

# BAPEN & MAG

Dr Simon Gabe  
BAPEN President

# BAPEN opening symposium

BAPEN activities

MAG & its impact  
over the past 20  
years

How good is  
nutritional care in  
your organisation?



# Activities

- Ailsa Brotherton  
Leading
- Health Foundation grant
- Regional events (ONCA),  
in North, Midlands,  
South & London

Nutritional care  
tool



- BIFA active
  - Position statement
- NG SIG developed

Special interest  
Groups



- Reforming: 3 themes
  - Malnutrition science
  - Must licensing
  - Quality &  
implementation

MAG



- VLE portal expanded  
but underutilised

eLearning



- Launching at BAPEN

IF Registry



- MTF
- ONCA

Policy &  
awareness



# BAPEN Nutritional Care



The intention behind the Health and Social Care Act 2012, Regulation 14 is to "make sure that people have hydration to sustain life and good health and reduce the risk that they receive care and treatment." To demonstrate their role, provider organisations "must do what is necessary to meet their nutrition and hydration needs, including the delivery of everyday routine care, this means that assessment and food must be provided to meet those nutritional supplements and/or parenteral nutrition."

In evaluating the quality of care provided, developed, tested and implemented a new instrument to measure than 150 different sets of data on NHS Trusts. The staff, patient surveys, mortality rates, hospital performance and infection rates.

This article outlines the development of a measurement tool for organisations to measure at a local level, and how it is provided and identify areas for improvements.

## Why there is a need for a nutritional care measurement tool

There has been a widespread recognition of the prevalence of malnutrition for a number of years, which has resulted in the publication of a plethora of standards and guidelines. Concerns regarding the quality of nutritional care led the CQC to undertake themed inspections (dignity and nutrition) in 2011-12, which highlighted shortfalls in care. Despite these efforts, there continues to be widespread failure to deliver system wide quality improvements in nutritional care across acute, community and care home settings, with the exception of small pockets of excellent practice.

Even though the UK is one of the leading countries in tackling malnutrition, actual measurement of nutritional care delivered has lagged behind other areas of care in the NHS, such as venous thromboembolism, cancer and diabetes. On a national scale, work

## BAPEN Wins Health Foundation Grant



## BAPEN Wins a Health Foundation Grant for Improvements in



Dr Ailsa Brotherton, Chair of the BAPEN Quality & Safety Committee, and Quality Observatory

BAPEN has been awarded £28,000 from the Health Foundation to improve nutritional care. The project will be led by Ailsa Brotherton (BAPEN Quality Fellow) and Kate Cheema, and will aim to improve the delivery of nutritional care.

### Why is this project important?

Every provider organisation is required by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Regulation 14) to make sure the individuals in care have enough to eat and drink to meet their nutrition and hydration needs and receive the support they need to do so. Individuals "must have their nutritional needs assessed and food must be provided to meet those needs. This includes where people are prescribed nutritional supplements and/or parenteral nutrition." (Source: CQC website).

7 | In South No. 30, February 2015.



## Improving the Management of Malnutrition

Nutrition screening and care



Dr Ailsa Brotherton, Chair of the BAPEN Quality & Safety Committee - www.bapen.org.uk

I stared at the words of the text message: 7/11

Three million people are malnourished in England. Around £19.6 billion per year in England! Around 10% of people according to BAPEN's National Screening. We require assistance to eat and drink. Thirty% need it, which equates to 13 million people (64% of them are in our hospitals every year). BAPEN care, sometimes for prolonged periods of time, is needed to accept the rising economic impact.

In this context, how do we create a culture where patients becomes the norm, a routine part of patient care? The problem of malnutrition for more than two decades and literature for at least four decades and, frankly becoming. We need to do something different and, as such, of course it cannot be eliminated. Evidence that delivery of improvements in nutrition and harms whilst improving an individual's quality of life.

### Understanding the challenge

Delivery of good nutritional care is everyone's responsibility - not just carers, nurses, dietitians, doctors, managers and commissioners. Few would argue that it is not an important topic, it's a basic right to receive food and drink and whilst individual care and medical treatment there is an expectation that food and support to eat and drink will be provided for all. As it's not everyone's responsibility it makes it vulnerable to no one professional leading and adopting accountability for delivery. Of course, his professional recognise the importance and challenges of providing good nutritional care but a high level of ambivalence exists in solutions. Recognising that basic nutritional care is important at an academic level is easy. Prioritising oral feeding of sick patients every mealtime is not. In a recent survey of BAPEN, FRCGS members and CN readers (n=346), 95% of respondents recognised the importance of nutritional care and the importance of providing



## BAPEN Nutritional Care Tool

Introducing the NEW...

## BAPEN Nutritional Care Tool

BAPEN has designed and launched the first Nutritional Care Tool, which enables organisations to not only measure the nutritional care they provide but also robustly demonstrate both compliance to nutrition-related care regulations and recognise the areas where improvements are required.

### Why is there a need for a new nutritional care measurement tool?

Widespread recognition of the prevalence of malnutrition over a number of years has resulted in the publication of a number of standards and guidelines (e.g. NICE Guidance (2006) and NICE Quality Standards (2012)).

Concerns regarding the quality of nutritional care led the Care Quality Commission (CQC) to undertake themed inspections (dignity and nutrition) in 2011-12 that highlighted shortfalls in care. Despite these efforts, there continues to be widespread failure to deliver system wide quality improvements in nutritional care across acute, community and care home settings, with the exception of small pockets of excellent practice.

Even though the UK is one of the leading countries in tackling malnutrition, the measurement of nutritional care has lagged behind other areas (such as VTE and cancer) in the NHS. Work on a national scale has largely been limited to the measurement of the prevalence of malnutrition (during the



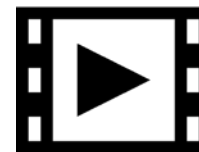
National Nutritional Screening Week) and although the Hospital Episode Statistics (HES) dataset contains a primary and secondary diagnosis code for malnutrition, it is rarely used and so cannot be adopted in an intelligent monitoring model. Although many Trusts are now regularly auditing nutritional screening practices, very few are auditing the quality of nutritional care delivered and, where such audits have taken place, it has been reported that many individuals who are at nutritional risk do not receive appropriate levels of additional nutritional care.

### What are the benefits of adopting the BAPEN Nutritional Care Tool?

How robust is the current level of assurance in your organisation? The questions outlined in Figure One are provided by BAPEN for Directors of Nursing and Trust Boards to help improve the level of assurance they see regarding the quality of nutritional care they provide (See Figure One).

Figure One: Questions to help the level of care provided

1. How much weight are patients losing in our care?
2. Do we measure weight changes in our patients?
3. How is our organisation currently assured that we are meeting the required standards for nutritional care?
4. How accurately is nutritional screening completed?
5. Are we recording the level of support given to patients who require assistance to eat and drink?
6. How well are our fluid and food record charts completed?
7. Where is the variation in the care we provide? Which wards in our Trust deliver good nutritional care and which ones require improvements?
8. Are we an outlier (positive or negative) for the quality of nutritional care we provide?



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- Health Foundation grant
- Regional events (ONCA),  
in Midlands, South &  
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Nutritional care  
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Policy &  
awareness



# Special interest groups (SIG)

## MDT group

Particular interest & expertise in an area of nutrition support

## Aim

Develop educational programs, tools, protocols, policies

## What topics?

- Suggestions from you
- Need to gauge the need

## Get involved

- Suggestions
- Volunteers



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# King's Fund Centre Working Party

Ivan Johnsto   Mike Nielson   Simon Allison   Marinos Elia   Ken Cottam   Peter Milla   John Lennard Jones   Tim Sizer   David Silk



Pat Wright   Suzanne Wood   Pat Howard   Christine Russell   Chris Holden   Carolyn Wheatley

