need to meet climate change targets.

The Eatwell Guide is a popular "starter" resource – a theme that was evident from the roundtable discussion – and has huge potential to bring about dietary change that benefits human health and the planet, so there is an urgent need for it to be supported with a joined-up effective communications strategy that provides clear and consistent advice and becomes the go-to source for trustworthy, accessible and credible advice on healthy eating. It's clear a national shake-up is needed and health professionals believe government could be doing far more to support this (see Table 3).

With such a large response, and engagement in the subsequent roundtable event, dietitians and nutritionists are clearly calling for action from government and have the following recommendations:

1. Re-assess the current communications and upscale the marketing and communications strategy using both traditional media such as print, TV and radio, and digital media, including social media, websites, videos and more apps
2. Create a central hub of diverse Eatwell Guide resources that cover areas such as shopping and cooking tips, food swaps, meal planning, motivational advice, budget-friendly ideas, recipes and quizzes
3. Develop portion size guidance and number of servings of each food group as a priority
4. Translate the Eatwell Guide into a range of different languages to support the multicultural nature of the UK, and provide resources that are tailored for different cultural groups and eating habits
5. Translate the Eatwell Guide into toolkits fit for use by all organisations providing food
6. Establish cross-government use of the Eatwell Guide in all departments, agencies and public bodies that include a food element includingthe Office for Health Improvement and Disparities, Defra, the Department for Education, the Department for Digital, Culture, Media and Sport, the Department for Levelling Up, Housing and Communities, the Department for Work and Pensions and the Department of Health and Social Care to ensure healthy eating messages are consistent 7. Use the Eatwell Guide as a starting point in all health and food related policy development and strategy.

The BDA is supportive of the messaging of this work led by dietitians and researchers. BDA CEO Liz Stockley said: "It's great to see dietitians and private partners taking the lead in collating views of the community and taking the lead on a series of recommendations. We are pleased to support this via the sourcing of member views and sharing it in *Dietetics Today* to amplify the message."

The project survey and research were supported by an educational grant from Danone.

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The importance of spotting sarcopenia

The Malnutrition Pathway has launched a fact sheet on sarcopenia, summarising the multiple factors that can contribute to the condition and the potential consequences to health

Writer info

Hilary Franklin is Malnutrition Pathway Coordinator and a Healthcare Communications Consultant

In light of the increasing evidence on the importance of preserving muscle mass as we age the Malnutrition Pathway (**www.malnutritionpathway.co.uk**) has developed a fact sheet focusing on sarcopenia (loss of muscle mass).

Written by Consultant Dietitians Dr Ann Ashworth and Dr Anne Holdoway, the sarcopenia fact sheet outlines why it is important to identify sarcopenia in all patients, whatever their BMI. It summarises the multiple factors that can contribute to sarcopenia and the potential consequences to health, giving practical advice on diagnosis and treatment according to the patients' current nutritional status.

Sarcopenia is estimated to cost the UK in the region of £2.5 billion per annum arising from the health services required to manage the consequences.

"Malnutrition, resulting from under or over nutrition, can lead to sarcopenia."

Malnutrition, resulting from under or over nutrition, can lead to sarcopenia. Recent evidence has found patients with malnutrition had approximately three to four times the risk of developing sarcopenia than those without malnutrition.

In fact, the prevalence of 'sarcopenic obesity', or obesity in combination with sarcopenia, is increasing in adults aged 65 and over. Care must therefore be taken to ensure that sarcopenia is not missed if the patient has overweight or obesity.

Disease, inactivity and poor nutrition can all contribute to sarcopenia and, whilst it is more common in older age, it can also occur in earlier life.

Figure 1 : Some of the consequences of loss of muscle mass

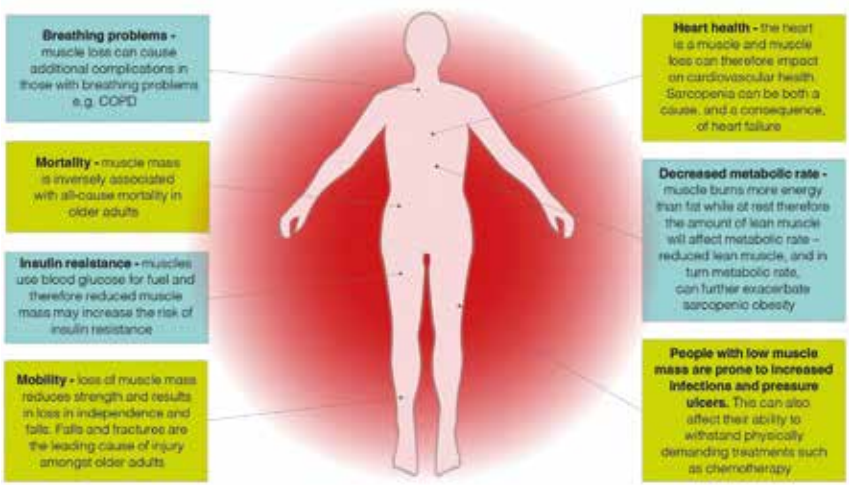
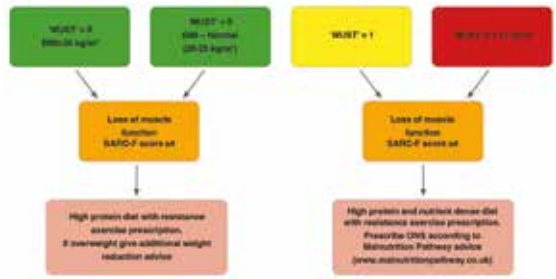


Figure 2: Managing malnutrition and sarcopenia in the community:



Left untreated, sarcopenia can affect recovery from surgery or injury, hamper response to treatment, reduce functional capacity or contribute to a more rapid deterioration in pre-existing conditions (see Figure 1).

The fact sheet gives advice on how to identify sarcopenia and malnutrition, detailing the principles of management of malnutrition and sarcopenia, including guidance on optimising nutritional intake, through diet and the inclusion of oral nutritional supplements when indicated, in combination with exercise.

"The COVID pandemic has further emphasised the impact of low muscle mass and muscle loss in impeding recovery," says Dr Anne Holdoway, Chair of the Malnutrition Pathway panel. "The combination of illness, reduced activity or bed rest, a poor appetite and reduced food intake frequently results in weight loss particularly amongst older people and those with chronic conditions. Muscle is often lost at a disproportionate rate to fat mass. For optimal recovery, it's important we get the message out to healthcare professionals, patients and carers about the importance of a protein-rich diet, combined with resistance-type exercise or activity tailored to the individual, to ensure muscle is repleted and a return to pre-illness function is achieved or improved."

"The consequences of not identifying and treating the sarcopenia can cause long-term adverse outcomes for patients whilst putting additional pressure on the health service," added Dr Ann Ashworth, Malnutrition Pathway Consultant Dietitian.

"Whilst in malnourished patients the presence of sarcopenia may be visually obvious, it is not always easy to identify sarcopenia in patients with overweight or obesity, where it is easily missed. We hope this fact sheet will assist healthcare professionals in identifying and managing sarcopenia."

The 'Sarcopenia: Loss of Muscle Mass' fact sheet is available free to healthcare professionals and can be downloaded from **malnutritionpathway.co.uk/sarcopenia**.

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Vitamin D and COVID-19: do latest studies support supplementation?

The PEN® Team produces Trending Topics which are articles published in timely response to recent media and journal articles, position statements and clinical guidelines, and are based on the most recent evidence/ publications at the time the article is written. This is an example of Trending Topic published in February 2021

Conversations continue on social media about the potential role of vitamin D supplementation in the prevention and treatment of COVID-19. The PEN Team noticed that a common rationale was that patients with COVID-19 tended to have lower vitamin D status (25(OH)D levels). We decided to take a look at two recent studies that reported this connection to determine if the results support vitamin D supplementation to improve COVID-19 outcomes.

The research

First, we looked at an observational study by De Smet et al. that noted that patients with COVID-19 had progressively lower 25(OH)D levels with more severe COVID respiratory disease.[1] The study authors also observed that those with vitamin D deficiency were almost four times more likely to die (adjusted odds ratio [OR] 3.87; 95% confidence interval [CI], 1.30 to 11.55). Vitamin D deficiency was prevalent among the patients with COVID-19 infections, more so among the men (67%) than among the women (47%). These researchers adjusted for several variables that are risk factors for COVID-19 mortality (age, ethnicity, chronic lung disease, coronary artery disease/hypertension, diabetes and extent of lung damage).

From other vitamin D research, we know that the marker for vitamin D status (25(OH)D) can be lowered by infections.[2] Therefore, low 25(OH)D levels may not reflect poor vitamin D status in a person with an infection. De Smet et al. were not able to determine whether what looked like a vitamin D deficiency was actually a nutritional deficiency or whether the COVID-19 infection lowered the participants 25(OH) D, making these patients appear to have a vitamin D deficiency.[1] For this reason, this observational study does not provide evidence that vitamin D supplementation would be helpful for improving outcomes of a COVID-19 infection.

The second study we examined was a randomised control trial of vitamin D supplementation in people with mild symptomatic and asymptomatic COVID-19 infections. Rastogi et al. randomised 40 people with mild COVID-19 infections to 60,000 IU/day of vitamin D3 or placebo for seven days.[3] The researchers observed that more participants in the intervention group became COVID-19 RNA negative before day 21 compared to participants in the control arm (62.5% versus 20.8%, P<0.018). Vitamin D supplementation lowered fibrinogen levels significantly but not the other inflammatory markers (SARS-CoV-2 RNA, D-dimer, procalcitonin CRP and ferritin). These researchers only reported differences in indirect markers[3] and did not report World Health Organization-recommended patient-important outcomes (patient survival and patient health care system use over the course of clinical illness).[4] The PEN Team thinks that this trial does not answer the question of whether vitamin D supplementation improves COVID-19 outcomes.

"Dietitians should support all adults and children to meet recommended Vitamin D intakes"

What This Means

After reviewing these studies, the PEN Team has two key questions:

1 What is the relationship between vitamin D deficiency and COVID-19 severity?
2 What is the impact of vitamin D supplementation on patient-important outcomes, such as disease severity, hospitalisation and death?

Before dietitians can make recommendations on the use of vitamin D supplementation to improve COVID-19 outcomes, randomised control trials examining the prevention of COVID-19 (including severe COVID-19) and the treatment of COVID-19 with patient-important outcomes are needed.

At this point in time, dietitians should continue to support all adults and children to meet the recommended nutrient intakes for vitamin D. See the International Dietary Reference Guidelines Collection at **https://bit.ly/3DxLcT9**.

This is an example of Trending Topic published in February 2021. As the evidence and research in this area has progressed since it was published, we acknowledge that new evidence will be available on this topic.