1991



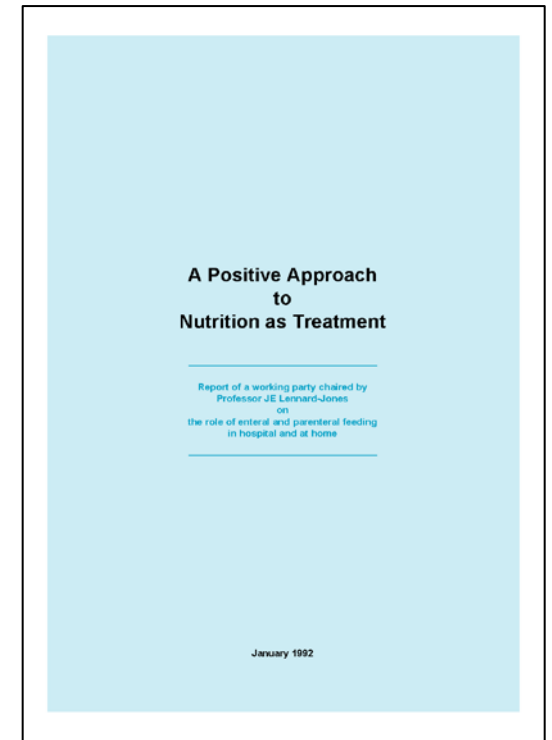
1991

- Kings Fund working party



1992

- Kings Fund report

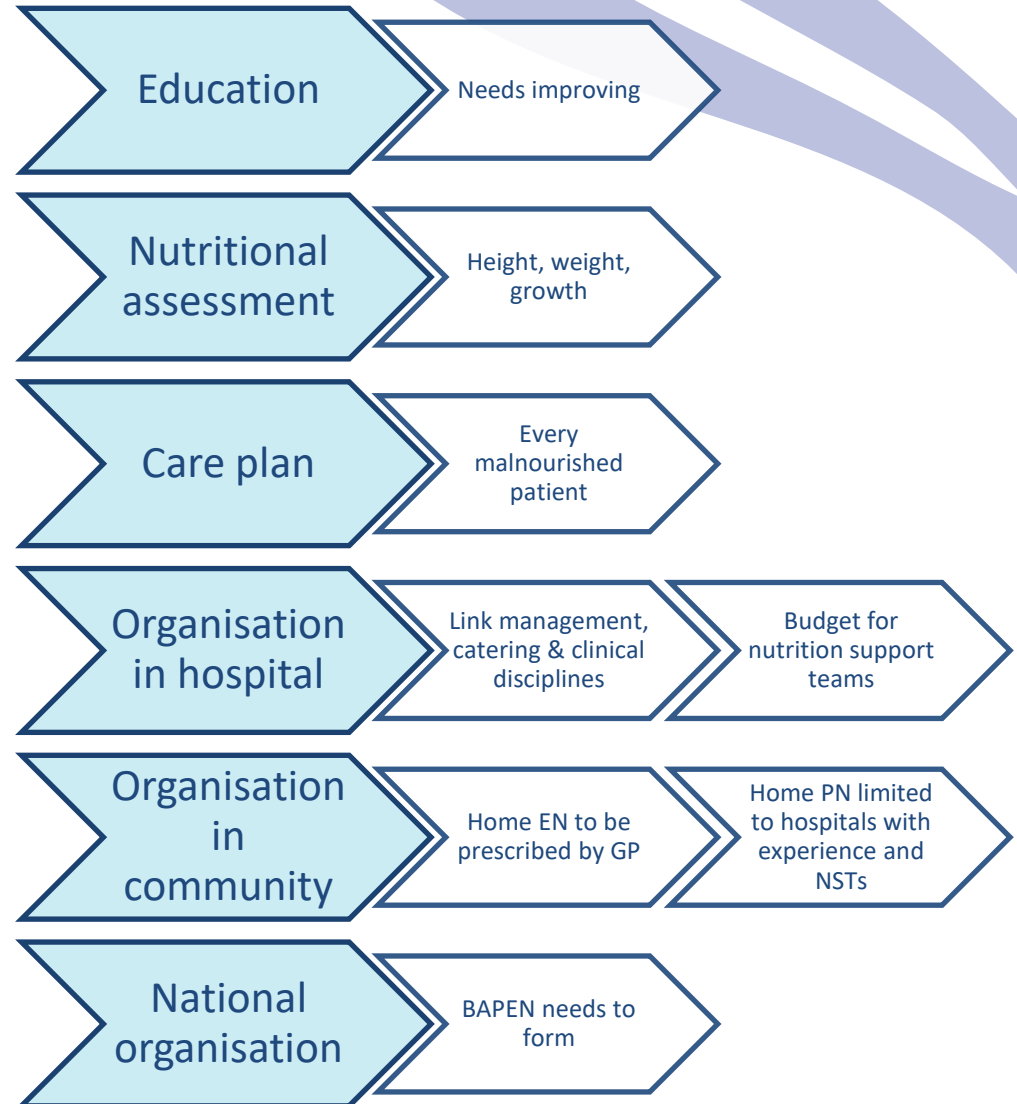


# Aims & recommendations

## A Positive Approach to Nutrition as Treatment

Report of a working party chaired by  
Professor JE Lennard-Jones  
on  
the role of enteral and parenteral feeding  
in hospital and at home

January 1992





1991

- Kings Fund working party

1992

- Kings Fund report





1991

- Kings Fund working party

1992

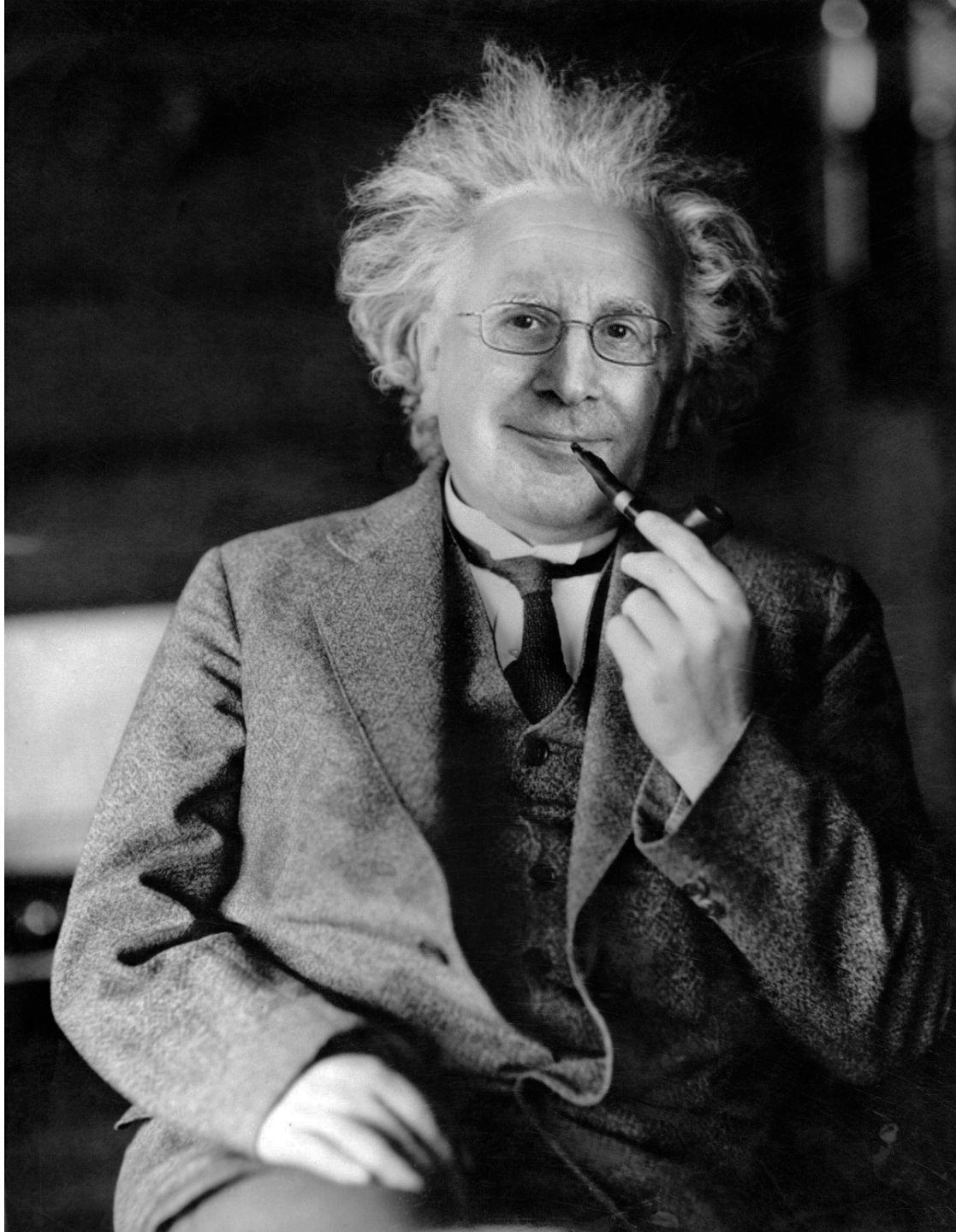
- Kings Fund report

1998

- MAG formed

**MAG**

Malnutrition Advisory Group  
A Standing Committee of BAPEN



Elia

# Malnutrition Advisory Group (MAG)

Why?

- Malnutrition in the community: not identified & ONS not prescribed

Goal

- Improve detection of malnutrition
- Develop a screening tool for the community

# The MAG Screening Tool

**MAG**  
Malnutrition Advisory Group  
A Standing Committee of BAPEN

Guidelines for Detection and Management of Malnutrition

Dr Marinos Ella  
Chairman of MAG and Editor



**MAG**  
Malnutrition Advisory Group  
A Standing Committee of BAPEN

Explanatory Notes for the Screening Tool for Adults at Risk of Malnutrition



November 2000

**STEP 1** Perform assessment according to Items I, II and III and record below  
(Nurse, GP or health worker – see Explanatory Notes document for details)

**Item I** Body mass index (BMI)

Height (m)	Weight range (kg) for BMI (kg/m <sup>2</sup> ) category		
	A (<18.5)	B (18.5-20)	C (>20)
1.50	<16.8	16.8-21.2	>21.2
1.55	<18.1	18.1-20.8	>20.8
1.60	<19.7	19.7-20.2	>20.2
1.65	<21.3	21.3-20.2	>20.2
1.70	<23.0	23.0-19.2	>19.2
1.75	<24.7	24.7-18.2	>18.2
1.80	<26.4	26.4-17.2	>17.2
1.85	<28.1	28.1-16.2	>16.2
1.90	<29.8	29.8-15.2	>15.2
1.95	<31.5	31.5-14.2	>14.2
2.00	<33.2	33.2-13.2	>13.2
2.05	<34.9	34.9-12.2	>12.2
2.10	<36.6	36.6-11.2	>11.2
2.15	<38.3	38.3-10.2	>10.2
2.20	<40.0	40.0-9.2	>9.2
2.25	<41.7	41.7-8.2	>8.2
2.30	<43.4	43.4-7.2	>7.2
2.35	<45.1	45.1-6.2	>6.2
2.40	<46.8	46.8-5.2	>5.2
2.45	<48.5	48.5-4.2	>4.2
2.50	<50.2	50.2-3.2	>3.2
2.55	<51.9	51.9-2.2	>2.2
2.60	<53.6	53.6-1.2	>1.2
2.65	<55.3	55.3-0.2	>0.2
2.70	<57.0	57.0-0.2	>0.2
2.75	<58.7	58.7-0.2	>0.2
2.80	<60.4	60.4-0.2	>0.2
2.85	<62.1	62.1-0.2	>0.2
2.90	<63.8	63.8-0.2	>0.2
2.95	<65.5	65.5-0.2	>0.2
3.00	<67.2	67.2-0.2	>0.2

**Item II** (Unintentional weight loss in previous 3-6 months)

Body wt (kg) (before wt loss)	Weight loss category**		
	A (>10%)	B (5-10%)	C (<5%)
30	>3.0	3.0-4.5	<4.5
34	>3.4	3.4-4.6	<4.6
38	>3.8	3.8-4.7	<4.7
42	>4.2	4.2-4.8	<4.8
46	>4.6	4.6-4.9	<4.9
50	>5.0	5.0-5.1	<5.1
54	>5.4	5.4-5.2	<5.2
58	>5.8	5.8-5.2	<5.2
62	>6.2	6.2-5.2	<5.2
66	>6.6	6.6-5.2	<5.2
70	>7.0	7.0-5.2	<5.2
74	>7.4	7.4-5.2	<5.2
78	>7.8	7.8-5.2	<5.2
82	>8.2	8.2-5.2	<5.2
86	>8.6	8.6-5.2	<5.2
90	>9.0	9.0-5.2	<5.2
94	>9.4	9.4-5.2	<5.2
98	>9.8	9.8-5.2	<5.2
102	>10.2	10.2-5.2	<5.2

**Item III** Other factors

- History of decreased food intake, loss of appetite or dysphagia (and whether improving or deteriorating)
- Clothes and/or jewellery (e.g. rings on fingers) have become loose fitting (weight loss)
- Psychological and physical disabilities (active disease) likely to have contributed to weight loss

**NUTRITIONAL RISK CATEGORY:**

**STEP 2** Calculate overall risk category

Use BMI and weight loss category calculated in Step 1 to determine overall risk of malnutrition. If not possible to calculate either Item I or Item II, establish overall risk using Item III. Establish overall risk collectively using Item III alone.

BMI (kg/m <sup>2</sup> )	WEIGHT LOSS** (% over 3-6 months)		
	A	B	C
18.5-20	>10%	10-5%	<5% (or wt gain)

**High Risk:** A with B, B with C, or C with C. (or A with B, B with C, or C with C)

**Medium Risk:** A with C, or B with A.

**Low Risk:** C with A, or C with B.

**Patients Record**

Height (kg)	BMI (kg/m <sup>2</sup> )	% Weight loss	OVERALL RISK CATEGORY

**STEP 3** Management (See Explanatory Notes document for details)

- Set aims and goals
- Address underlying condition undernutrition (identifiable nutrient deficiencies and protein-energy combinations may be used)
  - Food
    - Availability (every attractive food of good nutritive value at and between meals)
    - Assistance (with shopping, cooking or eating)
    - Avoidance (home, dining clubs, organisations)
  - Supplements – additive to food
    - Used when food has been ineffective for over a month
    - Given when food has been ineffective for over a month
    - More effective in patients with BMI <20 kg/m<sup>2</sup>
    - Choice should include patient's acceptance of palatability/taste/flavour
  - Enteral tube feeding
    - Refer to dietitian or nutrition team
- Monitor effect of interventions and if appropriate revise aims and goals.

**MAG**  
Malnutrition Advisory Group  
A Standing Committee of BAPEN

# Malnutrition Action Group (MAG)

## The tool

- Launched in 2000
- Formed the basis of MUST
- Scoring system complicated

## 'MUST' developed

- The first tool formed steps 1 & 2
- Step 3 added for hospital patients



**BAPEN**  
Advancing Clinical Nutrition  
Reg. Charity No: 1023927

## THE 'MUST' REPORT

### Nutritional screening of adults: a multidisciplinary responsibility

Professor Marinos Elia  
Chairman of MAG and Editor



2003



## Step 1 + Step 2 + Step 3

**BMI score**      **Weight loss score**      **Acute disease effect score**

<p><b>BMI kg/m<sup>2</sup>      Score</b></p> <p>&gt;20 (&gt;30 Obese) = 0</p> <p>18.5-20 = 1</p> <p>&lt;18.5 = 2</p>	<p><b>Unplanned weight loss in past 3-6 months</b></p> <table border="1"> <tr> <th>%</th> <th>Score</th> </tr> <tr> <td>&lt;5</td> <td>= 0</td> </tr> <tr> <td>5-10</td> <td>= 1</td> </tr> <tr> <td>&gt;10</td> <td>= 2</td> </tr> </table>	%	Score	<5	= 0	5-10	= 1	>10	= 2	<p>If patient is acutely ill and there has been or is likely to be no nutritional intake for &gt;5 days</p> <p><b>Score 2</b></p>
%	Score									
<5	= 0									
5-10	= 1									
>10	= 2									

*If unable to obtain height and weight, see reverse for alternative measurements and use of subjective criteria*

*Acute disease effect is unlikely to apply outside hospital. See 'MUST' Explanatory Booklet for further information*

### Step 4

#### Overall risk of malnutrition

Add Scores together to calculate overall risk of malnutrition  
Score 0 Low Risk    Score 1 Medium Risk    Score 2 or more High Risk