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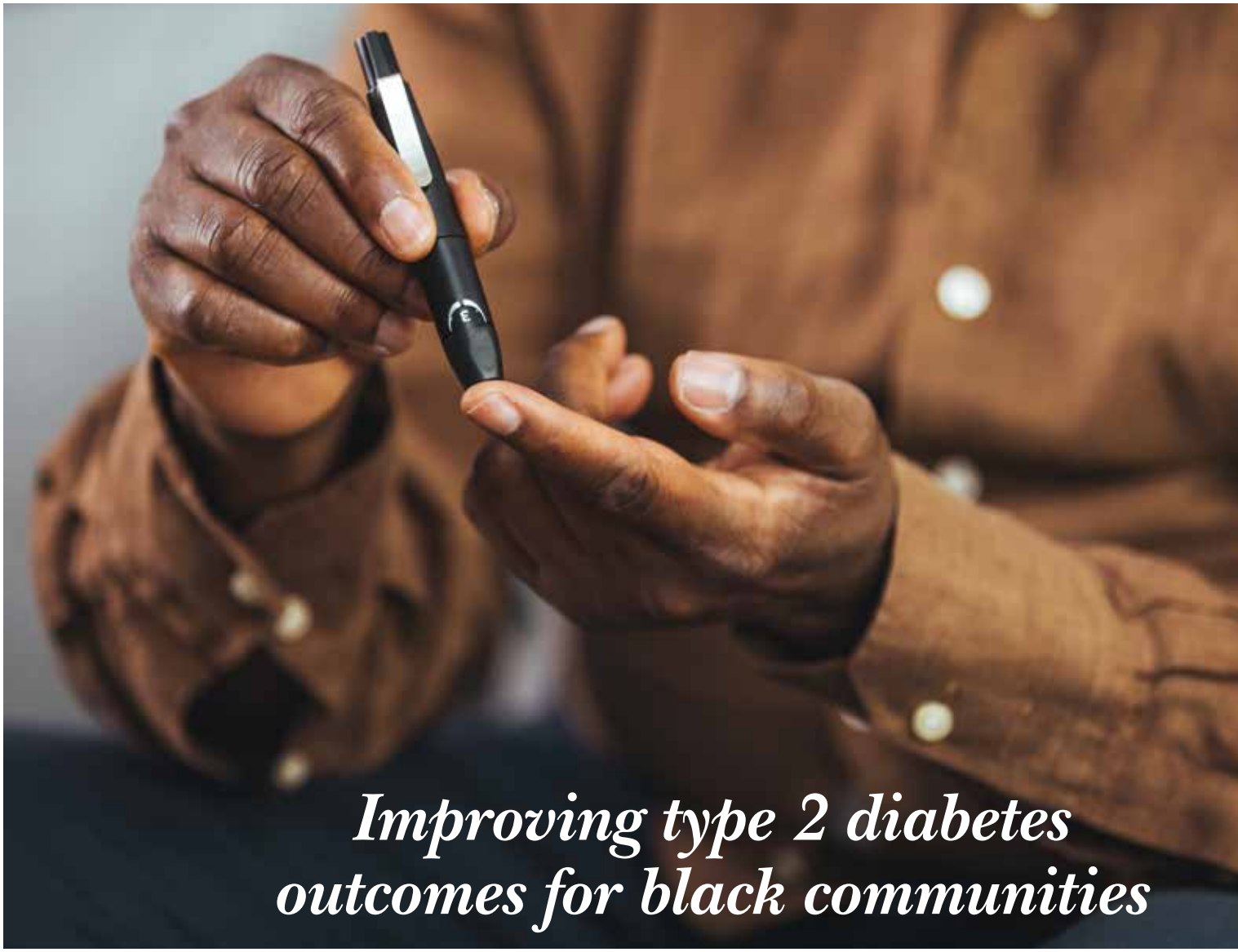

Improving type 2 diabetes outcomes for black communities

People from black African origin ethnic groups are more than three to five times more likely than white Europeans to develop type 2 diabetes mellitus. **Ellouise Simpson** explains how dietitians can improve outcomes

Writer info

Ellouise Simpson RD is a specialist diabetes dietitian
Instagram @DietitianEllouise

Type 2 diabetes mellitus (T2DM) is a chronic metabolic condition, characterised by insulin resistance.

T2DM can affect anyone. However, research identifies people from black African origin ethnic groups to be more than three to five times more likely to develop this condition compared with white Europeans (Goff, 2019) and on average develop the condition 10 years earlier (Paul et al., 2017). While genetics plays a role in disease aetiology, wider health and social determinants that affect health disparities are also known to have a significant impact on disease prevalence. Therefore, in addition to tailored and culturally appropriate nutrition advice, a holistic approach is needed in the management of T2DM within black African and Caribbean people.

Black communities in the UK report healthcare professionals lack cultural understanding – advice provided has limited cultural relevance or is poorly adapted. On the other hand, many dietitians also feel unequipped to provide nutrition counselling that is culturally appropriate. Black African and Caribbean people are underrepresented in nutrition and dietetics. The HCPC diversity data report in 2021 states that 2% of dietitians identify as black.

How can dietitians add value and help improve outcomes?

People living with T2DM need to be empowered, listened to and understood, without judgement, stereotyping, bias and assumption. As registered dietitians the care we provide should be holistic – the aim is not to focus on the medical model but rather treat the whole person. Using an upstream approach with diabetes care helps us to address the root cause and not treat the symptoms standalone. For that reason, it is important we acknowledge and respect differences and authentically seek to learn more about

the whole person. Black communities are vibrant and energetic and the culture is often scaffolding for their tradition, religion and culinary choices, all of which are handed down from generation to generation.

Food is typically at the core of many black families and, as we are aware, nutrition and lifestyle choices are vital to the management of T2DM. Therefore, all dietitians must seek to learn more about black African and Caribbean culture and cuisine as this will provide insight and support culturally appropriate dietetic care and improved outcomes.

Patient empowerment is defined as "a process through which people gain greater control over decisions and actions affecting their health". The journey begins with building a genuine rapport with your patient, then you can share meaningful education, shine a light on less desirable nutritional and lifestyle choices which aren't supporting their diabetes management and then empower them to make better decisions which fit within their culture. In turn, this will be self-empowering, acting as a positive feedback loop.

Improving type 2 diabetes outcomes from an institutional level

Increased racial diversity in dietetics is important as it is linked to improved outcomes for many conditions. To improve representation, the conversation must be started to introduce a strategy to ensure underrepresented groups are represented.

- We could improve the exposure of the dietetic profession to minority ethnic students by visiting schools for career events in diverse communities
- Ensure recruitment teams at universities are diverse and, once students are on the course, clinical placements are inclusive
- Invite people from black African and Caribbean communities to facilitate practical cooking sessions to create authentic meals and share their lived experiences

"The goal is not to replace someone's cultural food with other foods but rather provide nutritional education and cooking choices to help improve overall health"

The power of working together

The goal is not to replace someone's cultural food with other foods but rather provide nutritional education and cooking choices to help improve overall health. The responsibility of improving care for black people living with diabetes and improving representation does not solely lie in the hands of the dietetic profession as underrepresentation occurs in many healthcare professions. Therefore, let's do our part and learn more about the cultures we care for. Ultimately the aim is for the workforce to be reflective of the population they serve.

Make it practical

Typical dish	Meal description	Healthy tip
Ackee and saltfish	Ackee and saltfish is Jamaica's national dish. Ackee is a fruit and is grown in abundance in Jamaica, and served with salted codfish sautéed with vegetables, ground provisions, herbs and spices. Ackee and saltfish is eaten as a favourite for breakfast, brunch, lunch and dinner.	Once your saltfish has boiled and the salty water drained off (on average twice) the saltfish is now mostly cooked. Use a good quality non-stick pan and measure out your oil (you can also use a spoon to do this). Over time, aim to cut down the amount of oil you use for this dish.
Curry goat	Curry goat or mutton is a popular Jamaican dish. The meat is sealed off in oil and then ingredients such as garlic, onion, ginger, hot peppers and herbs are tossed in. As all the ingredients infuse together, the meat is slowly cooked until tender. Potatoes are commonly added and this increases the thickness of the sauce. Typically served with rice and peas, and coleslaw.	Cook your meat first, then add the onions and spices. If the meat begins to catch on the pan, add some water, turn down the heat and use a lid. The steam will help to cook the meat and you will have benefited from using less oil overall.
Saturday soup	As the name implies this soup is mainly enjoyed on Saturdays. This is a hearty chicken or lamb soup full of flavour and is very filling. Pumpkin is used as the base with added vegetables and ground provisions such as yam, green banana, potatoes, carrots and corn on the cob. Additionally, dumplings made from plain flour, water and a pinch of salt is added to the soup.	Soup mix is often added to a Caribbean Saturday soup. On average, one sachet contains 5g of salt. Therefore, consider flavouring your soup with more herbs and spices – choose mixes which contain less salt and, overall, gradually reduce the amount of salt you add to your cooking daily.
Fried plantain	Plantains are a member of the banana family. They contain more starch than a regular banana and need to be cooked before eaten. Ripe plantains are sweet and, when fried, the surface becomes caramelised and moreish. Fried plantain is the most popular method of cooking but it can be roasted, steamed or boiled. Plantains are usually eaten as a side dish and accompany many Caribbean meals.	There are a variety of cooking methods available to cook plantains, such as steaming, boiling or roasting. These methods all have health benefits as there is less oil used. However, if you do want to fry your plantain, ensure you measure your oil, drain off any excess and even try using an air fryer.

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Stigma and inclusive language in dietetics

How do we as dietitians, dietetic assistants and student dietitians, need to change to reduce weight stigma and be inclusive with our language?

Writer info

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The British Dietetic Association has for just over a year been proud to have published guidelines which aim to reduce weight stigma from all its published material and communications[1] by ensuring that non-stigmatising language and imagery with respect to weight and body size are used.

Leading on from this, the association's journal, the *Journal of Human Nutrition and Dietetics (JHND)*, is exploring how these guidelines can be incorporated within an academic journal.[2] As we are spending some time considering stigma and inequalities in dietetics and how they manifest in academic writing, it is essential that we consider how as dietitians we can practise in the most inclusive way possible. While we are aware that stigma can be present in many forms, for the purpose of this article we are focusing on stigma associated with body weight/size.

Firstly, before being able to consider issues of inclusion, including language and stigma, it is important to recognise our own position, privileges and history. Two of the authors writing this are male white dietitians, part of a minority of around 6% of the UK dietetic profession. Yes, with that there could be push factors which have meant that we are both no longer in day-to-day clinical practice because of that. But also, we need to recognise that it is perhaps not by chance we have both moved into academic roles. It is possible that we saw role models and mentors like us in these non-traditional or academic positions, or we were advantaged that these role models (including doctors and researchers) took interest in us as we were similar to them. However, as authors all of us want to be open and honest in terms of acknowledging our privileges and bias – and actively doing something about it. Therefore, we sought to include others and think how those without visible role models can be supported to help develop and strengthen our profession.

To be clear, it is important to recognise we all live with privileges and barriers due to who we are and sometimes these cannot be helped. What is important is to recognise how these factors affect our judgement, behaviours and interaction with people – often before we have even met them (in the form of biases – both conscious and unconscious). And, importantly, we need to recognise how these intersectional factors impact others. Then, we are faced with a choice – do we choose to exploit our privileges for our own gain (continue inequality) or use them to be an upstander and ally by enabling others to have and use the voice that they have but that society often does not allow them to use or ignores? This can be a challenge as ideally there should be no speaking on behalf of groups without including individuals from that group, which is perfectly voiced in the phrase 'nothing about us, without us'. However, we also live in a society where there are multiple layers of intersecting inequality and characteristics so this can be extremely difficult.

Perhaps one compromise is to develop a clear approach on how we can be inclusive to all and promote not only equality but also equity.

One model that has been developed is the 'coin model' of privilege and critical allyship.[3] This takes the approach mentioned above that we need to recognise our own positions of privilege and then use this to challenge structures which enable injustice and health inequalities. When doing this, it can require a critical look at how we do this, from one of 'offering charity' to people with less privilege to try and 'save' them, to one which works in solidarity, sharing the platform to collectively act in partnership together. This may seem obvious and something that should be automatically part of our practice; however, the literature suggests that as a profession at times we are less supportive than we would perhaps like to think.[4]

"The way in which we communicate with our patients and colleagues is key to developing relationships"

Not many would argue that eliminating weight stigma is important. However, this is still recognised as an issue within both society and our profession. In the UK it has been recognised that dietetic students display high degrees of stigmatising attitudes towards people living with obesity,[5] which has moved to the profession, via the BDA demanding action from the government to include weight stigma as part of its Obesity Strategy.[6] But the question remains: how does stigma affect people living with overweight and obesity?

The way in which we communicate with our patients and colleagues is key to developing effective patient/practitioner relationships, with the words we use impacting on future healthcare engagement from not only us as dietitians but by all other healthcare professionals too.

NADYA'S THOUGHTS ON DIETITIANS, AS A PERSON LIVING WITH OVERWEIGHT OR OBESITY

"Dietitians must be cognisant that people living with obesity have been 'lectured' to for their entire lives. To have a dietitian in your own corner, treating you with empathy but more importantly, as an individual and not just as a 'meal plan'. To be your ally in the good and bad! Just like your teacher at school played a pivotal role in your childhood and adolescent years, so can a dietitian, provided they respect wholeheartedly the person sitting in front of them."

What is the problem with weight stigma and inequality?

In society, as well as in healthcare and therefore dietetic practice, traditionally discussions around stigma have tended to focus on the nine protected characteristics set out by law within the UK Equality Act (2010),[7] which include sex, age, race, disability and sexual orientation. One key area that has only recently started to be discussed (and now hopefully challenged) is that of body weight, size and shape. Weight stigma is not included within the Equality Act, and as such has not been afforded the same protection from discrimination and bias as the other nine characteristics, despite it being widespread throughout our society.[8] However, depending on the extent of the obesity, it could come under the protected characteristic of disability.