### Step 5

#### Management guidelines

<p><b>0 Low Risk</b></p> <p><b>Routine clinical care</b></p> <ul style="list-style-type: none"> <li>Repeat screening           <ul style="list-style-type: none"> <li>Hospital – weekly</li> <li>Care Homes – monthly</li> <li>Community – annually for special groups e.g. those &gt;75 yrs</li> </ul> </li> </ul>	<p><b>1 Medium Risk</b></p> <p><b>Observe</b></p> <ul style="list-style-type: none"> <li>Document dietary intake for 3 days</li> <li>If adequate – little concern and repeat screening           <ul style="list-style-type: none"> <li>Hospital – weekly</li> <li>Care Home – at least monthly</li> <li>Community – at least every 2-3 months</li> </ul> </li> <li>If inadequate – clinical concern – follow local policy, set goals, improve and increase overall nutritional intake, monitor and review care plan regularly</li> </ul>	<p><b>2 or more High Risk</b></p> <p><b>Treat*</b></p> <ul style="list-style-type: none"> <li>Refer to dietician, Nutritional Support Team or implement local policy</li> <li>Set goals, improve and increase overall nutritional intake</li> <li>Monitor and review care plan           <ul style="list-style-type: none"> <li>Hospital – weekly</li> <li>Care Home – monthly</li> <li>Community – monthly</li> </ul> </li> </ul> <p><small>* Unless detrimental or no benefit is expected from nutritional support e.g. imminent death.</small></p>
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**All risk categories:**

- Treat underlying condition and provide help and advice on food choices, eating and drinking when necessary.
- Record malnutrition risk category.
- Record need for special diets and follow local policy.

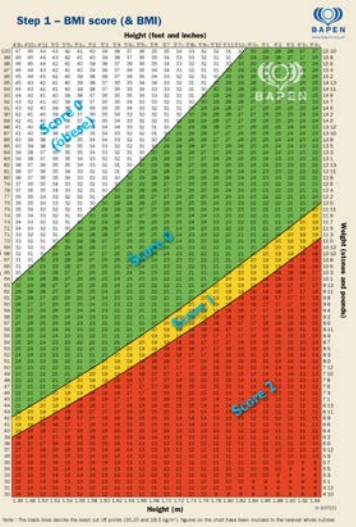
**Obesity:**

- Record presence of obesity. For those with underlying conditions, these are generally controlled before the treatment of obesity.

Re-assess subjects identified at risk as they move through care settings

See The 'MUST' Explanatory Booklet for further details and The 'MUST' Report for supporting evidence.

# 'MUST': accessories



**Step 2 - Weight loss score**

KILOGRAMS				STONES AND POUNDS			
Score 0	Score 1	Score 2	Set point	Score 0	Score 1	Score 2	Set point
< 5%	5-10%	> 10%	kg	< 5%	5-10%	> 10%	st/lb
Weight loss in last 3 to 6 months				Weight loss in last 3 to 6 months			
kg	Less than 5kg	Between 5kg and 10kg	More than 10kg	st/lb	Less than 10st	Between 10st and 20st	More than 20st
30	1.6-3.3	3.4-6.7	6.8	4.0	0.9-0.7	0.8	0.8
31	1.6-3.4	3.4	4.2	0.4	0.4-0.9	0.8	0.8
32	1.7-3.6	3.6	5.1	0.4	0.4-0.8	0.8	0.8
33	1.7-3.7	3.7	5.3	0.4	0.4-0.8	0.8	0.8
34	1.8-3.8	3.8	5.5	0.4	0.4-0.8	0.8	0.8
35	1.8-3.9	3.9	5.7	0.4	0.4-0.9	0.8	0.8
36	1.9-4.0	4.0	5.9	0.4	0.4-0.9	0.8	0.8
37	1.9-4.1	4.1	6.1	0.4	0.4-0.9	0.8	0.8
38	2.0-4.2	4.2	6.3	0.4	0.4-0.9	0.8	0.8
39	2.1-4.3	4.3	6.5	0.4	0.5-0.10	0.9	0.9
40	2.1-4.4	4.4	6.7	0.4	0.5-0.10	0.9	0.9
41	2.2-4.6	4.6	6.9	0.5	0.5-0.10	0.9	0.9
42	2.2-4.7	4.7	7.1	0.5	0.5-0.11	0.9	0.9
43	2.3-4.8	4.8	7.3	0.5	0.5-0.11	0.9	0.9
44	2.3-4.9	4.9	7.5	0.5	0.5-0.11	0.9	0.9
45	2.4-5.0	5.0	7.7	0.5	0.5-0.11	0.9	0.9
46	2.4-5.1	5.1	7.9	0.5	0.5-0.11	0.9	0.9
47	2.5-5.2	5.2	8.1	0.5	0.5-0.12	0.9	0.9
48	2.5-5.3	5.3	8.3	0.6	0.6-0.12	0.9	0.9
49	2.6-5.4	5.4	8.5	0.6	0.6-0.12	0.9	0.9
50	2.6-5.6	5.6	8.7	0.6	0.6-0.13	0.9	0.9
51	2.7-5.7	5.7	8.9	0.6	0.6-0.13	0.9	0.9
52	2.7-5.8	5.8	9.1	0.6	0.6-0.13	0.9	0.9
53	2.8-5.9	5.9	9.3	0.6	0.6-0.13	0.9	0.9
54	2.8-6.0	6.0	9.5	0.6	0.6-0.13	0.9	0.9
55	2.9-6.1	6.1	9.7	0.6	0.6-0.13	0.9	0.9
56	2.9-6.2	6.2	9.9	0.6	0.6-0.13	0.9	0.9
57	3.0-6.3	6.3	10.1	0.7	0.7-1.1	1.0	1.0
58	3.1-6.4	6.4	10.3	0.7	0.7-1.1	1.0	1.0
59	3.1-6.6	6.6	10.5	0.7	0.7-1.1	1.0	1.0
60	3.2-6.7	6.7	10.7	0.7	0.7-1.1	1.0	1.0
61	3.2-6.8	6.8	10.9	0.7	0.7-1.1	1.0	1.0
62	3.3-6.9	6.9	11.1	0.7	0.7-1.1	1.0	1.0
63	3.3-7.0	7.0	11.3	0.7	0.7-1.1	1.0	1.0
64	3.4-7.1	7.1	11.5	0.7	0.7-1.2	1.0	1.0

**Alternative measurements: instructions and tables**

If height cannot be obtained, use length of forearm (mid) to calculate height using tables below. (See the 'MUST' Explanatory Booklet for details of other alternative measurements (knee height and armspan) that can also be used to estimate height).

**Estimating height from olecranon length**

Measure between the point of the elbow (olecranon process) and the midpoint of the pronator (base of the 5th metacarpal process) (at least if possible).

Age group	Male (cm)	Female (cm)	Male (in)	Female (in)
10-14 years	1.47-1.51	1.47-1.51	5.8-6.0	5.8-6.0
15-19 years	1.51-1.55	1.51-1.55	5.9-6.1	5.9-6.1
20-24 years	1.55-1.59	1.55-1.59	6.1-6.3	6.1-6.3
25-29 years	1.59-1.63	1.59-1.63	6.3-6.5	6.3-6.5
30-34 years	1.63-1.67	1.63-1.67	6.4-6.6	6.4-6.6
35-39 years	1.67-1.71	1.67-1.71	6.6-6.8	6.6-6.8
40-44 years	1.71-1.75	1.71-1.75	6.7-7.0	6.7-7.0
45-49 years	1.75-1.79	1.75-1.79	6.9-7.1	6.9-7.1
50-54 years	1.79-1.83	1.79-1.83	7.0-7.3	7.0-7.3
55-59 years	1.83-1.87	1.83-1.87	7.2-7.4	7.2-7.4
60-64 years	1.87-1.91	1.87-1.91	7.4-7.6	7.4-7.6
65-69 years	1.91-1.95	1.91-1.95	7.5-7.7	7.5-7.7
70-74 years	1.95-1.99	1.95-1.99	7.7-7.9	7.7-7.9
75-79 years	1.99-2.03	1.99-2.03	7.8-8.0	7.8-8.0
80-84 years	2.03-2.07	2.03-2.07	8.0-8.2	8.0-8.2
85-89 years	2.07-2.11	2.07-2.11	8.1-8.3	8.1-8.3
90-94 years	2.11-2.15	2.11-2.15	8.3-8.5	8.3-8.5
95-99 years	2.15-2.19	2.15-2.19	8.5-8.7	8.5-8.7
100 years	2.19-2.23	2.19-2.23	8.6-8.8	8.6-8.8

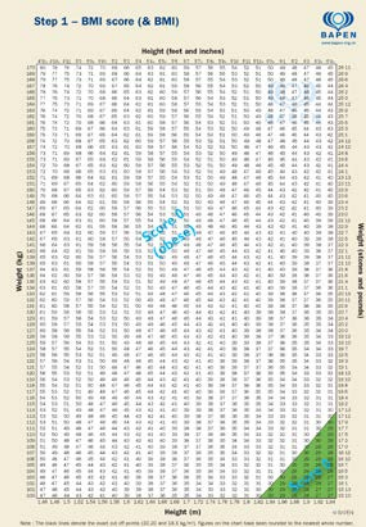
**Estimating BMI categories from mid upper arm circumference (MUAC)**

The subject's left arm should be held at the elbow at a 90 degree angle, with the upper arm held parallel to the side of the body. Measure the distance between the bony protrusion on the shoulder (acromion) and the point of the elbow (olecranon process). Mark the midpoint.