This is exemplified in the language used when discussing people living with obesity, such as 'obese' or 'war on obesity', where people are dehumanised by being classified by their weight or seen as something that needs to be fought against. This 'military' language' can imply a 'bad' side of obesity in this 'war' already stigmatising individuals that they are on the 'wrong' team in this 'war'. This manifests itself in language, in imagery, and in the attitudes and practices of healthcare practitioners (including dietitians), and is seen particularly in media portrayals of people living with obesity.[8]

ANN'S THOUGHTS ON DIETITIANS, AS A PERSON LIVING WITH OVERWEIGHT OR OBESITY

"Language is a key element of humanity. It has been described as the way we perceive and share information about our environment, ourselves and others. The words we use can engage, enhance and nurture all the positive emotions which leave us feeling liked, loved and appreciated. However, they can also leave us feeling confused, disliked and unloved or even unlovable. Mind your language."

Therefore, a simple first step is for dietitians to use person-first language and non-stigmatising imagery in their personal and professional lives. They should advocate that others also do this and speak up when stigmatising words and images are used by organisations and in the media.

Although there is a lack of legal protection, the debate has been started with the introduction of a Body Image Bill[9] to the UK Parliament in February 2022, which sets out to make it a legal requirement for any online image that has been digitally altered to be clearly labelled as such. Additionally, this is part of a scheme of work to include the risks of how body image is portrayed in the Online Harms Bill,[10] so although not implicitly protected in legislation, there is movement towards more protection, which strengthens the need to challenge stigma and bias with respect to weight, body shape and size.

It is not only people living with obesity who face stigma and discrimination. Those living at lower body weights can also face prejudice and exclusion, which can be direct or indirect. There are concerns about the medicalisation of language relating to supplemental products, for example. Sociologically, this could involve reconceptualising food from something an individual consumes to something that is done to an individual – they are given a feed rather than offered a supplement or drink. In addition, people living with constitutional thinness can be misdiagnosed as having an eating disorder and discriminated against for having a lower body weight.

As discrimination and stigma can be a barrier to seeking healthcare and lead to poorer mental and physical health, it is vital as health professionals and dietitians that we work to remove stigma and discrimination across society and especially in the areas of health and food in which we work. As dietitians/assistants we must acknowledge our own privileges and biases and how these influence the care we provide for patients. And this must start in education as students.

It is not only the patients we care for who need us to consider how we use our coin of privilege and critical allyship – we also need to do this with each other. This approach needs to extend to voices within dietetics, by challenging ourselves (alongside other established voices in our profession) to support the voices of under-represented communities within our profession. This includes supporting members across all our diverse communities to consider dietetics as a profession that is achievable and potentially right for them.

"It is not only people living with obesity who face discrimination. Those living at lower body weights can also face prejudice"

Going further when seeking to write about dietetics, we need to support these voices to be heard, here in *Dietetics Today*, in future editions of the *Manual of Dietetic Practice*, and in undertaking projects and research for publication with diverse populations. This could mean offering mentorship and authorship to develop others. It is likely also to mean sharing or even stepping aside to allow for a more diverse and inclusive voice of our profession to be seen in all that we do, beyond the ward and the clinic room, through into media messaging and our professional and academic publications. This we feel is not a brave or bold ambition, it's simply being socially just and morally right, and it will be good for our profession.

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By being more diverse in thought and in actual person then we will make better decisions for our patients and colleagues and as a profession – making it healthier, hopefully happier, and more resilient to the future, helping our wonderful profession to become the best it can be.

As dietitians we need to listen more, and not judge

As mentioned previously, it is key to listen to people living with overweight and obesity as everything that we do should have them at the heart of it. These include feelings that society and individuals feel less important because of their body weight. To quote Maggie: "I felt I could not be sick and take time off work as it would be seen as my fault. The harm language can do builds from being at school through sport or uniforms not fitting and feeling you cannot achieve your dreams. In so many settings throughout my life I have been made to feel that I did not matter."

When we consider language, as Ann describes it: "Language is a key element of humanity" and Nadya reminds us: "Dietitians must be cognisant that people living with obesity have been 'lectured' to for their entire lives." So, we need to move on as a profession to work alongside, rather than simply give advice, as Nadya put it: "To have a dietitian in your own corner, treating you with empathy but, more importantly, as an individual and not just as a 'meal plan'." By working alongside our service users and carers, we will not only achieve far more, but we can also start to address some of the harmful perceptions some have about dietitians, such as the 'food police', which can only be positive for our profession. Our name itself can mean that patients and colleagues have a pre-conceived idea of what we will advise on – we have to ensure right from the start we dispel those myths and be the true patient advocate in all that we do.

What can we do moving forwards?

At the *Journal of Human Nutrition and Dietetics*, we have taken a five-point approach to move to becoming more inclusive and to work towards removing weight stigma for future publications.

1. Use person-first language; stop defining people by their disease or condition – so we use 'people living with obesity or diabetes', rather than the 'obese' or 'diabetic'
2. Support and encourage authors to publish data that highlights the diversity of their study population and explain why this is important/needed
3. Ask that data is presented in a way that is not defined by perceptions of superiority, e.g. list number of female participants then male participants or ethnicity data based on alphabetical order and not as often with white first
4. Seek to expand the diversity of authorship – so that a wider range of voices can be seen and heard
5. Support person-centred dietetic care, and challenge care which is 'done to' people and populations and is not done in partnership

For the profession as a whole, we should look at how as individual practitioners and also teams we can work to help the voices at the edge of our teams and the communities we serve to be heard and represented. We need to consider how inclusive we are being to ensure the dietetic care we offer is developed with people in collaboration not as simply passengers. These are not answers, but are more our reflections of an ongoing journey of how we might make dietetics as fair and inclusive as it can be. We hope that this article has made you stop, pause, think – perhaps even feel slightly uncomfortable. Because to truly address stigma we cannot be passive and we cannot be comfortable – we have to actively make changes and get out of our comfort zone to acknowledge and then address our biases to make real change and be a true ally. We hope that you will join us in this journey of reflection and debate, and together we can help to make dietetics more inclusive.

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Working with people with Learning Disabilities

Briony Caffrey explains why it is important to ask the right questions

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On average, males with learning disabilities die 22 years younger, and females 26 years younger, than the rest of the population. The 2021 LeDeR report from Kings College London was produced for NHS England and investigates deaths of people with learning disabilities. Amongst the findings is evidence that half of all deaths were avoidable.[1a] The review, which started at Bristol University in 2015, highlights that healthcare is not timely, appropriate or effective and as result this leads to undiagnosed, untreated conditions, premature and often avoidable deaths.[1] The reasons are multifactorial and encompass all level of services.[4, 5, 1, 1a.] As a Learning Disability Specialist Dietitian, I often find myself asking questions such as, "What is the skill and knowledge set needed to effectively work with this client group?" or "Is this specialist? Is this general?"

Dealing with the challenges

My caseload is really varied due to the range of dietetic vulnerabilities. Eating, drinking and swallowing difficulties contribute towards high enteral feeding prevalence;[7] furthermore, this group is at greater risk of malnutrition, obesity, gastro intestinal (GI) conditions and GI cancers relative to the rest of the population.[7,8]

> **"Complex communication needs reduce the ability for this group to accurately describe symptoms"**

One point of particular consideration is that complex communication needs reduce the ability for this group to accurately describe symptoms. Pain or discomfort may be misinterpreted by family, carers and health and social care staff, leading to early indicators of illness being missed.[6]

As dietitians, it is our call to be curious about the dietetic presentation and whether there may be undiagnosed digestive conditions which are not being verbally described. It is important we don't accept thinking such as "this is normal for him" or "she's always been like this". We need to ask questions of ourselves such as "when did the change occur?", "have all reasonable steps been taken to eliminate possible reasons for the presentation?" We should always aim to start with the least invasive steps, but should consider ways to rule out other possible causes, such as a scan or a stool or blood test.

It may also be difficult for the person to either consent to or tolerate investigations/interventions including changes to diet. However, this is key and is where LeDeR identifies failings. The Mental Capacity Act (MCA) 2005 and the Equality Act 2010 provide legal guidance. If we are uncertain if a person can consent to, or understand, our dietetic intervention, then a capacity assessment is indicated. Reasonable adjustments need to be made to ensure that people with LDs can access effective health services. Varied approaches can be taken to support the person to engage such as de-sensitisation, social stories or, where appropriate, medication.

The five most frequently-reported long-term health conditions for people who died in 2021 and received an initial review were: epilepsy (33%, n=364), cardiovascular conditions (33%, n=357), mental health conditions (32%, n=355), sensory impairment (25%, n=269) and dysphagia (23%, n=250).

Making a difference

Consider these questions:

- "Is a capacity assessment needed regarding acceptance of dietetic treatment?"
- "Have all reasonable adjustments been made to meet this person's needs?"
- "Could there be an undiagnosed digestive condition?"
- "Is the relevant information available for the assessment?"
- "Who else do I need to communicate with to support and implement the nutritional plan?"

My dietetic role working with people with LD as part of a multidisciplinary team brings magic and meaning, a strong value base, variety, diversity, equity and, above all a person-centred approach.

The next time you complete a dietetic intervention with someone with an LD, remember you are in a position to really make a difference to their health outcomes by asking the right questions.

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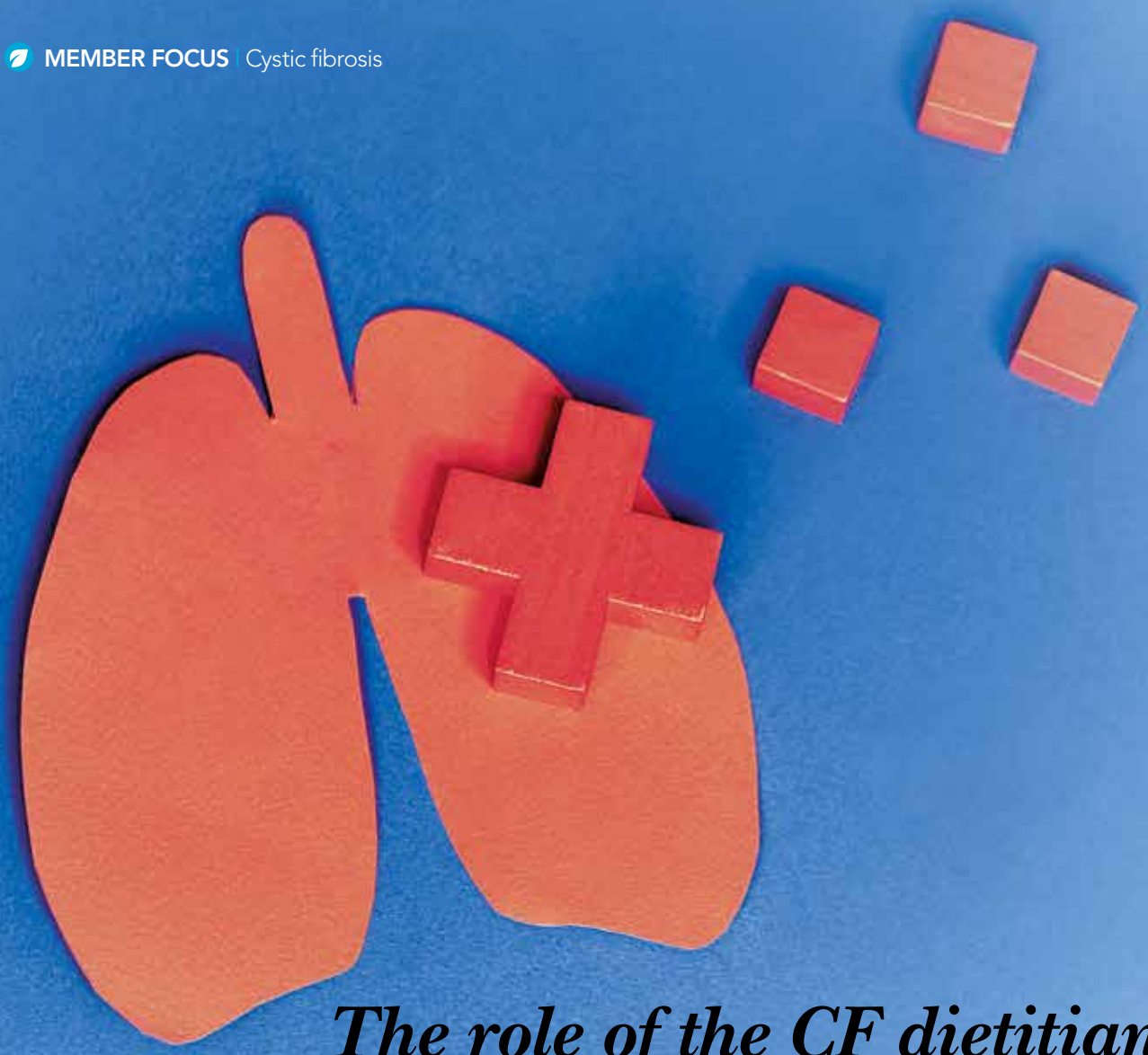

The role of the CF dietitian in the transformative era of CFTR Modulator Therapy

Joanne Barrett highlights the changing nutritional landscape of cystic fibrosis with the introduction of CFTR modulator therapies

Writer info

Joanne Barrett is Lead Specialist Cystic Fibrosis Dietitian at West Midlands Adult Cystic Fibrosis Centre, University Hospitals Birmingham NHS Foundation Trust

Cystic Fibrosis (CF) is the most common life-limiting genetic disease in the UK affecting around 10,000 people.[1] It is a complex multisystem disorder, leading to frequent respiratory exacerbations and respiratory failure, pancreatic insufficiency, fat soluble deficiency, CF-related diabetes (CFRD), liver disease and osteoporosis.

CF dietitians work as part of a multidisciplinary team and have a leading role in the management of pancreatic enzyme replacement therapy (PERT), fat soluble vitamin therapy and CF-related diabetes. Until recently, CF nutritional management guidelines recommended high energy intakes of 110-200% of those required by healthy individuals to enable patients to achieve their growth potential and body mass index (BMI) targets associated with better lung function: > 50th centile for children aged 2-18 years and BMI 22-23kg/m^2 for adults.[2] This approach has been successful at improving the nutritional status, lung function and life expectancy of people with CF. However, it has also contributed to an increasing number of patients with overweight or obesity.[3] This prevalence has increased further since the introduction of new highly effective

KNOWLEDGE BOOSTER

- BDA CF Dietitians Group – **bda.uk.com/specialist-groups-and-branches/cystic-fibrosis-specialist-group.html**
- Cystic Fibrosis Trust Nutritional Management Guidelines – **cysticfibrosis.org.uk/the-work-we-do/resources-for-cf-professionals/consensus-documents**
- CF Trust Life Saving Drugs – **cysticfibrosis.org.uk/the-work-we-do/campaigning-hard/life-saving-drugs**
- CF Source UK (pharma) – **cfsource.co.uk/**

precision medicines – cystic fibrosis transmembrane conductance regulator (CFTR) modulator therapies.

What are CFTR modulator therapies?

CFTR therapies treat the underlying cause of cystic fibrosis by correcting CFTR protein dysfunction present in the chloride channels of epithelial cell membranes. The first of these drugs – ivacaftor (Kalydeco) – became available on the NHS in 2016 to approximately 5% of patients who had the appropriate genotype. Triple CFTR therapy – elexacaftor/tezacaftor/ivacaftor (Kaftrio) – became available to the majority of adult patients with the commonest CFTR mutation, delF508, in 2020 and paediatric patients over the age of six years in 2022. Clinical trials of Kaftrio demonstrate a 14% improvement in lung function, 75% decrease in frequency of respiratory exacerbations and 1kg/m^2 BMI increase over 24 weeks.[4, 5]

What has been the impact of CFTR modulator therapies on the nutritional management of cystic fibrosis?

Prior to the availability of Kaftrio, the BMI of the UK CF population had been steadily increasing and CF dietitians were starting to advise more patients on modifying their energy intake to prevent excess weight gain. However, since Kaftrio, significant proportions of adult patients have started to have overweight and are requiring weight management advice.

Dietetic management has responded to this change and is now focused on a high quality, healthy eating approach to weight management and achieving a favourable body composition. Assessment of body composition is beginning to be used in clinical practice to assess nutritional status, as evidence indicates that muscle mass is more strongly associated with lung function than BMI.[6]

The many co-morbidities and complications of CF remain: patients still require advice on the management of PERT, prevention of constipation and other gastrointestinal complications, and many patients have diabetes, low bone mineral density and still require fat soluble vitamin supplementation. Additionally, modulator therapy has increased female fertility and more patients have become pregnant on modulator treatments requiring highly specialised nutritional advice.

What have been the challenges? How have CF dietitians responded to this change?

This change has occurred extremely rapidly with many patients experiencing a reduction in respiratory symptoms after a few days of treatment and significant weight gain over a few months. This is a new experience for patients with CF – most have experienced poor appetite and difficulty gaining weight at some time in their life, and some have not previously found eating pleasurable.[7] Guided by clinical advice, patients prioritised high fat, high calorie foods, associated weight gain with good health, and weight loss with respiratory exacerbation. Consequently dietary intakes of patients tend to be higher in energy, added sugars, refined foods, and lower in fruit, vegetables and dietary fibre.[8-10] As healthy eating messaging has not previously been relevant to them, their knowledge base is limited. Changing patients' perceptions of body weight and established life-long eating behaviours focused on weight gain is therefore particularly challenging.

CF dietitians have been working with patients to educate them on how to manage their weight with the adoption of healthy eating principles and behaviours which include lower fat choices, healthy snacking and recognising hunger cues. Modulators must be taken with fat-containing food twice a day to ensure the drug is absorbed effectively, and grapefruit should be avoided as this is an interaction. Patients require practical advice to incorporate this into their diet, whilst simultaneously trying to reduce their fat intake. Alongside our physiotherapy colleagues, we have been encouraging our patients to be more physically active. Patients who are trying to reduce their energy intake require advice on how to do this. Patients are needing time to adjust to the 'new me' and become behaviour change 'ready'. Some patients are struggling with a change in their body image, whilst others require reassurance that eating fewer calories and losing a small amount of weight is not going to compromise their health.

Kaftrio became available at a time when we were unable to see our patients regularly as they were shielding during the COVID-19 pandemic, therefore delivering this advice has also been a challenge. In response to this, new models of virtual care and home monitoring are emerging, with services becoming increasingly outpatient-based. Many dietitians have used innovative ways to provide education, advice and support remotely using smart phone applications, developing online education programmes and webinars.

What will be the future role of the CF dietitian ?

The future health trajectory of patients with CF is still unknown. CFTR modulators are expected to improve the survival of patients with CF.[11] In an ageing CF population, co-morbidities such as obesity, osteoporosis, cardiovascular disease and cancer are expected to be more common.[12]

CF dietitians will continue to have a central role in advising and educating patients on how to achieve an optimal nutritional status, but this is increasingly focused on a high quality dietary intake and a healthy weight. Nutritional guidelines already reflect some of these changes.[13] Furthermore, assessment of body composition is likely to become a routine part of clinical practice.

Future research is needed to understand the impact of CFTR modulators on the nutritional requirements and optimal nutrition outcomes for patients with CF. We must not forget that 10% of patients still do not have a CFTR modulator therapy appropriate for their genotype, and some are unable to tolerate the side effects of these drugs. These patients will continue to require a traditional approach to nutritional management.

Observing the transformative effect CFTR modulator therapy is having on the health of patients with CF has been remarkable and the role of the CF dietitian will continue to evolve as more genetically targeted therapies are developed.

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CLINICAL

this month:

Features

HOW SERVICE EVALUATION STUDIES CAN SUPPORT SERVICE IMPROVEMENT
When to consider performing a service evaluation study and how to go about it
Maria Barrett

DIETETIC INTERVENTION WITHIN FAMILY-BASED TREATMENT FOR ANOREXIA NERVOSA
An evaluation of whether a specific nutritional intervention using a food pyramid educational tool would support increased parental confidence and empowerment in refeeding
Ruth Devenish

How service evaluation studies can support service improvement

Maria Barrett looks at when to consider performing a service evaluation study and how to go about it

KEY POINTS

1. Designing a service evaluation study can be daunting. However, if you imagine that you are designing a quality improvement project, a lot of the same tools that are used in project planning can be used here.

2. To help devise your research question, it is helpful to perform an exploratory literature review. This not only informs your own study question and methodology, but will also provide the evidence you need to strengthen your argument when attempting to engage stakeholders.

3. If you are a leader/manager and you anticipate the need for devising a business case to fund a service initiative, then encouraging your team to perform a service evaluation not only generates a lot of the evidence needed for the business case but also instils important research skills within your team.

From time to time as clinicians, we might find ourselves pondering whether current service provision is meeting the needs of our patient cohorts or whether there is something we can do to improve efficacy and efficiency. In this article, I discuss the process of undertaking a **service evaluation study** and, from this, devising a **business case** to implement service change. This will be illustrated with the example of a recently published service evaluation study.[1]

Identifying potential service improvement

I work in an intestinal failure team who care for those who require home parenteral nutrition (HPN). Prior to study commencement, the European Society for Clinical Nutrition and Metabolism[2] (ESPEN) recommended that vitamins A, B12, D and E be monitored every 6-12 months in those on HPN. Even though vitamin C plays an important immunoregulatory role in our physiology, it was not referenced in the guideline. In our patients, I noted that vitamin C concentrations were only checked in those in whom insufficiency was suspected. I wondered whether vitamin C insufficiency was more prevalent among our patients than current monitoring revealed, and thus if there was a need to monitor these concentrations more regularly.

When I proposed this question to my MDT, we decided that I should investigate whether vitamin C concentration checks should be included among the micronutrient concentrations that were routinely monitored. This presented the question of whether I needed to undertake an audit, a service evaluation study or a research study.

Is it audit, service evaluation or research?

The differences between each type of investigation are shown in Table 1. The Health Research Authority also provides some helpful tools to help answer this question, which can be found at the following links:

hra-decisiontools.org.uk/ethics/
hra-decisiontools.org.uk/research/

For our patients, there was no standard/guideline recommending that vitamin C concentrations be regularly monitored in those on HPN, so it was not an audit that I needed to undertake. I therefore had to decide whether it was research (i.e. requiring ethical approval) or was it service evaluation? As my team and I did check vitamin C concentrations in those in whom we felt it was clinically indicated – meaning it was a part of the current service – the question I was asking was "what standard does my service achieve?" I therefore concluded I needed to undertake a service evaluation.

Where to begin

When aiming to undertake a service evaluation, designing the study can be daunting. However, if you imagine that you are designing a quality improvement project, a lot of the same tools that are used in project planning can be used here. A helpful resource that breaks down the stages of project planning and the tools that can be used at each stage can be found on the NHS Improvement website.[4] Thus, in a similar format, for service evaluation study design, one can begin by *gaining key stakeholder support*.

To identify the key stakeholders (i.e. the key people with an interest/influence), a process map tool can be used (Figure 1). For my patients, their micronutrient concentrations are monitored when they attend for their HPN appointment. I therefore mapped this process – beginning from the point they attend, through to venepuncture, to laboratory analysis and finally reviewing the resultant level.

From this, it was clear that I needed to engage not just those clinicians involved in the HPN clinic but also the biochemistry department and the outpatient (OP) clinic phlebotomy team.

A stakeholder analysis is a useful tool to determine the

Table 1: Is it research?

Research	Clinical audit	Service evaluation
Designed to derive generalisable new knowledge	Designed and conducted to produce information to inform delivery of best care	Designed and conducted solely to define or judge current care
Designed to test a hypothesis	Designed to answer "does this service reach a predetermined standard?"	Designed to answer 'what standard does this service achieve?'
Addresses clearly defined questions, aims and objectives	Measures against a standard	Measures without reference to a standard
Study design may involve allocating patients to intervention groups	No allocation to intervention	No allocation to intervention
Normally requires Research Ethics Committee review		

Note: Adapted from the "Defining Research' table produced by the Health Research Authority[3]

Figure 1: Process map of micronutrient level monitoring in our HPN patients

level of impact of each stakeholder and the degree of desired participation from each.

Table 2: Stakeholder analysis

High power	**Satisfy** Patient	**Manage** Medical director, duty biochemist
Low power	**Monitor** Research department	**Inform** Dietitians, HPN clinicians, OP clinic staff
	Low impact	**High impact**

Top tips for stakeholder engagement

- Incorporating research into daily clinical practice is a key strategic focus of the recently published *Allied Health Professions' Research and Innovation Strategy for England*[5] – this includes adopting research skills to drive service improvement and innovation
- Be well informed of the accurate facts and figures
- If applicable, share examples of how the proposed change works elsewhere

Registering your service evaluation

Once key stakeholders are engaged, and it has been agreed the service evaluation will go ahead, this is the time to register your service evaluation with your Trust's research department.

Even though service evaluation is not classed as 'research', it needs to be registered with the research department – much like how you would register an audit with your audit department. Your research department will send you the necessary forms to complete. This will likely include a study protocol template. This is a helpful prompt of the kinds of questions you will need to ask when planning your study.