Ask the subject to lift arm hang loose and measure around the upper arm at the midpoint, making sure that the tape measure is snug but not tight.

If MUAC is <23.5 cm, BMI is likely to be <20 kg/m<sup>2</sup>.  
If MUAC is <32.0 cm, BMI is likely to be <30 kg/m<sup>2</sup>.

The use of MUAC provides a general indication of BMI and is not designed to generate an actual score for use with 'MUST'. For further information on use of MUAC please refer to the 'MUST' Explanatory Booklet.



## 'MUST' Calculator

The 'MUST' calculator can be used to establish nutritional risk using either objective measurements to obtain a score and a risk category or subjective criteria to estimate a risk category but not a score.



Please select which method of nutritional screening is to be used:

**Objective Measurements**

Complete all relevant fields and your results will automatically appear below. [Clear all values](#)

Current weight (Imperial)  st  lb [Imperial](#) [Metric](#)

Current height (Imperial)  ft  in [Imperial](#) [Metric](#)

Weight 3-6 months ago (Imperial)  st  lb [Imperial](#) [Metric](#)

Acute disease effect (ADE)\*\*  ADE  **\*\*Acute Disease Effect (ADE) - select yes if acutely ill and if there has been or is likely to be no nutritional intake for more than 5 days. Note that ADE is unlikely to occur outside hospital.**

# MUST App



	Territory	Units
1	● Europe	4.16K
2	● USA and Canada	257
3	● Asia Pacific	244
4	● Latin America and The Caribbean	124
5	● Africa, The Middle East, and India	45

# 'MUST' UK reach

## Supported by NICE

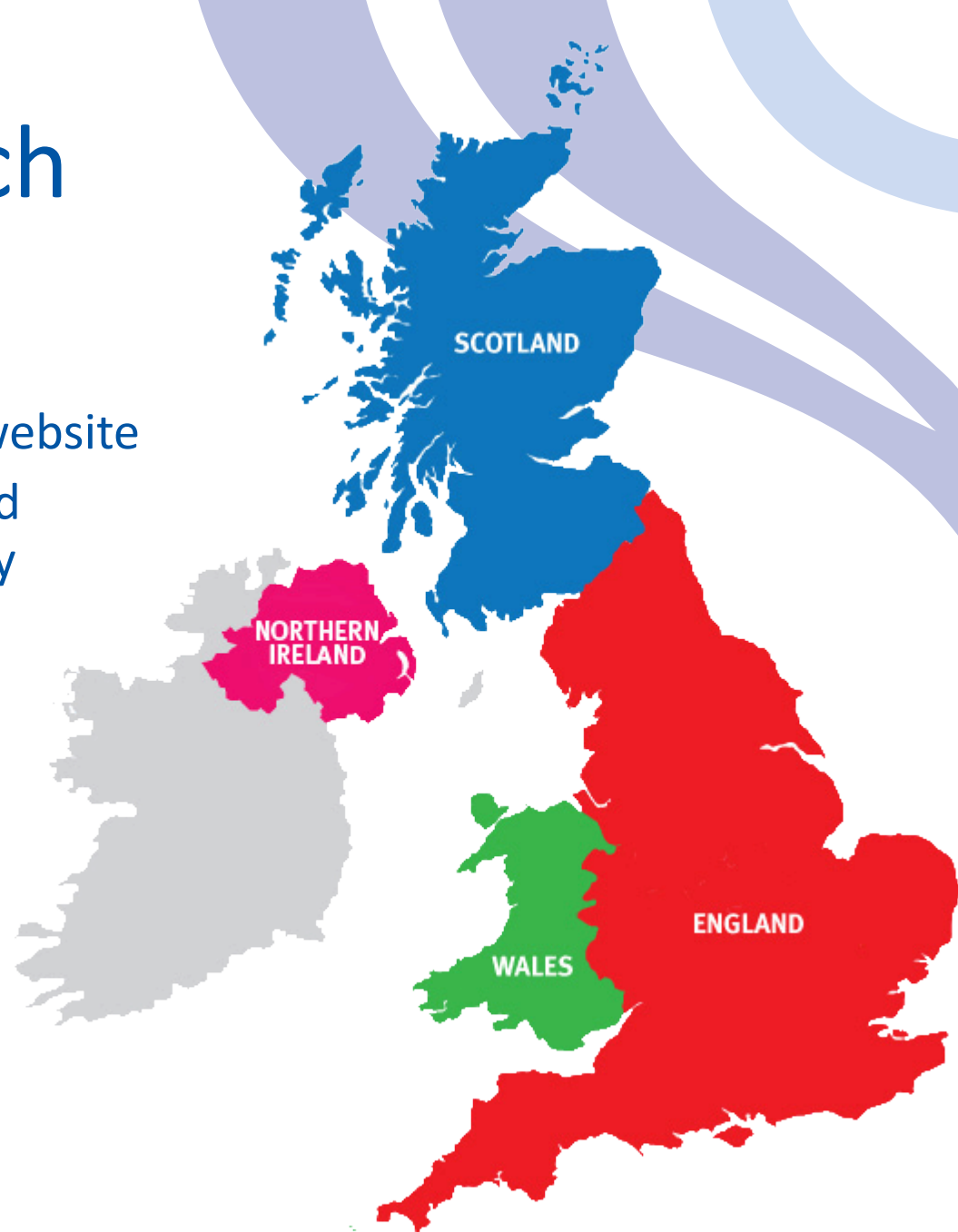
- Link to eLearning on NICE website
- Example of a resource to aid implementation of a Quality Standard