Aims and objectives

As with any quality improvement project, *setting clear aims and objectives* precisely outlines the expectations of your project and clearly details how it will be known that the desired state has been achieved. For a service evaluation, formulating your research question will form the basis of your primary aim.

To help devise your research question, it is helpful to perform an exploratory literature review. This not only informs your own study question and methodology, but will also provide the evidence you need to strengthen your argument when attempting to engage stakeholders and provide the evidence required to write a brief 'background/rationale' statement in your study protocol.

Rapid evidence synthesis (also known as a rapid review) is a form of literature searching that is currently meeting with growing popularity in the health research world. This method applies itself well to a time-strapped clinical working environment as it is less time consuming than a systematic review, while still providing a helpful structure to perform an effective review of a clinical topic. For more information on rapid evidence synthesis, please visit the Cochrane Methods website[6] or watch the Cochrane Learning Live webinar[7] on this topic.

For my own service evaluation, my team and I agreed that we were most interested in understanding whether vitamin C insufficiency is prevalent enough in our population to prompt regular blood monitoring. We therefore agreed the following **primary aim**: *"To estimate the prevalence of vitamin C insufficiency among patients with intestinal failure dependent on home parenteral nutrition."*

Top tips for performing a literature review

- Speak with your *Trust librarian* who can set you up with an NHS Athens account that grants you access to relevant evidence databases and resources
- Your librarian can also help you with refining your research question and devising a suitable *search strategy*

I also set myself the goal of unearthing any factors which were significantly associated with those who were vitamin C insufficient (if any). This could be useful information for any future trials that hoped to explore possible risk factors. My **secondary objective** therefore was: *"To evaluate if any factors are significantly associated with vitamin C insufficiency within this population."*

Your aim and objectives can then be translated into outcome measures or 'endpoints'. For example, the endpoints devised for my service evaluation were:

Primary endpoint

Percentage prevalence of vitamin C insufficiency

Secondary endpoint

Comparison of associated factors between patients with and without vitamin C insufficiency

Defining the scope

Within project planning, clarifying that which lies within and outside the project scope prevents the risk of assumptions being made. This concept is applied to service evaluation through clear articulation of (a) the methodology, and (b) the inclusion and exclusion criteria.

For my service evaluation, the methodology was derived from *advice from key stakeholders* and *current processes*.

As there would be an additional cost to checking the plasma vitamin C concentrations, the biochemistry team advised we first check the patients' CRP concentrations. If <10, we would then proceed with sending the vitamin C blood samples for analysis. This is so the concentrations

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being checked were clinically reliable. Thus we required buy-in from the biochemists to perform a manual CRP check before the rest of the blood samples were processed. Vitamin C samples also needed to be received within two hours of collection, so OP clinic staff needed to be engaged and ready to send samples within that time-frame.

From discussions with key stakeholders, the following process steps were agreed:

- Weekly review of OP clinic lists to identify those that meet the inclusion criteria
- Weekly emails to the duty biochemist and OP clinic staff to advise on the number of patients from that weekly clinic who would require a plasma vitamin C check (this included a reminder that lithium-heparin vacutainers would be required for the blood collection and that samples needed to be sent to the lab within two hours of collection)
- Weekly liaison with the dietetic team who would be performing the dietetic assessments and collecting the relevant information
- Patients were informed that routine micronutrient monitoring would also include a check of their plasma vitamin C concentrations and that this sample would not be processed if their inflammatory markers were raised. Consent to perform blood monitoring was obtained as part of routine practice

Data collection

Providing all data collectors with a data collection table will help ensure the desirable data ('variables') are provisionally collected. This can then be transferred to a data spreadsheet. Note: adherence to Trust Information Governance protocols to protect all collected data is essential.

Statistical analysis

All quality improvement projects have an evaluation strategy. For service evaluations, this often comes in the form of a statistical analysis plan. If you don't feel confident on this bit (and often even if you do), I would advise you speak with your Trust statistician. Most NHS Trusts have access to statistical advice, so contact your research department and ask their advice on who you should contact. If you do not have access to a statistician, contact your local CAHPR (Council of AHP Research) hub.[8] Each region has a hub, and their purpose is to promote and develop AHP research. Your hub will often be able to direct you towards AHPs who can support.

Even in the planning stages of a study, broadly deciding on the statistical analysis you aim to undertake is important as this will help you determine what details (i.e. data variables) should be collected. Additionally, and importantly, it will help you decide how many patients you will need for your study. There is little point in undertaking a service evaluation study if you don't intend to include enough participants to give you 'meaningful' results. Another way of saying this is you wish to sufficiently power your study to avoid both a *type 1 error* (reporting your findings as significant when they have actually occurred by chance) and a *type 2 error* (reporting no significant finding when there actually is).

For my service evaluation, a sample size calculation could not be performed as I did not have previous data to base this calculation on. In other words, I could not predict the standard deviation (or variance) of my primary endpoint. If I estimated a standard deviation value that was too high, I risked including more participants than was necessary. If estimated to be too low, I risked not including enough participants to find the required effect (i.e. a type 2 error). Instead I applied a general rule of thumb that can be used for pilot studies (i.e. small studies that test a concept and explore feasibility). I decided a small pilot study met the purpose of the question I was asking as I was not aiming to derive generalisable results that could be applied to the nationwide HPN population (i.e. I was undertaking service evaluation not research). Instead, I was asking if vitamin C insufficiency was prevalent enough among my own population to warrant checking these concentrations more regularly.

Thus for such studies, Browne[9] recommends one 'use at least 30 subjects or greater to estimate a parameter' if undertaking a two-armed trial (i.e. comparing two groups). As I intended to analyse one parameter (i.e. plasma vitamin C concentrations), I estimated that a sample size of 30 patients would be sufficient to answer my question.

Other reasons for contacting your local CAHPR hub:

- If you anticipate that your study might have a small financial cost attached to it, your local CAHPR may know where to direct you to apply for these funds
- CAHPRs are always keen to know where budding researchers might be found. If you are interested in learning more about what research training opportunities are out there for AHPs in your area, either for yourself or other members of your team, CAHPR can add you to their mailing that shares information on a wide range of available opportunities

So I have my data, now what?

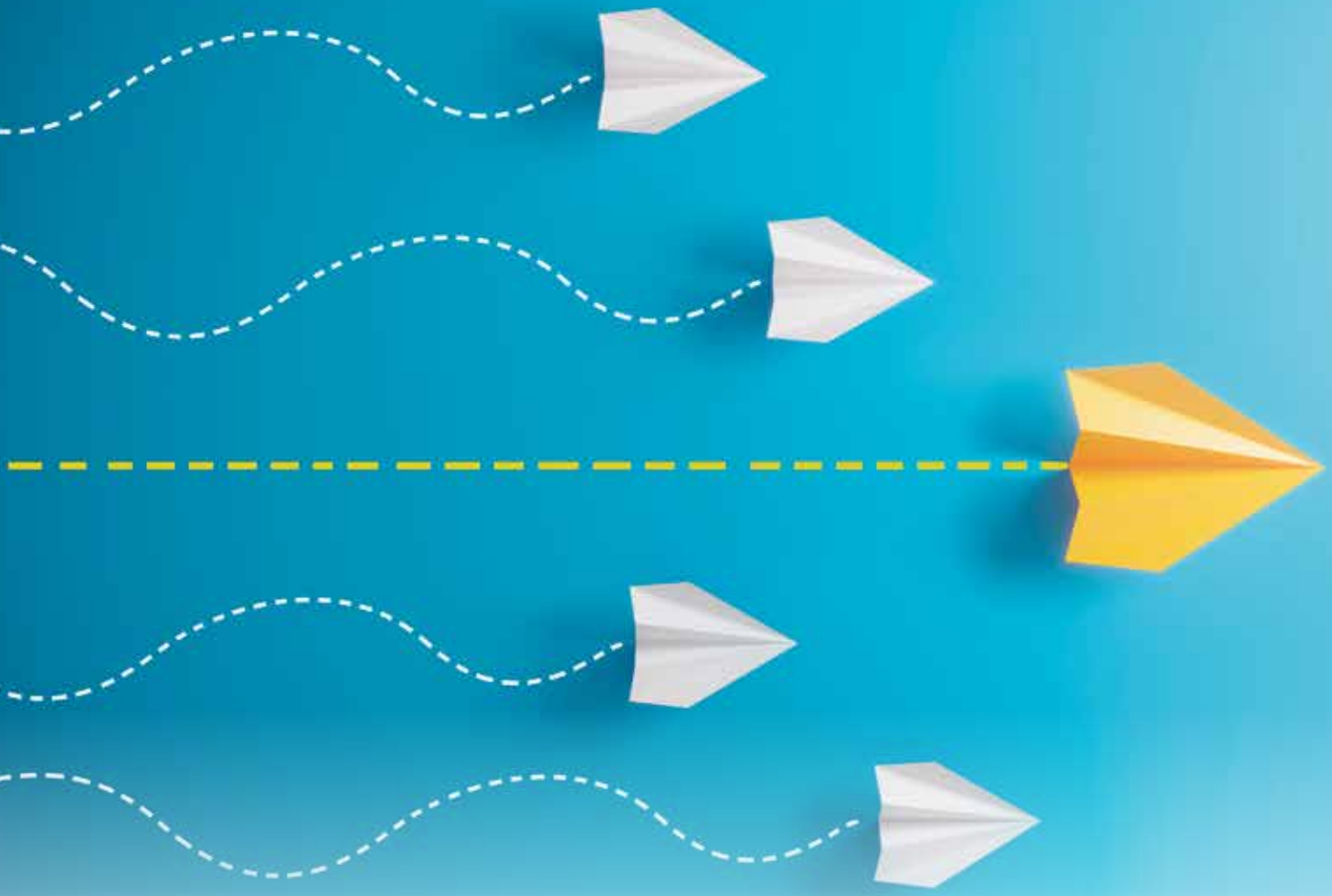
Well this is where you refer back to your statistical plan. For my service evaluation, I had two groups – those who were vitamin C insufficient and those who were vitamin C sufficient. To work out prevalence, I just needed to calculate the percentage of my group that were vitamin C insufficient. If that is all you are interested in then – great! You can stop there.

However, I wanted to understand a little more than that. Namely, I wanted to understand more about why current HPN provision was not meeting the vitamin C needs of those with insufficient concentrations. I appreciate I may lose some of my readers at this point, so I understand if you wish to bow out here and move on to the next section. But for those who wish to understand why I did what I did, then please read on.

I expected there to be a linear relationship between HPN provision of vitamin C and plasma vitamin C concentration – if I gave more vitamin C in the HPN solutions I expected to see a concurrent rise in plasma vitamin C concentrations. This is called a *correlation analysis*. It can be measured in one of two ways:

- Pearson correlation (the comparison of raw data)
- Spearman rank correlation (the raw data is converted to a ranking order and the correlation between these two ranked variables is compared)

THINK DIFFERENTLY ABOUT BOWEL TRANSIT



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If your data is normally distributed, you can perform a Pearson correlation analysis. If your data is not normally distributed (i.e. non-parametric), you should perform a Spearman rank correlation.

When I measured the correlation between weekly HPN provision of vitamin C and the corresponding plasma vitamin C concentration, my analysis showed me that there was a *positive* correlation. In other words, for every unit increase in HPN vitamin C provision there was a corresponding *increase* in plasma vitamin C concentration. This was interesting because it told me that my patients were likely dependent on HPN provision of vitamin C. In other words, those who had sufficient levels did not do so because they were getting vitamin C from an alternative source (such as oral diet or supplementation).

I also looked at the difference in characteristic traits between my two groups. To analyse this, I first needed to judge if my variables were continuous (i.e. a quantitative variable that is continuous in one direction; for example, small bowel length) or categorical (i.e. has two or more categories; for example, yes/no or male/female). I compared *categorical* variables using Chi square analysis.

For *continuous* variables, I first needed to determine if my comparative groups are *independent* or *paired*. As there were different people in each of my groups, they were classed as independent. Then, judging from whether my group data was normally distributed or not, I could either perform a student's t test (if normally distributed) or a Mann Whitney U test (if non-parametric). For more information on deciding on which test to use when statistically comparing two groups, please refer to the algorithm in Figure 2.

When I compared the two groups, they did not significantly differ. This, again, was an important result, as it meant that the insufficient vitamin C concentrations were more likely to be related to HPN provision than any other variable.

Reviewing your results

Once you have generated your results, it is time to disseminate them to the key stakeholders (and the wider team members) and decide if there is a need for service change. Based on your results, you could undertake an 'options appraisal' to explore a number of possible resolutions and evaluate the pros and cons of each one. Begin by first evaluating the option 'do nothing' – what risks did your service evaluation highlight? Now outline possible service initiatives which could mitigate these risks and again explore the pros and cons of each option (for example, improved/unchanged patient outcomes, increased/reduced costs, increased/reduced staff time). Do these options present a more favourable state to the option of 'do nothing'? If so, which option is preferable?

Also, you have put all the work in so why not publish it? Not only would it be a great achievement for you and your team, but other teams would likely derive benefit from reading your evaluation. If unsure where to start with writing for publication, I would again urge you to speak with your local CAHPR hub or contact the BDA.

Developing a business case

So now you have your results (or arguments) for making a change, you might now need to write a business case to convince decision-makers to fund your proposed service initiative. For this next step, you have likely already completed a lot of the key stages:

- Clearly demonstrated the need for the service change
- Performed a literature review that evidences your rationale
- Mapped the process
- Gained key stakeholder support
- Performed an options appraisal
- Defined the scope of the proposed initiative
- Assessed the feasibility of implementing the service change
- Gauged any additional costs (staff time, materials, etc.)

Depending on your study design, your service evaluation may also have generated some results that could be used to forecast cost savings. Once calculated, extrapolate your estimated costs and savings to the whole service population. Then calculate the *return on investment* (also known as return on asset), by dividing your savings by your costs and presenting as a ratio or percentage.

Next, devise a *risk management strategy*; outlining the possible risks that may arise from implementing the service initiative, how you propose to mitigate that risk, who will take responsibility for this and when you intend to review that risk management plan.

Finally, consider how you intend to evaluate the benefits brought by this service initiative. You should be a dab hand at evaluation strategies by this point!

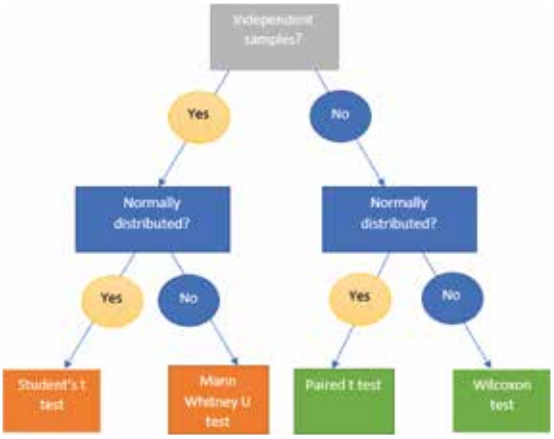

Figure 2: Which statistical test to use for comparing two groups?

Conclusion

It is certainly worthwhile to undertake a service evaluation study when analysing current service provision. If you are a leader/manager and you anticipate the need for devising a business case to fund a service initiative, then encouraging your team to perform a service evaluation not only generates a lot of the evidence needed for the business case but also instils important research skills within your team.

Top tips for writing a business case

- Clearly state the need for your case
- Link your case to NHS policy and priorities, and your Trust's objectives and plans
- Present all financial aspects in as much detail as possible

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BDA EVENTS → GET INSPIRED

Dietetic intervention within family-based treatment for anorexia nervosa

Ruth Devenish explains how she went about an evaluation to understand views on whether a specific nutritional intervention using a food pyramid educational tool would support increased parental confidence and empowerment in re-feeding

KEY POINTS

1. The key focus of phase one in the Family-Based Treatment (FBT) manual for anorexia nervosa and additionally the Maudsley family treatment approach is empowering parents with the task of re-feeding their young person. This assumes that parents have adequate knowledge and skills, albeit with the support of their practitioner.

2. As no specific nutritional education is currently written into these therapies for parents or young people, we were curious as to whether there was a need for this. Both these approaches have been impacted on by cultural advice linked to recent obesity campaigns, where parents can start questioning themselves on their knowledge around food choices.

3. We have relooked at how we empower parents via undertaking a small-scale evaluation project within the Dorset eating disorder service to understand parents' and young people's views on whether a specific nutritional intervention using a food pyramid educational tool would support increased parental confidence and empowerment in re-feeding their young person.

The key focus of phase one in the Family-Based Treatment (FBT) manual for anorexia nervosa[1] and additionally the Maudsley Family Treatment approach (FT-AN)[2] is empowering parents with the task of re-feeding their young person.

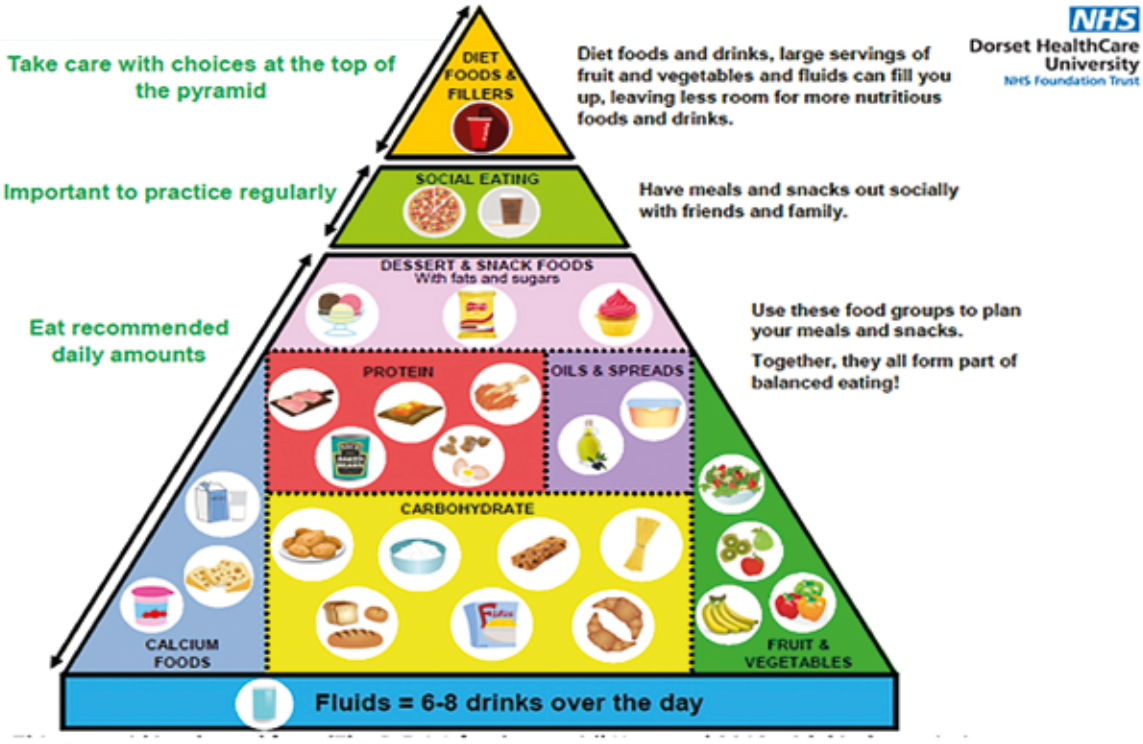
Prescribed meal plans are not recommended within FBT (despite reference to their use in FT-AN). Rienecke et al[3] states that, within FBT, parents are asked to make all eating-related decisions for their child, and are given the responsibility to bring about weight restoration. Therapists are advised to give guidance and advice, but to encourage the parents to come up with their own plan.

Apart from within a potential consultancy role, specific dietetic intervention for parents or young people is not advocated within the FBT manual.[1] As dietitians play a central role in most eating disorder treatment teams, I thought it was worth exploring evidence for the value of nutritional intervention within FBT. Whilst clinical practice guidelines for dietitians working with young people have been published for the FT-AN treatment model[4] and guiding principles and skills within FBT[5], there is overall recognition within current eating disorder psychological manualised therapies of a low endorsement of dietetic input.[6] This can result in dietitians outside of a hospital setting being uncertain about their role and scope of practice.[7]

While we know that our parents are knowledgeable and are aware of the need for weight restoration for their young person, in clinical practice we're seeing their knowledge impacted by recent drives and campaigns to address obesity challenges together with mixed messaging within social media. Parents can start questioning themselves on their knowledge base around food choices or be heavily influenced by choices that their young person's eating disorder deems important. Both influences can impact on their confidence and ability to support nutritional change.

As building confidence is a key part of parental empowerment, I looked at how a dietetic role could support our parents in the re-nourishment stages, whilst staying true to the FBT model of moving away from prescribed meal plans. I also considered whether

Figure 1: Food pyramid guide to balanced eating



This pyramid is adapted from 'The R.E.A.L food pyramid' Hart et al 2018 with kind permission

an intervention for young people would be supportive. As such, I undertook a small-scale evaluation project during 2020/21.

A food pyramid education tool, adapted from the R.E.A.L Food Pyramid[8] (Recovery from Eating Disorders for Life Food Pyramid) was the focus of the nutritional intervention given during the project. This was to support the explanation of balanced eating and food inclusive messages (Figure 1).

Whilst the Eatwell Guide[9] has been embraced by all of us, due to obesity demands it has had to adapt. Clinicians were noticing parents and young people struggling with how the new messages work for them, particularly in the context of those with an eating disorder. Part of this evaluation was linked to a comparison between the two educational tools.

The key evaluation questions for the project were:

- Can using a food pyramid educational tool be an effective way to increase parental confidence and empowerment?
- Would young people themselves also benefit from a specific nutritional intervention during their recovery journey?
- Is a specific nutritional intervention beneficial alongside the current manualised FBT approach?

Nutritional tools to support practitioners within the service were also considered, together with their usefulness for dietitians working within eating disorders and non-specialist areas.

Method

During phase 1 of FBT (start of treatment) parents were invited to take part in the project from within two different treatment pathways. The first was those receiving individual therapy (n=12), and the second was those receiving adapted FBT group therapy (n=16).

Those parents receiving individual therapy had the food pyramid education tool given as a handout.

Those parents receiving group therapy had a specific nutritional education session using the food pyramid tool. This included a knowledge-based session together with ensuring information was translated into practical information.

During phase 3 of FBT (end of treatment), parents (n=11) and young people were invited to reflect back and consider the usefulness of the food pyramid education tool within their treatment journeys, with a comparison made with the Eatwell Guide.[9] Young people were invited to take part in the project who had received individual treatment (n=16), together with those who had received the group nutritional intervention (n=11).

A combination of questionnaires and reflection groups were used to gather information from parents and young people, together with professional voices.

This evaluation project was undertaken during the COVID pandemic, which meant that questionnaires were all sent out via post or via email, with the option of a telephone review. Group interventions and reflection groups were all held virtually.

Results

I was interested to know how much obesity-related health messages might be impacting on the way parents were making their food choices.

"Parents are aware of the need for weight restoration but sometimes question themselves and lose confidence"

As shown in Graph 1, feedback from parents' questionnaires of those receiving individual therapy indicated that these messages were impacting on approximately 50% of the parents questioned. This feedback included many concerns over 'unhealthy' snacks, the choice of diet and low-fat foods being the norm, and not realising the impact on their young person's recovery journey. This percentage is in keeping with what we are experiencing in practice.

When I asked the same question to our parents who were having group intervention, I picked up a much smaller impact of obesity messages on their food choices. As this is not in keeping with what we experience, this may have been due to:

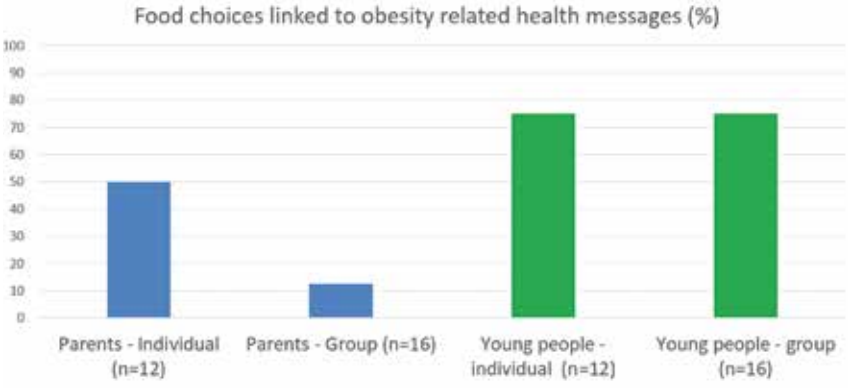
1. Parents filling in their questionnaire just before the session started, so there was no time to explore it with them
2. Several parents answering that they felt they just followed a 'healthy diet'. This can be a common starting point for our parents, where we see the impact of mainstream healthy eating advice intertwined with some diet cultural messages

When the same question was asked to parents, but linked to the food choices of their young person, it was significantly higher, at 75% for both groups (Graph 1). Common themes were low fat, low carb, and use of diet products. A small number did cite environmental concerns impacting on food choices, such as vegetarianism. Several parents also reported that they just didn't know what their young person was searching online or being influenced by.