## National guidelines

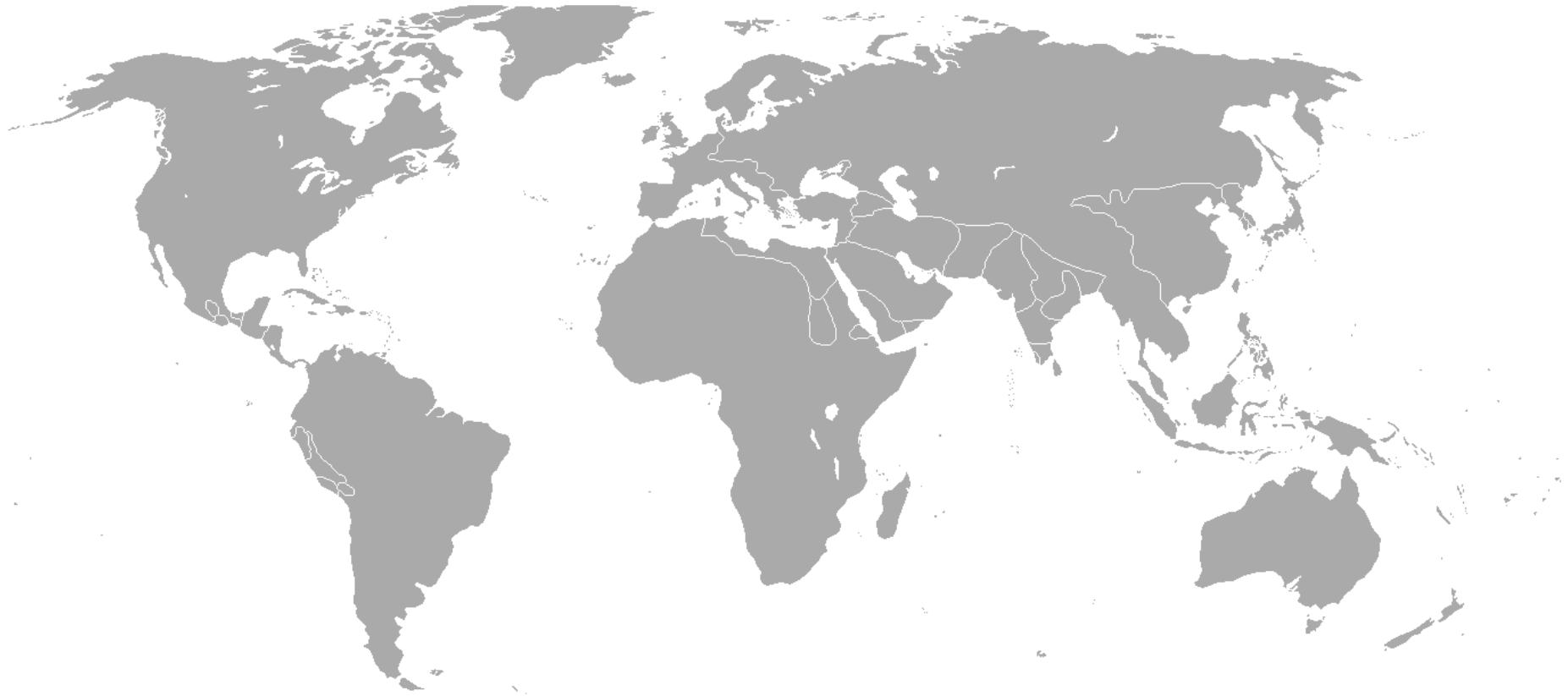
- For all 4 nations

## Primary screening tool

- 85% hospitals
- 92% care homes
- 75% mental health units



# 'MUST' global reach



'MUST' materials are available in the following languages:



French



German



Italian



Portugese



Spanish

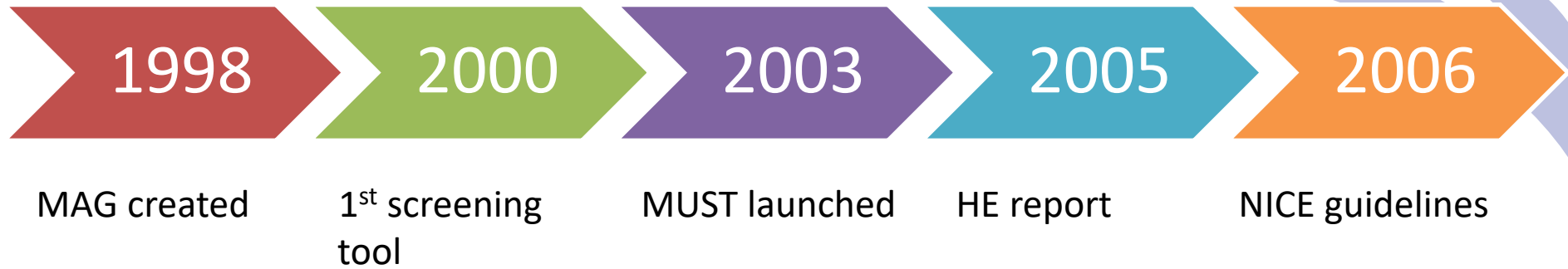


Chinese



Arabic

# MAG timeline



# Cost of malnutrition

> £7.3 billion / year  
More than obesity

But...

- No government policy focus
- No allocation of resources



BAPEN

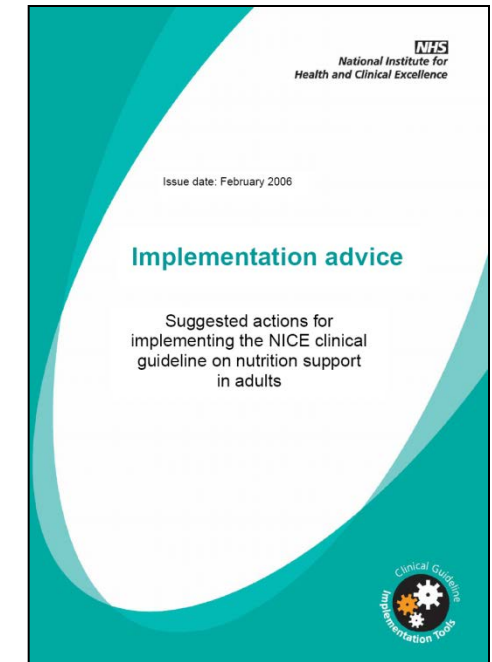
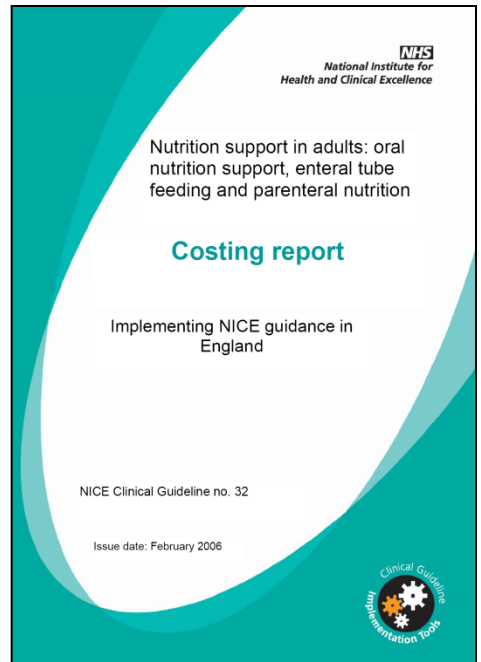
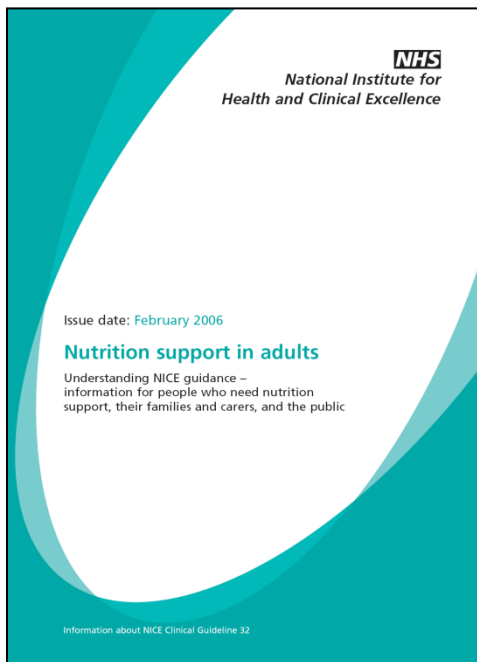
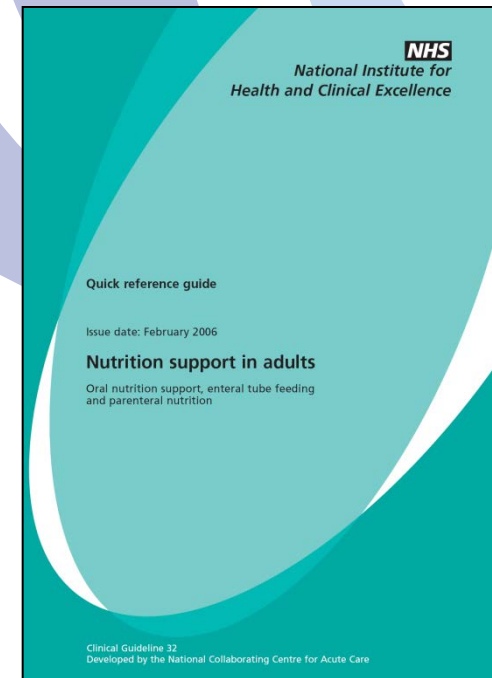
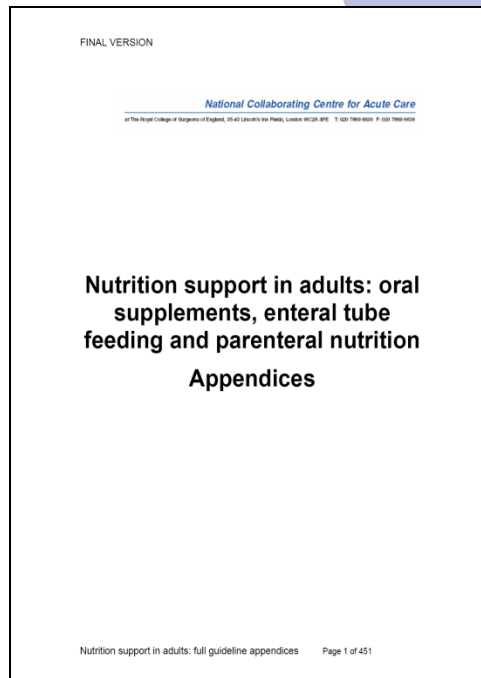
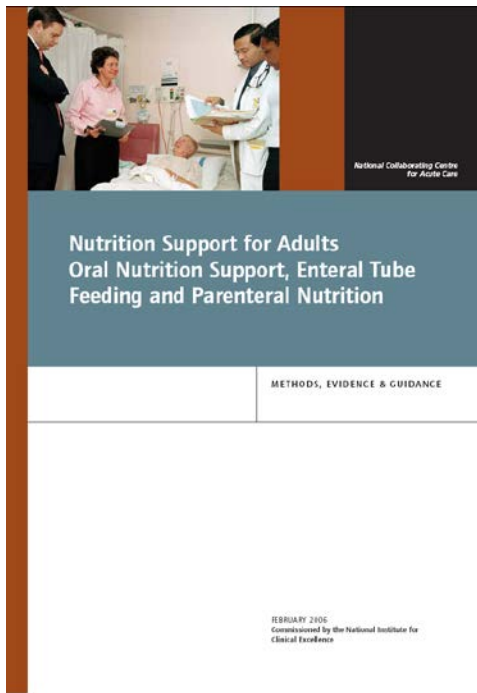
Advancing Clinical Nutrition