To support their answers, parents provided the following reflections:

Firstly some feedback on health messages that are likely to impact on food choices within the re-feeding phases:

- "This required a huge shift in our thinking as parents…social media makes you think it's normal to eat low-fat products… now we know more about what is needed, to eat in a balanced way."



Graph 1: Graph showing the possible impact of obesity-related health messages on food choices

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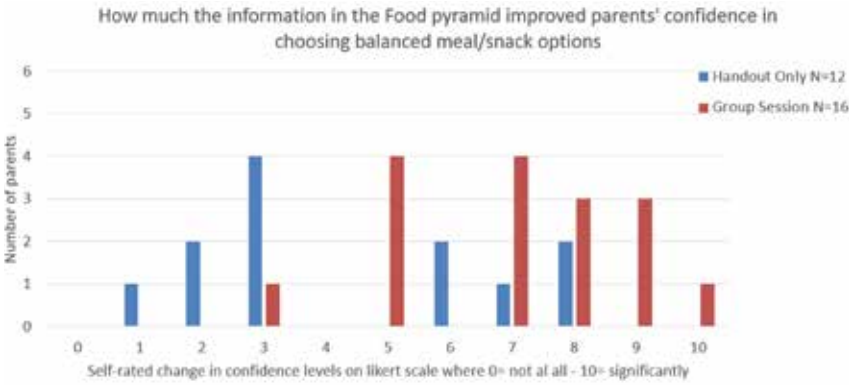


Graph 2: Graph showing how much the information in the food pyramid improved parents' confidence in choosing balanced meal and snack options

- "The media has you in a 'health bubble', which isn't really health."
- "Media influences are still there, making you question what you are eating."

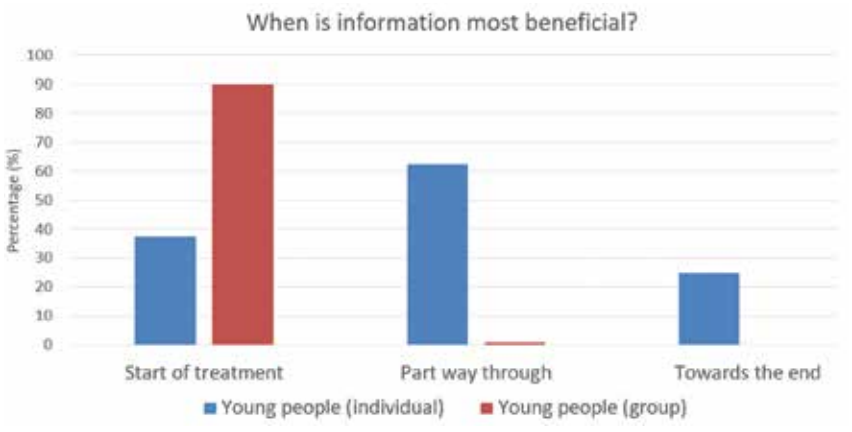
In contrast these are the quotes from parents that were less influenced by current health messages:

- "Aware of mixed messages in the media, I take these with a pinch of salt, and make my own decisions."
- "Generally I am much more influenced by my upbringing (home grown, home-cooked, all in moderation)."

My first step in evaluating the use of the food pyramid was to provide it as a visual guide to parents in the first phase of their treatment journey, in the form of a handout. Overall results showed small improvements in confidence levels (Graph 2).

What was highlighted as a common theme was that, although parents did rate some improvements in their confidence levels, to be more effective the food pyramid needed to be explained, and made more practical, translating it into actual meals and snacks. This makes sense when you consider the high levels of anxiety at the start of treatment, and parents needing to make decisions on what foods to feed their young person.

Results from the first group of parents were very helpful and allowed me to consider how to deliver the food pyramid messages in a more practical way. I wanted to know if a slightly different approach would increase parental confidence levels further.



Graph 3: Graph showing when in their recovery journey young people would have found nutritional information most beneficial

Comparing the group's results with those who received the handout, we found parents who received specific nutritional education delivered in a group session rated themselves to have higher levels of confidence in choosing meal and snack options for their young person (Graph 2).

Parent group reflections that linked to improved confidence levels included the following:

- "I stopped overthinking about what I was feeding my daughter (perceived 'unhealthy snacks'), and then I was able to move forward."
- "Helped all of us to know why eating all food groups is important and not to cut anything out."
- "Helpful for us all to hear the same message." (Parents and young people together)
- "Can feel like I'm battling alone, without information."
- "Quietly reassuring that there's not a big mystery to this for us anymore."

The next results are linked to the evaluation question "Would young people themselves also benefit from a specific nutritional intervention during their recovery journey?"

"To be more effective, the food pyramid needed to be made more practical, translating into meals and snacks"

In order to help answer the evaluation question, young people were asked about their nutritional beliefs at the start of their treatment journey. The following statements were part of their feedback:

- "I tried to completely remove fat and carbohydrates from my diet because people say that you put on weight eating these. Heard these messages from talking with friends at school, online articles."
- "Sugary snacks and meals out were bad, and not something that could be regularly incorporated into general life."
- "Countless messages, honestly, all dairy is bad and 'fattening', sweets and sugars are awful, sauces are bad, fats and oils are bad, fruit is too sugary, etc etc."
- "You can't have 'unhealthy' foods like biscuits, cake, chocolate, as they will make you fat."

These beliefs are very much connected to our parents' responses of the impact of obesity-related messages they thought their young people were influenced by.

Young people receiving individual therapy (n=16) were asked if they would have liked specific nutritional information on the food pyramid during their recovery journey.

The majority of young people (87.5%) answered 'yes', that they would have liked this information.

The reason two young people said they didn't want this information was linked to one not feeling that their recovery was impacted on by specific nutritional beliefs, and the other one feeling that it would have been too overwhelming for them to have received it.

I asked both groups of young people (individual and group interventions) when they would have liked this information.

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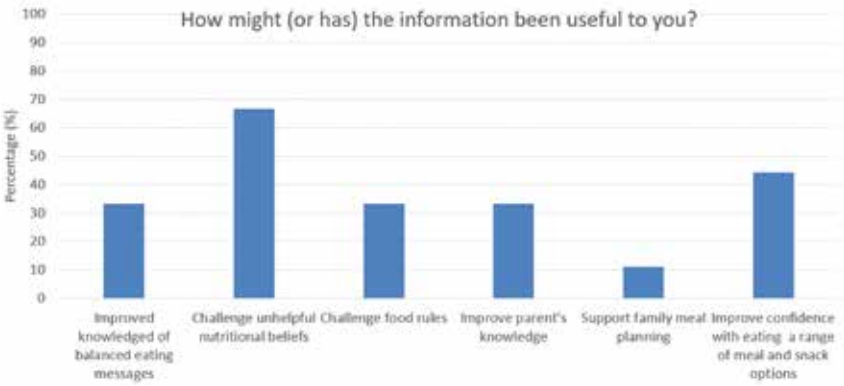


Graph 4: Graph showing how nutritional information might be or has been useful to young people in their recovery journeys

As you can see from Graph 3, those in the individual treatment group were more likely to consider it helpful part way through treatment, although several did want it at the start.

The young people receiving group treatment had the food pyramid education session at the start and found it valuable at this stage of their recovery.

Young people found the messages in the food pyramid supportive in challenging nutritional beliefs, and valued the importance of a specific nutritional intervention within their recovery journey.

"Young people found the messages in the food pyramid supportive in challenging nutritional beliefs"

I was interested to know how the messages in the food pyramid might be or had been useful to our young people.

As you can see from Graph 4, the highest percentage felt it helpful to support them to 'challenge unhelpful nutritional beliefs'. Other ways that scored highly were 'improved confidence with eating a range of meal and snack options' and 'improved knowledge of balanced eating messages'. A few young people felt that it would 'improve their parents' knowledge', which is something worth considering when we're focusing on parents modelling balanced eating messages within the family therapy approaches.

The next results were about which nutritional education tool would best support young people during their recovery journey.

Firstly, a summary of themes from young people's reflections from the Eatwell Guide[9] were as follows:

The positives of the Eatwell Guide:	The negatives of the Eatwell Guide:
Liked the circle shape	It encourages me to choose low-fat options
Good visuals	It encourages me to calorie count
	It supports me to choose fewer cakes and sugary foods

When young people were asked this question within a reflection group, they concluded that the Eatwell Guide supported their eating disorder voice (the internal noise which is experienced as part of anorexia). This is obviously a concern when we are considering a tool to support wellness and recovery.

When young people were asked about the food pyramid tool (Figure 1), a summary of themes from their reflections were as follows:

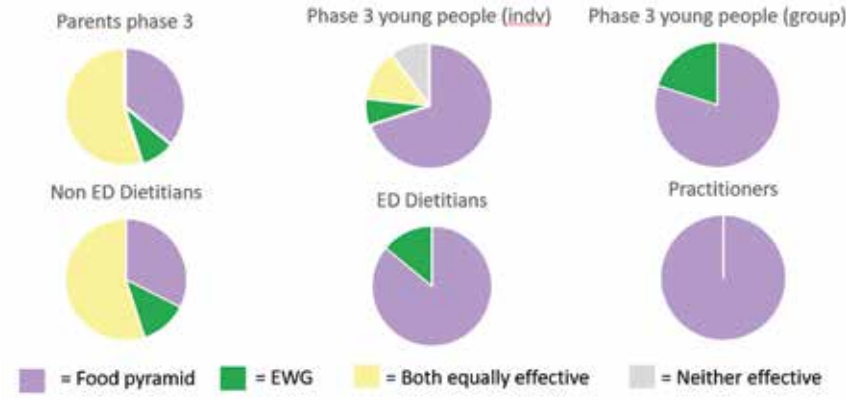
Positives of the food pyramid:	Negatives or things to improve about the food pyramid:
It encourages balanced eating	A circle format is easier to understand than a pyramid
It promotes the importance of all food groups	
It normalises social eating	
It supports the inclusion of dessert and snack foods	

To gain a slightly wider view of these tools that we had available to us to support balanced eating messages, I sought views from parents at the end of their journey in our service, together with some professionals. These included:

- Eating disorder practitioners, working with young people in our service (n=8)
- Dietitians specialising in eating disorders (ED) within our south west interest group (n=10)
- And dietitians locally, working with young people, but non-eating disorder specialists (n=6)

The results in Graph 5 show that our eating disorder practitioners really liked the food pyramid. Young people found it really helpful, as did eating disorder dietitians. Our phase 3 parents and non-eating disorder dietitians had similar views on both guides being useful, with some favouring the food pyramid over the Eatwell Guide.

The final question was "Is a specific nutritional



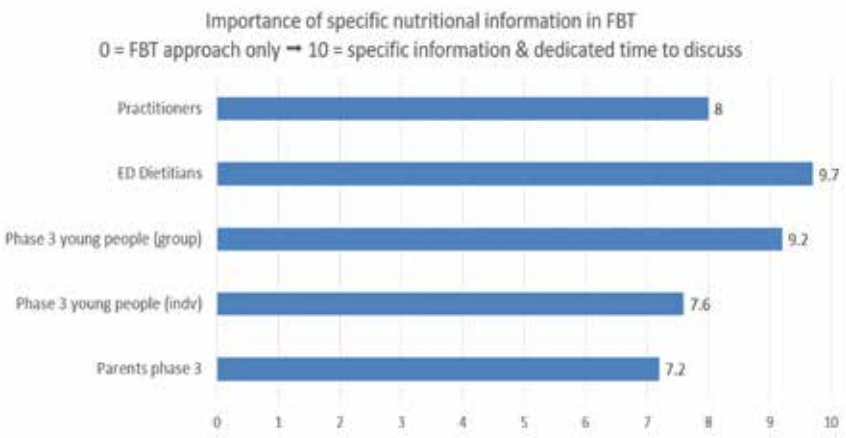
Graph 5: Which nutritional educational tool would best support balanced eating messages or help challenge nutritional beliefs?

intervention beneficial alongside the current manualised FBT approach?"

In addition to the results provided so far, Graph 6 illustrates the views of both family and professional voices.

Eating disorder dietitians unsurprisingly scored the highest for the importance of a specific nutritional intervention.

This was followed by those young people who'd received the group nutritional intervention. However, all groups overall felt specific nutritional intervention was of benefit alongside family-based treatment.



Graph 6: Results showing feedback from the question: "Is specific nutritional education important within the current manualised FBT approach?"

Discussion

Whilst parental empowerment is such a key part of the family treatment models, this evaluation study showed how adding a specific nutritional education to the manualised FBT approach can support increased parental confidence levels. Whilst the family treatment models for anorexia nervosa have been published relatively recently,[1,2] ongoing exposure to healthy eating messages that can intertwine those linked to our diet culture can mean parents getting stuck in their confidence levels with how to support the re-nourishment of their young person.

Having an educational tool to support balanced eating messages and food inclusivity that young people and parents could identify with was also an important part of this evaluation.

In line with concerns from the Mental Health Specialist Group of the BDA[10], our dietetic team had questioned the usefulness of the current Eatwell Guide[9] in our service, and I wanted to discover how our adapted R.E.A.L food pyramid could be used to support balanced eating messages for parents and young people.

Overall, the results showed the most effective way to increase parental confidence and empowerment was via a specific nutritional education delivered within a group session. This included a knowledge-based session on food groups together with the practical application to meal and snack choices. As improved confidence levels were rated amongst all group attendees, the benefit of a group intervention would seem to be important beyond those impacted on by the current diet culture. The role of parent interactions and peer support within a group session was observed to be important. This included the sharing of meal and snack ideas, and parents sharing successes with the re-introduction of some challenging food items.

The majority of young people in this evaluation project did want to receive nutritional information on the food pyramid during their recovery journey.

The benefits were linked to supporting them to challenge their eating disorder, as well as improving confidence in balanced eating messages and food choices.

Those that had received a group dietetic intervention valued this approach, and this could be expanded upon for everyone.

Whilst the food pyramid education tool was shown to be an effective way to increase parental confidence and empowerment, young people were also able to connect with it too. They expressed significant concerns with the current Eatwell Guide[9], which matched those of professionals within our service.

The use of the food pyramid as an educational tool outside of an eating disorder context showed emerging connectiveness with non-eating disorder dietitians and parents.

Conclusion

Overall, this evaluation showed that a specific nutritional intervention was beneficial alongside the current family-based treatment models. The intervention given worked alongside the FBT approach of not providing prescribed meal plans to families, but providing another way to empower parents with the skills and confidence to be able to plan and prepare their own meal and snack structure that met their family routines and cultural preferences. This was confirmed by professional views, and supported by young people too.

Whilst parents and young people valued the dietetic role to deliver the nutritional intervention in this study, further research into this area would support its value and integration within the current FBT manual.

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ONLINE

APPROPRIATE PRESCRIBING GUIDANCE FOR DIETITIANS
Provider: British Dietetic Association
Venue: Online
Cost: BDA Members £75, non-members £120
Details: This module is aimed at all dietitians: newly qualified or practising for many years; those working in an acute setting, the community or on a freelance basis; adult and paediatric-focused dietitians.
How to book: bda.uk.com/events/e-learning.html

INTRODUCTION TO NUTRITION IN MENTAL HEALTH, LEARNING DISABILITIES AND EATING DISORDERS FOR AHPS
Provider: British Dietetic Association
Venue: Online
Cost: BDA members £75, non-members £120
Details: To provide healthcare workers with an essential overview of nutrition in mental health, learning disabilities and eating disorders so that they can support service users' physical health needs.
How to book: bda.uk.com/events/e-learning.html

USING BEHAVIOURAL CHANGE TOOLS IN CHILDHOOD OBESITY
Provider: Dr Laura Stewart T/A AppleTree
Dates: Various dates in 2022/23
Venue: Online
Cost: £295
Details: Practical virtual training on using behavioural change tools in childhood obesity from a leading expert.
How to book: appletreeconsultancy.com/training/training

PROBIOTICS & IRRITABLE BOWEL SYNDROME
Provider: PrecisionBiotics
Venue: Online
Cost: Free
Details: Understand the presentation and impact of IBS, the psychological components associated, and the influence of the gut microbiome.
How to book: precisionbiotics.science/resource-centre/cpd-learning-hub/probiotics-irritable-bowel-syndrome/

NOVEMBER

STARTING OUT IN FREELANCE UPDATED CONTENT!
Provider: British Dietetic Association
Date: 10 November
Venue: BDA office, Birmingham
Facilitators: Jill Scott and Fiona Hinton
Details: This interactive and information-packed course provides an ideal opportunity for dietitians thinking of embarking on a freelance career to equip themselves with the practical tools and know-how to get started. Meet and network with other like-minded dietitians to share and exchange ideas in a supportive environment.

ADVANCING SKILLS FOR DELIVERY OF THE BDA WORK READY PROGRAMME
Provider: British Dietetic Association
Date: 21 & 22 November
Venue: Virtual classroom
Facilitator: Sue Baic
Details: To support the roll-out of the BDA Work Ready Programme, this course, held over two half-days, has been developed to consolidate and advance practice in health promotion in the workplace using BDA Work Ready Programme tools. 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.

ADVANCING DIETETICS IN MENTAL HEALTH (TWO-DAY COURSE) NEW COURSE!
Provider: British Dietetic Association
Date: 28 November & 12 December
Venue: Virtual classroom
Facilitators: Caroline Frascina and Ellie Paterson
Details: This new 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 wanting to specialise in or who have an interest in mental health; or 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.

COELIAC DISEASE: FURTHER MANAGEMENT AND ITS COMPLEXITIES
Provider: British Dietetic Association
Date: 24 November
Venue: BDA office, Birmingham
Facilitator: Fiona Moor
Details: This new blended learning course is aimed at those dietitians who have completed the online pre-course Introduction to Coeliac Disease and its Management module and are looking to further their skills and dietetic practice. We will discuss the complexities of coeliac disease, patient compliance and the nutritional adequacies of the gluten-free diet, along with discussions on dietetic-led coeliac services and case studies.

DIETETIC SUPPORT WORKERS – ENHANCING TEACHING SKILLS FOR THE DELIVERY OF GROUP EDUCATION
Provider: British Dietetic Association
Date: 28 November
Venue: Virtual classroom
Facilitator: Dr Fiona McCullough
Details: Aimed at DSWs working in both acute and community settings, this course will be suitable for those relatively new in post and as a useful update for those with some previous knowledge and experience.

DECEMBER

RESEARCH SYMPOSIUM
Date: 7 December
Venue: thestudio, Birmingham
Details: The Symposium provides dietitians, dietetic students and researchers with an opportunity to showcase their research, highlight the ongoing development of dietetic practice, and be published in the BDA Journal of Human Nutrition and Dietetics (JHND).
How to book: bda.uk.com/symposium

INTERNATIONAL SPORT + EXERCISE NUTRITION CONFERENCE
Provider: ISENC 2022
Dates: 18-20 December
Venue: Manchester Metropolitan University, All Saints Campus, Oxford Road, Manchester, M15 6BH
Cost: £320-£450
Details: The conference is a high-level educational event, endorsed by the BDA, SENF and AfN, for sports nutritionists, personal trainers, students and any professional interested in sports nutrition.
How to book: isenc.org/product/international-sports-exercise-nutrition-conference/

COURSE IN FOCUS

DIAGNOSIS AND MANAGEMENT OF COW'S MILK ALLERGY IN INFANTS AND CHILDREN
Provider: British Dietetic Association
Date: 5 & 6 December
Venue: Virtual classroom
Facilitators: Dr Lisa Waddell and Lydia Collins Hussey
Details: This is an interactive study day, covering two half-days, designed for those dietitians new to allergy or who need a basic level of knowledge. Attendance will enable dietitians to acquire the knowledge towards meeting the competencies set out by NICE and the Royal College of Paediatrics and Child Health on the recognition, diagnosis and management of cow's milk allergy.

GET LISTED
To get your course or event listed please email publications@bda.uk.com

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 Classroom (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**.

JANUARY 2023

CONSOLIDATING DIETETIC PRACTICE IN DIABETES
Provider: British Dietetic Association
Date: 10 January
Venue: Virtual classroom
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.

ADVANCED DIETETICS IN EATING DISORDERS (TWO-DAY COURSE)
Provider: British Dietetic Association
Date: 16 & 23 January
Venue: Online
Facilitators: Lisa Waldron and Stephanie Sloan
Cost: BDA member £280, non-member £390
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. This course is aimed at dietitians new to eating disorders who need more depth than the BDA Introduction to Mental Health, Learning Disabilities and Eating Disorders course or dietitians wanting to specialise in or who have an interest in eating disorders.

DIETETIC PRACTICE IN DIABETES – THE NEXT STEP
Provider: British Dietetic Association
Date: 17 January
Venue: Virtual classroom
Facilitator: Diana Markham
Details: Designed for both dietitians who have previously taken part in the Consolidating Dietetic Practice course or those with some experience in diabetes management who are looking to further their skills and dietetic practice.

INTRODUCTION TO MENTAL HEALTH, EATING DISORDERS AND LEARNING DISABILITIES UPDATED CONTENT!
Provider: British Dietetic Association
Date: 30 January
Venue: Virtual classroom
Facilitators: Caroline Frascina and Ellie Paterson
Details: The course is an introduction for dietitians new to the area of mental health, learning disabilities and eating disorders, with a very practical emphasis on improving skills and applying knowledge to increase confidence and decision-making in these clinical areas.

BDA Classroom prices	
BDA members	£155
Non-members	£215
Support workers (BDA members)	£140
Support workers (non-members)	£170

BEHAVIOUR CHANGE SKILLS PART 1 – PATIENT CENTRED SKILLS
Provider: Behaviour Change Training
Dates: 30 & 31 January
Venue: Online via Zoom
Cost: £495
Details: This course focuses on enhancing the communication skills essential for effective conversations about health.
How to book: bctonline.co.uk

FEBRUARY

INTRODUCTION TO DIETARY MANAGEMENT OF ADULTS WITH INFLAMMATORY BOWEL DISEASE
Provider: British Dietetic Association
Date: 3 February
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; be able to refer to current national and international guidelines/standards for the management of IBD.

MANAGEMENT OF CHRONIC KIDNEY DISEASE STAGES 3-5

Provider: British Dietetic Association
Date: 6 February
Venue: Virtual classroom
Facilitator: Fiona Willingham
Details: This course has been developed to help dietitians to 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. The day aims specifically to support the development of registered dietitians in the autonomous care and treatment of individuals diagnosed with CKD stages 3-5.

DIETETIC SUPPORT WORKER – ENHANCING COMMUNICATION SKILLS IN PRACTICE

Provider: British Dietetic Association
Date: 8 February
Venue: Virtual classroom
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.

ADVANCED DIETETICS IN EATING DISORDERS (TWO-DAY COURSE)

Provider: British Dietetic Association
Date: 23 & 24 February
Venue: BDA office, Birmingham
Facilitators: Lisa Waldron and Stephanie Sloan
Cost: BDA member £280, non-member £390
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. This course is aimed at dietitians new to eating disorders who need more depth than the BDA Introduction to Mental Health, Learning Disabilities and Eating Disorders course or dietitians wanting to specialise in or who have an interest in eating disorders.

INTRODUCTION TO CRITICAL CARE DIETETICS NEW COURSE!

Provider: British Dietetic Association
Date: 28 February
Venue: BDA office, Birmingham
Facilitator: TBC
Details: Are you new(ish) to ICU dietetics? Then this could be the course for you. The BDA Critical Care Specialist Group has developed the Introduction to Critical Care Dietetics to support foundational level learning. The course aims to improve your awareness of the dietetic and physiological principles that are essential to working in the critical care setting, whilst supporting you to develop the confidence required to autonomously work in this environment. The course will involve some pre-course learning hosted in the BDA Learning Zone followed by an interactive face-to-face study day where you will learn amongst peers as you work your way through a number of critical care scenarios, enabling you to practically apply the knowledge learnt in the pre-coursework and further develop your network of ICU colleagues.

The course is aimed at those new to working in critical care, especially those working in isolation without a team of critical care dietitians to support them. It is aimed primarily at bands 6 and 7 who have just moved into the specialism of critical care or are having to provide clinical cover to this area. They will be working in the area but not experienced.

This course is also running online on 14 March 2023.

APRIL

INTRODUCING THE PRINCIPLES AND PRACTICE OF BEHAVIOUR CHANGE

Provider: British Dietetic Association
Date: 25 April
Venue: BDA office, Birmingham
Facilitator: Dr Kirsten Whitehead
Details: To introduce the concept of behaviour change with delegates beginning to develop the knowledge and skills required to use strategies as tools in communication with patients and to ensure a service user-centred approach.

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bda.uk.com/calendar

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