BAPEN

Advancing Clinical Nutrition

**The cost of disease-related malnutrition in the UK and economic considerations for the use of oral nutritional supplements (ONS) in adults**

M. Elia (Chairman & Editor)  
R. Stratton, C. Russell, C. Green, F. Pan





Before I really, really retire  
I would love to see a  
nutrition week in the UK

# 2007

## Malnutrition prevalence

- affects almost 1 in 3 subjects
- all ages
- Mainly originates in the community

## High risk

- admission to hospital and care homes
- admission from another care setting

## Screening

- Nutritional screening policies and practice varied between and within healthcare settings



**BAPEN**

Advancing Clinical Nutrition

## **NUTRITION SCREENING SURVEY IN THE UK IN 2007**

A Report by BAPEN  
British Association for Parenteral and Enteral Nutrition

**Nutrition Screening Survey and Audit  
of Adults on Admission to  
Hospitals, Care Homes and Mental Health Units**

MAIN DATA COLLECTION: 25 -27 SEPTEMBER, 2007

CA Russell and M Elia  
on behalf of BAPEN and collaborators

# 2008

## Malnutrition prevalence

- As before: affects almost 1 in 3 subjects

## High risk

- Not all hospitals or mental health units 'handing on' nutrition information on patients at malnutrition risk on discharge

## Screening

- Many hospitals, care homes and mental health units not calibrating scales for weighing regularly in contravention of a DH alert



**BAPEN**

Advancing Clinical Nutrition

## NUTRITION SCREENING SURVEY IN THE UK IN 2008

**HOSPITALS, CARE HOMES AND MENTAL HEALTH UNITS**

NUTRITION SCREENING WEEK SURVEY AND AUDIT  
(MAIN DATA COLLECTION: 1-3 JULY, 2008)

A report by the British Association for Parenteral and Enteral Nutrition (BAPEN)

C A Russell and M Elia  
on behalf of BAPEN and collaborators

# 2010

## Malnutrition prevalence

- Higher than in previous surveys

## High risk

- >1 in 3 admitted to hospital at risk
- >1 in 3 admitted to care homes at risk
- >1 in 5 admitted to mental health units

## Screening

- BAPEN's 'MUST' most commonly used screening tool by participating centres
- Republic of Ireland included



**BAPEN**  
Advancing Clinical Nutrition

## NUTRITION SCREENING SURVEY IN THE UK AND REPUBLIC OF IRELAND IN 2010

A Report by the  
British Association for Parenteral and Enteral Nutrition (BAPEN)

**HOSPITALS, CARE HOMES AND MENTAL HEALTH UNITS**

NUTRITION SCREENING WEEK SURVEY AND AUDIT  
(MAIN DATA COLLECTION: 12-14 January 2010)

C A Russell and M Elia  
on behalf of BAPEN and collaborators

# 2011

## Malnutrition prevalence

- 1 in 4 adults on admission to hospitals
- 1 in 3 adults admitted to care homes
- 1 in 5 adults on admission to mental health units

## High risk

- Most affected were high risk
- Nutritional screening policies & practices vary between and within health-care settings
- Continuing lack of awareness of standards relating to weighing scales

## Screening

- 'MUST' is the most commonly used nutritional screening tool in all care settings.
- 85% hospitals
- 92% care homes
- 75% mental health units



**BAPEN**

Advancing Clinical Nutrition

## NUTRITION SCREENING SURVEY IN THE UK AND REPUBLIC OF IRELAND IN 2011

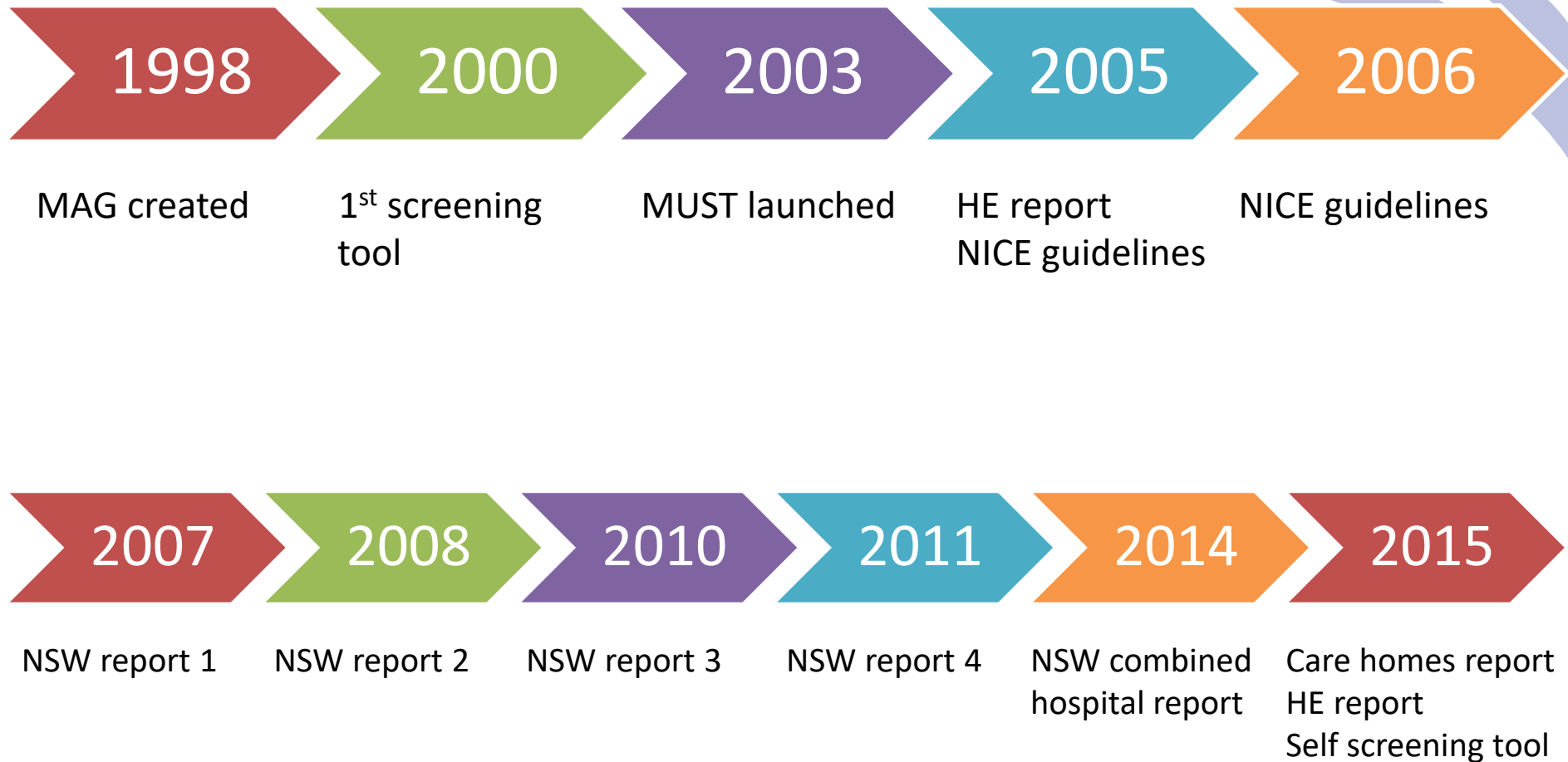
A Report by the  
British Association for Parenteral and Enteral Nutrition (BAPEN)

### HOSPITALS, CARE HOMES AND MENTAL HEALTH UNITS

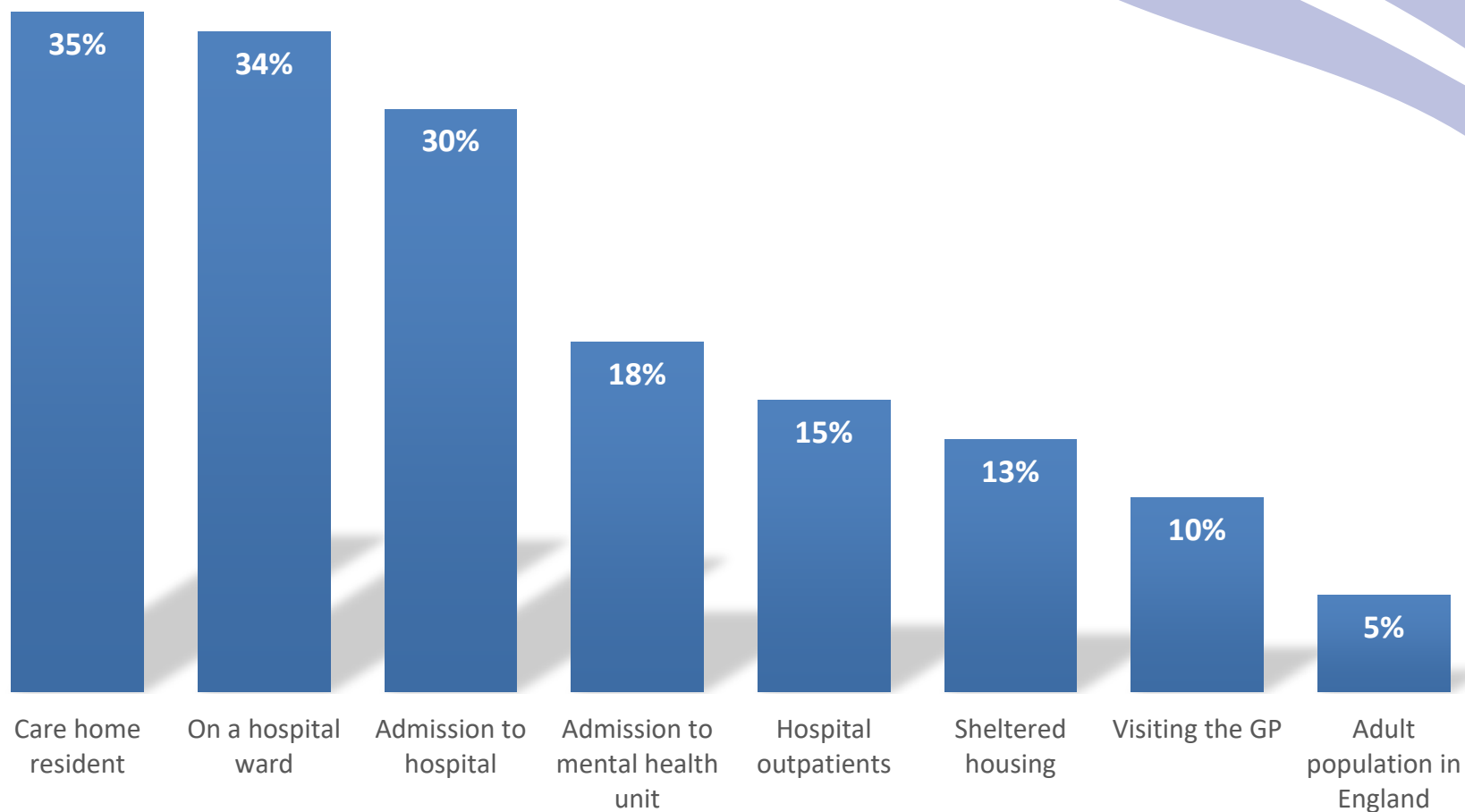
NUTRITION SCREENING WEEK SURVEY AND AUDIT  
(MAIN DATA COLLECTION: 5-7 April 2011)

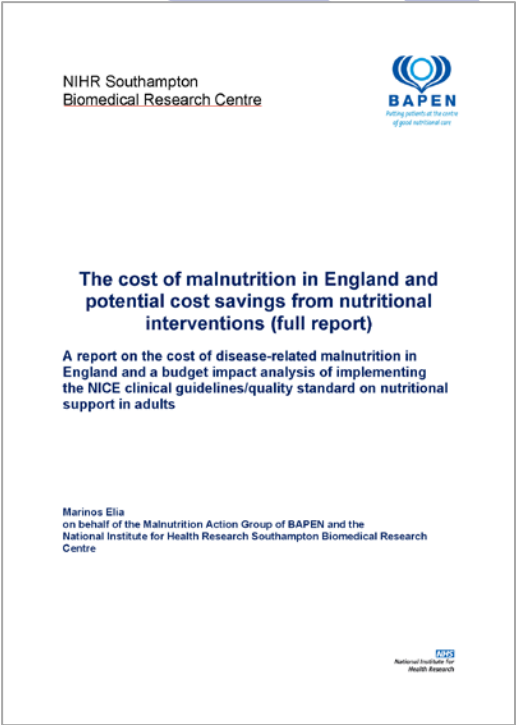
C A Russell and M Elia  
on behalf of BAPEN and collaborators

# MAG timeline



# Malnutrition is a common problem





# Self screening

**BAPEN** Putting patients at the centre of good nutritional care

Home About Us Self-Screening About Malnutrition Health Care Professionals

## Welcome to the BAPEN Malnutrition Self-Screening website

You will probably have found our website because you, a member of your family or someone you care for are worried about your weight because of unexplained weight loss or are experiencing a loss of appetite/poor appetite and not eating well.

During illness, we often don't feel like eating as much as usual and can lose weight unintentionally as a result. Maintaining weight or minimising weight loss when you're unwell can help you cope with any treatment you might be having, keep up your strength to undertake everyday activities and help you recover more quickly.

*NB this site is intended for adult self-screening only.*

[Learn More](#)

## Drivers

- Identified need to screen individuals earlier
- Empowering patients (DoH)

## Collaborative work

- Liaison with Royal Colleges & professional groups
- Carer UK support

# Prof Marinos Elia

BANS Chair

MAG Chair

John Lennard Jones medal, 2003

BAPEN Chairman, 2005-8

Development of 'MUST'

- Innovation Award (Health Business Awards), 2008

MNI ESPEN award (fighting malnutrition), 2008

Numerous BAPEN publications

Cost of malnutrition (economic) reports

Pennington lecture, 2012

BAPEN Faculty



# Christine Russell

BANS committee, 1995

BAPEN Council

BAPEN Exec, 2005-8

BAPEN Treasurer, 2005-8

John Lennard Jones medal, 2005

NSW reports, 2007, 2008, 2010, 2011, 2016

MNI ESPEN award, 2008

Combating Malnutrition: Recommendations for Action, 2009

'MUST' implementation

Sheltered housing and other reports

Development of eLearning

Pennington lecture, 2012

Chair of BAPEN Faculty, 2011-16



# The spirit of BAPEN ...



# The spirit of BAPEN ...





# BAPEN opening symposium

BAPEN activities

MAG & its impact  
over the past 20  
years

How good is  
nutritional care in  
your organisation?



# How good is nutritional care in your organisation?

Interactive session with expert panel

Twitter feed / text / app for live questions

Julie MacDonald facilitating

